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BY MICHAEL F. CHILTON

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M. F. Chilton

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Bibliography.
This thesis began as a study of the Hospitals and Charitable Institutions Act of 1885, which provided an interesting example of colonial legislation in the 1880s. It seemed to be a significant piece of legislation and at least one authority considered it '...the most important act in the history of New Zealand hospitals.' Further investigation, however, revealed that there was little background material available on the subject. A cursory study of primary material indicated the possibility of a detailed survey of colonial hospitals and charitable aid. Thus a political investigation expanded into a study of the social, economic and political aspects of hospitals and charitable aid in New Zealand from 1877 to 1892, with particular emphasis on the crucial period between the abolition of the provinces and the passage of the 1885 Act.

The year 1877 was chosen as a starting point because at this time the central government assumed full responsibility for hospitals and charitable aid and brought down the first colonial bill on the subject. The year 1892 was selected as a concluding date because, in his report of that year, the Inspector of hospitals and charitable institutions for the first time felt able to comment extensively on the operation of the Hospitals and Charitable Institutions Act. It could be inferred that he considered the new system to be in reasonably full working order, thus closing a period of foundation. Moreover, it was in the early 1890s that the Parliament and public of New Zealand showed less interest in hospitals and charitable aid as such, than in the previous decade. Because of the nature of the subject, a combination of the thematic and chronological techniques has been employed.

Important source material was found in manuscripts deposited in the National Archives and in the annual hospital reports, parliamentary debates and contemporary newspapers. Secondary sources proved useful for particular aspects of hospitals and charitable aid, or as general background material.

Among the difficulties encountered, the paucity of primary material on hospitals prior to 1881 and on charitable aid throughout the whole period, were the most frustrating. Although the primary sources were generally reliable, a few proved to be of suspect quality.
An example of this was provided by an 1877 questionnaire, which asked hospitals their average weekly number of inmates. Most hospitals divided their total number of patients by 52 or made an estimate. The return for Napier was extraordinarily high. The reason for this might have eluded a researcher but for the footnote fortunately appended:

'The number of patients in the institution is about 14 daily which multiplied by 7 will give 98 weekly.'

Instances where statistics should not be taken at face value are noted in the text and appendices. Some detailed lines of inquiry were restricted by the demands of time and space.

The thesis attempts a close study of social welfare in New Zealand 1877-92, the period immediately preceding the Liberal legislation which put New Zealand in the forefront of developments in the welfare state. It provides a possible basis for further studies in social welfare, particularly in the period 1892-1938. There also appears to be a considerable amount of primary material available for the study of a subject allied to hospitals and charitable aid, the treatment of lunatics in nineteenth century New Zealand. An extensive investigation of friendly societies, too, seems possible.

I am indebted to a number of people whose interest and advice have assisted me in this study. In particular I should like to express my gratitude to my supervisor, Mr. W.J. Gardner, who suggested the topic of hospitals and charitable institutions, and provided invaluable guidance throughout the year. I should also like to thank the following for their assistance.

Dr F.O. Bennett of Christchurch.
Miss J.S. Hornabrook and Mrs A.B. Coleman of the National Archives, Wellington.
Mr. B.K. Jones of the New Zealand Medical Association.
Miss J. Kirkcaldie of the Photographic Section, Alexander Turnbull Library.
Mr. R.C. Lamb of the Canterbury Public Library.
Miss L.A. Dovey of the University of Canterbury Library.

2 IA 1 77/4946 (77/4288) Napier Hospital to Colonial Secretary's Office, 4 August 1877.
Thanks are also due to the staffs of the General Assembly Library, the Alexander Turnbull Library, the Canterbury Public Library, the Canterbury Museum and the Library and Geography Department of the University of Canterbury. I am also grateful to my typist, Mrs S. Carss, for her excellent work and cooperation, and to my wife for her constant help and encouragement.

Michael F. Chilton.
MAPS AND ILLUSTRATIONS.

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ABBREVIATIONS AND USAGE.

Abbreviations.

(a) General.

AJHR Appendices to the Journals of the House of Representatives.
AJLC Appendices to the Journals of the Legislative Council.
MLC Member of the Legislative Council.
NZMJ New Zealand Medical Journal.
PD New Zealand Parliamentary Debates.

(b) Newspapers.

AES Auckland Evening Star. NZH New Zealand Herald.
ES Evening Star. ODT Otago Daily Times.
LT Lyttelton Times. P Press.

(c) Provinces.

A Auckland. N Nelson.
C Canterbury. O Otago.
HB Hawkes Bay. T Taranaki.
M Malborough. Wd Westland.
Wn Wellington.

Usage.

(a) Colonial. The term 'colonial' is used because 'colony-wide' is awkward and 'national' would be anachronistic.

(b) Numbers. Generally, numerals are employed for numbers over ten.

(c) Manuscript References. For example, IA 1 77/4946 (77/4288) Nelson Hospital to Colonial Secretary's Office, 4 August 1877. IA refers to the Department of Internal Affairs (National Archives).
1 is the series number.
77/4946 is the number of the file to which this document is attached.
77/4288 is the number of the particular document, in this case, the letter from Nelson Hospital.
Normally the document number is employed only where the file number alone would make the document difficult to locate. The most common examples of this are the bulky files of returns from hospitals and local bodies.
(d) Hospital names. Nearly one third of New Zealand hospitals were referred to by two or more names. The most common combination was that of the town in which the hospital was situated and the name of the district it served. All other hospitals were named after the town in which they were located and in this thesis this principle has been applied to those hospitals with dual names. Contemporary records indicate that only one hospital was commonly referred to by the name of the district it served: this was the 'Dunstan' Hospital, situated at Clyde. The following is a list of hospitals with dual names.

<table>
<thead>
<tr>
<th>Town</th>
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<tr>
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<td>Greytown</td>
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<td>Clyde</td>
<td>Dunstan</td>
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<tr>
<td>Lawrence</td>
<td>Tuapeka</td>
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<tr>
<td>Riverton</td>
<td>Wallace and Fiord</td>
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<tr>
<td>Invercargill</td>
<td>Southland</td>
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</table>

(e) MacGregor. The surname of an inspector of hospitals and charitable institutions, Dr Duncan MacGregor, is spelt in some secondary sources as 'McGregor' or 'Macgregor'. The files of the National Archives, however, show that the Inspector signed his name as 'MacGregor'.
I. INTRODUCTION: EARLY DEVELOPMENTS, 1840-77.

English public hospitals in the nineteenth century were of two main types; the voluntary general hospitals and the poor law infirmaries or 'municipal hospitals'. The voluntary hospitals were maintained by private subscriptions, which were supplemented by appeals, legacies, donations and endowments. They ministered, usually with the aid of a proficient honorary staff, to those of the poorer classes requiring specialized medical attention. The infirmaries, maintained from city or county rates, attracted less public attention but served a much larger population.

Patients in both kinds of hospital were invariably from the poorer classes. This link between sickness and poverty was strengthened by the provision of outdoor medical relief to the destitute. That granted by the voluntary hospitals was adequate, but hardly rivalled poor law medical relief which was particularly attractive because it was commonly accompanied by a grant of 'nourishment'. The intermittent increases in all forms of outdoor relief brought increased vigilance from poor law officials and their attempts to curtail it gained support from political economists, who believed that such relief encouraged, rather than restrained, the growth of pauperism.

1 B. Abel-Smith The Hospitals 1800-1948 p 89.
The wealthier classes showed no inclination to enter any sort of institution when they were ill and normally were cared for in their homes by their physicians and domestic staff.

Although there was spasmodic interest in founding hospitals in New Zealand and a small government institution was situated at Auckland as early as 1841, little was achieved until the matter received earnest consideration from the Government in 1845. Largely due to the efforts of Governor Grey, sufficient money for the erection of hospitals in each of the four centres - Auckland, Wellington, Wanganui and New Plymouth - was granted the following year. The foundation stone for Wellington Hospital was laid in November 1846 and that of Auckland the following year. Maoris were admitted free and although a nominal fee was charged to the European working people who formed the majority of patients, it is doubtful that its collection was rigidly insisted upon.

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4 Ibid.
The young settlement of Dunedin boasted a hospital as early as 1851. A hospital was in existence at Lyttelton in the same year but it was not until 1862 that such an institution was located in Christchurch. A further 23 hospitals were established in the next 15 years.

The early settlers naturally followed English models when they founded their hospitals and, to some extent, retained the attitude that the care of the sick and the restriction of infection was a voluntary public duty. Some modification, however, was inevitable because of the nature of settlement in the colony. The virtual absence of the very rich and the small numbers of the very poor meant the disappearance of the customary sources of patronage and the traditional type of patient. A sparse population and the general isolation of communities contributed to the development of the widespread feeling that the provision of medical facilities was the duty of the community as a whole.

Contemporary standards of medical practice were not high. Hospitals, like the communities they served, had to contend with problems of sanitation, water supply and lighting. These were often complicated by such difficulties as unsuitable buildings and untrained staff.

5 F.O. Bennett Hospital on the Avon pp 12-13.
The doctor in charge of the institution frequently had to attend to a private practice as well as his hospital duties.

There was rarely any form of official inspection. Probably the most potent antidote to negligence was the threat of public scandal and this somewhat arbitrary mechanism was liable to do more harm than good. Most hospitals, however, were able to maintain a standard adequate to perform their major function, which was the provision of accommodation for those who would otherwise have been unable to obtain ready access to a doctor.

With the expansion of the goldfields in the 1860s came a proliferation of hospitals in Central Otago, Westland and, to a lesser extent, Thames. These hospitals were maintained by generous subscriptions and donations from the predominantly transient populations, which were able to obtain a subsidy, usually £1 for £1, from the generally reluctant provincial governments.6

Early medical attention on the goldfields had been of a doubtful character - quacks had been active and temporary or emergency hospitals ill-constructed.7 Some hospitals failed to overcome this initial handicap; others developed into relatively efficient institutions and

6 For the location of the goldfields' hospitals, see maps following pp 14, 23.
7 See, for example, P.R. May The West Coast Gold Rushes p 291.
formed the backbone of the colony’s rural cottage hospital system. The evolution of this system coincided with the growth of a similar movement in England. 8

Variations in provincial wealth produced an irregular distribution of hospitals. All Otago hospitals, except Dunedin, were maintained by voluntary subscriptions supplemented by a government subsidy. Fostered by a strong spirit of local pride and competition, their numbers manifested the prosperity of the province.

With a few notable exceptions besides the goldfields, the other New Zealand hospitals were soon maintained primarily by their respective provincial governments, whose pecuniary state was often reflected in the facilities provided. Government control, however, did not preclude voluntary fund-raising activities and other forms of local participation in hospital affairs.

Within this framework the diversity of New Zealand hospitals became a notable feature. Variety in size and standards was largely a result of community spirit, communications with other centres, available funds and the competence of staff. Most localities experimented with different ratios of government and local body officials, medical practitioners and laymen, so that the composition and size of controlling boards were far

8 Abel-Smith p 102.
Early colonists in distress were usually aided by kindly neighbours, community collections, or a combination of these. Death, sickness and desertion, particularly of the breadwinner, were major causes of poverty. In the few cases where no public aid was rendered, the provincial governments appear to have assumed responsibility and provided a more or less adequate grant. An Ordinance of 1846, which made the near relatives of destitutes liable for their support, achieved little.\(^9\)

The first friendly society in New Zealand was founded at Wellington in 1843 and in the following year others were established at Nelson and Auckland.\(^10\) The movement experienced a steady growth and by late 1850 there were at least 11 societies in the colony.\(^11\)

The rapid growth in New Zealand's population, engendered by the gold rushes, increased the number of people requiring charitable aid. Voluntary aid organized itself in an attempt to meet the demand and benevolent societies were formed in several centres.\(^12\)

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9 An Amendment, passed in 1877, also fared badly. See, for example, *AJHR* 1883 H3A p ii.
10 *AJHR* 1886 H1A p 1.
11 *Ibid* pp 1-2. All belonged to the Manchester Unity Independent Order of Odd Fellows.
12 This may have been the result of Australian influence. *Australian Encyclopaedia* Vol V p 2 states that there was a benevolent society at Sydney as early as 1820.
church groups sometimes complemented the work of the larger benevolent societies which, as secular bodies of local philanthropists, were often founded with the support of the local borough council. The first significant organization of this nature was probably the Otago Benevolent Society, which held its inaugural meeting in April 1862.¹³

Increased demands on the provincial governments for all kinds of assistance resulted in the utilization of an institution which already provided succour to the poor. The old English workhouse-infirmary relationship was inverted, so that in New Zealand poor-relief was supervised by the hospitals.

In practice, a measure of indoor relief came under the auspices of the main hospitals in that most of them tacitly provided a few beds for the aged sick, who would otherwise have had to rely on ordinary charitable aid. This was extended at Auckland Hospital where, in 1867, the recently-vacated mental wards were employed as a home for old people.¹⁴ An inquiry in 1871, however, revealed that these occupants were in a pitiable state of filth and neglect. The ensuing scandal resulted in the formation of the Auckland Ladies' Benevolent Society

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¹³ P.J. Whelan 'The Care of Destitute, Neglected and Criminal Children in New Zealand, 1840-1900' p 21.
¹⁴ F.C. Rauch 'The History of the Auckland Hospital and Auckland Hospitals and Charitable Aid Board, 1847-1974' p 111.
which undertook the management of the Old Women's Home.\textsuperscript{15}

In a few centres, particularly those where there was little public aid but a growing demand, a permanent relieving officer was appointed to supervise the distribution of charitable aid. This took the form of direct grants of money or comforts and the provision of relief work. The position of relieving officer which entailed a close liaison with hospital authorities, was often combined with that of immigration officer. This suggests that immigrants were a major source of indigence in the colony. Death or disease on the voyage out could leave large families without a provider and those in poor health on embarkation, seeking the 'salubrious climate' of New Zealand, frequently became a charge on the province concerned.

Orphaned, neglected and destitute children were cared for by church institutions which received government subsidies. These institutions, originally intended for the benefit of Maori children, soon became predominantly European in response to the necessity of the latter community. In regions without institutions, maintenance was sometimes provided from the charitable aid vote.\textsuperscript{16} At the close of the provincial period there were ten institutions for the care of needy children.\textsuperscript{17}

\textsuperscript{15} Ibid p 112.  
\textsuperscript{16} Whelan pp 21-95.  
\textsuperscript{17} Ibid p 119.
As in the case of the hospitals, there was considerable local variation in the scope, standard and distribution of charitable aid. Many of the poor were too proud to accept charity and others in need did not qualify for it. It certainly did not eliminate the prevalent harsh conditions, but served to ameliorate the plight of a few.

The period 1877-92 was one of transition from a provincial to a colonial system. The next two chapters show the state of medical services and charitable aid from 1877 to 1885. Chapter four is devoted to a survey of administration and finance which were in need of reform. Principles that confronted legislators seeking to remedy this situation are examined in chapter five and the succeeding chapter covers political conflicts in the legislative process itself.

The basis for a uniform colonial system was laid down in the Hospitals and Charitable Institutions Act of 1885. Its operation from 1886 to 1892 welded diverse medical and charitable services into a colonial system which, in turn, fostered attitudes that were to have a significant impact on the social welfare of New Zealand.
II. PROGRESS IN PUBLIC HEALTH, 1877-85.

In its second generation as a European settlement, New Zealand was a crucible in which the crude facilities of the pioneers were mixed with the revolutionary advances of European medical science: the improved techniques of the old world were called to the assistance of the new. The earlier inherited attitudes of New Zealanders towards matters of health and hygiene, however, were still deeply entrenched in the life of the colony in the 1880s.

The threat of epidemics, especially typhoid, the 'colonial fever', was always present in the insanitary conditions of town life in New Zealand. Poor or non-existent sewage systems, the activities of domestic animals, the suspect quality of drinking water and the unhygienic handling of food all assisted in the spread of infectious diseases. At Ohinemutu, near the embryonic Rotorua sanatorium, an outbreak of typhoid was blamed on the sulphur fumes of the site, but was soon traced to the sanitary arrangements of a large hotel which discharged its sewage near a hot creek, used by the Maoris for cooking and washing purposes and a river which supplied drinking water. The surrounding area too, was in an unhealthy condition, being 'littered with refuse of all kinds'.

1 AJHR 1883 H3A p 21.
Outbreaks of cholera in Spain, France and Italy were reported in some detail by the newspapers and New Zealand shared the world-wide fear of epidemics. News of the advent of smallpox in Australia quickly produced quarantine measures in New Zealand. In London, the smallpox epidemics of 1877 and 1881 resulted in the rapid expansion of fever facilities and emphasized the need for these elsewhere. In New Zealand, local authorities were required to notify the Central Board of Health, in Wellington, of 'infectious diseases' - cholera, smallpox, typhus and typhoid fevers, diphtheria and measles - and were responsible for the application of both preventive and remedial measures.

Under the Vaccination Acts of 1863 and 1871, and parts of the Public Health Acts of 1872 and 1876, vaccination of every child born after 1 March 1864 was compulsory. At first the machinery for implementing these measures was inadequate, but with the employment of Public Vaccinators, the assistance of the Registrars of Births and the enforcement of penalties, it gradually became more effective. Wide powers for the inoculation

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2 Abel-Smith pp 120-121.
3 IA 19/1 Returns from local boards of health. These were supplied in accordance with sections 18 and 57 of the Public Health Act, 1876. Tuberculosis, not listed as an infectious disease, was a major cause of death in the colony.
of babies, public servants, children attending public
schools and all inmates of asylums and prisons, were
granted under the Public Health Acts. The relatively
high incidence of vaccinations, probably due as much
to public confidence and education as to statutory
provisions, accounts for the relative absence of
smallpox from New Zealand.

There were comparatively few degenerative diseases
because of the youth of the colony. This is reflected
in tables showing the ages of hospital patients. In
1884, for example, the median age was about 35.5

Domestic and industrial accidents accounted for
many hospital cases. Those incurred in the flax, min-
ing and sawmilling industries, in particular, were fre-
quently very serious. The dangers of the wound itself
could be compounded by those of infection. Surgery was
often performed with only perfunctory regard for clean-
liness and germs producing infection and septicaemia
(blood poisoning) were present on unclean hands, the skin
of the patient, instruments, dressings and elsewhere.
They could find easy access to the wound and inflame it,
sometimes with fatal results.

4 N.Z. Statutes 1872 No 68 pp 392, 393, 397; 1876 No 60
pp 410, 411, 415.
5 See Appendix A.
In the 1860s Sir Joseph Lister, Professor of Clinical Surgery at the Edinburgh School of Medicine, had introduced asepsis (surgical cleanliness) and anti-sepsis (use of chemical germicides). This practice was based on the work of Pasteur, but did not meet with widespread acceptance for about two decades.6

A few New Zealand doctors who had seen Lister's work in Edinburgh showed a keen appreciation of his principles and endeavoured to put them into practice.7 In October 1872 Professor Duncan MacGregor,8 who had been a pupil of Lister from 1867 to 1870, was responsible for the first major operation in the colony involving the new technique. He saved the patient's arm and probably his life, in an operation which included sterilization of the air with a carbolic spray every time the dressings were removed.9

From this time onwards antiseptic methods were employed at Dunedin and Doctors Hulme and Brown, who were trained in Edinburgh, instructed students in its

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7 R.V. Fulton Medical Practice in Otago and Southland in the Early Days p 292. Doctors Hunter of Dunedin, Monckton of Riverton and Ryley of Hokitika, are cited as examples. This source was noted in N.S. Murray 'The Life and Work of Dr Duncan Macgregor' p 92.
8 Professor of Philosophy at Otago University, later Inspector of Hospitals and Charitable Institutions.
9 Fulton p 292.
principles. The use of Listerian techniques throughout the colony was sporadic and probably not widespread until the 1880s. Even then, theory was not always put into practice. But by 1877 the Auckland Hospital Commissioners, at least, were aware of the existence of a danger which they described as:

'...a miasmatic atom - so minute as to have escaped detection as yet, and which ventilation cannot reach - that even permeates the solid structure, resulting in susceptible persons going into buildings so infected, with curable ailments, being subject to diseases of a very destructive character.'

Such an awareness reinforced demands for isolated fever wards, the closure of cesspools and other measures that reduced the constant menace of cross-infection and emphasized the prevention of sickness as well as its cure.

The era was one of significant growth in medical knowledge, and the new discoveries were generally well known in New Zealand within a few years. Eberth isolated the typhoid bacillus (1880) and those of tuberculosis (1882), diptheria (1883) and tetanus (1884) were discovered by Koch, Klebs and Nicolaier respectively. The work of Pasteur spanned the whole period.

10 Ibid p 294.  
11 AJHR 1877 H15 p 3.  
12 F.H. Garrison An Introduction to the History of Medicine pp 627, 856-857.
Many of New Zealand's doctors were born and trained overseas and introduced the latest techniques after their arrival in the colony. Others went overseas, either to take their whole medical course, or to complete the two-year course offered by the young medical school at Otago in the period 1877-84. The school enjoyed a close association with Edinburgh University in particular. This relationship was largely due to the personal influence of the school's first dean, Dr. J.H. Scott, who went to Otago directly from an Edinburgh appointment.¹³

The 'exceedingly high' record of New Zealand medical students at Edinburgh University prompted Sir Robert Stout to eulogize their performance in a parliamentary speech. In 1884 they held first and fourth positions of the eight that succeeded in materia medica (pharmacology), first and fifth of eighteen in general pathology and creditable performances in clinical surgery, practical physiology, surgery and the practice of physic.¹⁴

¹⁴ PD 52 p 110.
Hospitals in New Zealand 1881

Legend
- Hospitals

Source: AJHR, 1882, H23.
Wanganui, AJHR, 1883
H35, page 25.
Doctors, both in hospitals and general practice, placed great emphasis on the drugs available and formulated elaborate prescriptions to meet the demands of their cases. 'Drugs and dispensary' were important items in hospital expenditure and were often obtained on yearly contract from a local pharmacist. A strong faith in the medicinal qualities of alcohol was fostered by advertisements for spirits which claimed the support of 'leading Continental Physicians'. Although many of the medicines administered were of doubtful physical value they were, together with the doctor's 'bedside manner', an important form of psychotherapy which often contributed significantly to the patient's morale.

The importance of siting was appreciated at Auckland Hospital, where the design provided light, fresh air and scenery to enable nature, 'to do her part in furtherance of the physician's art.' Besides examining the medical facilities in his annual reports, the Inspector noted the presence, or otherwise, of wall pictures, library, flowers and church or benevolent society visits, all of which he considered valuable aids to the convalescent.

15 AJHR 1882 H23. In this, the earliest colonial survey expenditure, they were third of twenty four items. This position is generally retained in subsequent accounts.
16 AJHR 1877 H15 p 1.
17 AJHR 1883 H3A; 1884 H7A; 1885 H18; 1886 H9.
other hand, faith in nature alone was advocated by one correspondent who wrote:

'Teach the people, sir, to love regular hours, plain food and hard work, pure air, clean water and harmless recreation, but above all to avoid physic.' 18

For those who distrusted or despaired of established medical knowledge and its practitioners, quacks, or 'horse doctors', provided an alternative source of advice. A spirited correspondence was inaugurated by an advocate of further statutory provisions to protect the public from these rather unscrupulous 'medical' men, who, he claimed, were responsible for many unnecessary deaths and maimings. 19 One writer replied that 'properly qualified' practitioners were little different from and possibly worse, than others; 20 another correspondent countered that quacks had cured chronic disorders that the 'faculty' had given up and asserted:

'...it is my firm conviction that there is infinitely less danger to life from the treatment of many so-called quacks than from the diversity of treatment by drug medication of practitioners, who each play on their own particular string at the expense of their patient's health or life.' 21

The medical columns of daily newspapers offered a variety of remedies, which ranged from the innocuous to the punitive. Kaye's Worsdell's Pills rendered, 'the

18 EP 5 August 1882.
19 Ibid 31 July; 7 August.
20 Ibid 5 August.
21 Ibid 1 August. Also 10 August.
use of the doctor unnecessary in the family', those of
Professor Holloway cured 26 illnesses from
asthma and bilious complaints to weakness and worms of
all kinds. Clarke's World-Famed Blood Mixture was
content with curing, 'scrofula, scurvy, skin diseases
and sores of all kinds'; Doctor Churchill's Syrups of
the Hypophosphites was similarly modest. Widow Welche's
Pills, predictably, specialized in, 'inconveniences to
which the female frame is liable', but did not monopolize
this field.

Dr Bright's Phosphodyne is perhaps typical:

'...Best known remedy for Nervousness, Indigestion,
Liver Complaints, and all Functional Derangements:
extensively used in the Army and Navy, and highly
recommended by the Medical Faculty. Dr Bright's
Phosphodyne - Only reliable remedy for Weak and
Shattered Constitutions, Nervous Debility, Depres-
sion, Lassitude, Loss of Power, Pimples, Impov-
erished Blood, Premature Decline; thoroughly
re-establishes the general bodily health.'

Invariably customers were warned to, 'beware of a worth-
less imitation bearing a similar name', or of a rival
product with a 'New York' label. 22

Advertising was also conducted in letters and
circulars and induced annoyance in many registered

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22 This particular sample of advertisements was taken from
NZH, NZT, F and ODT of January 1880, but is typical of
the whole era.
medical practitioners:

'If the advertisements were always decent, we might have less to complain of. We should be sorry to let our boys and girls read some of the advertisements in the daily papers. Women instinctively avoid paragraphs of this kind, otherwise we might blush to place the daily paper on the table.'

The division between 'doctor' and 'quack', however, was not always easy to determine. Until 1867, registration of doctors was the responsibility of local magistrates alone and even if the candidate produced diplomas from unfamiliar colleges or testimonials that defied verification, his right to practice was rarely challenged. Wellington and Otago passed ordinances in an attempt to curb this trend and a similar procedure was contemplated in Canterbury.

The Medical Practitioners' Act of 1867 was more stringent than its predecessors in that registration was to be controlled by a central Medical Board and a medical practitioner of the province concerned was to act as assessor and examiner in conjunction with the resident magistrate. A qualifying degree, diploma or license was considered to be one which was awarded after a course of medical study of not less than three years.

Although it curtailed flagrant deception, the Act did not entirely remove the doubtful elements from

23 NZMJ Vol I p 105.
colonial practice. In many instances the examination was a formality and much trust was still placed in documentary evidence, sometimes of dubious validity. The ease with which degrees were gained in some American colleges contributed to this situation:

'It cannot be too well known that many American diplomas are not worth the parchment they are written on, as far as showing any skill in medicine is concerned ... More care should be taken in admitting men with foreign diplomas to the Register. It would be no hardship to ask a properly-qualified man to pass a test examination, and to produce evidence of good character from some reliable source, before registration.'

Nevertheless, an improvement in the general tone of medical practice was evident. The flagrant advertising characteristic of the provincial period was virtually abandoned and, in the larger hospitals, the resident house surgeon was forbidden to conduct a private practice. A professional attitude was also exhibited in the claim of the Taranaki Medical Association that further protection should be afforded to medical men, who should not have been, in their opinion, classed with 'hospital attendants'. Associations, official and otherwise, ostracised most of the less reputable practitioners.

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25 NZMJ Vol I p 211.
26 IA 1 82/1157 (80/1416) Taranaki Medical Association to Colonial Secretary, 24 March 1880. 'Hospital attendants' included stewards and nurses of both sexes.
One of the most significant events in the evolution of New Zealand's hospital and charitable aid system was the decision to appoint an inspector of hospitals. Limited powers of inspection had been given to local authorities under section 57 of the Public Health Act of 1876, but in many areas these appear to have fallen quickly into disuse.

The appointment of an inspector was probably first suggested in 1877:

'I would suggest that a medical man possessing hospital experience, and whose opinion would carry weight should be employed to visit and report upon all the Hospitals in the Colony and supply the Government with suggestions as to the best means of continuing their maintenance.'

Provision for an inspector was made in the unsuccessful bill of 1877, but the matter received little further attention until 1879, when it was incorporated in a draft of a Hospitals and Charitable Institutions Bill and accorded general approval. The Colonist noted that such an appointment would have the effect of restraining both extravagance and parsimony, thus protecting both the taxpayer and the inmate. A more precise definition of the proposed inspector's duties, particularly with regard to

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27 N.Z. Statutes 1876 No 60 p 391.
28 IA 1 77/3324 Memorandum to Colonial Secretary. Unsigned but almost certainly written by G.S. Cooper, Under-Secretary. N.d. but countersigned by a cabinet minister (D. Reid), 11 July 1877.
29 Colonist (Nelson) 30 December 1879.
audit, was sought by the New Zealand Herald. The principle of independent government inspection also received approval from the Opposition benches in the following Parliamentary session.

On 3 March 1880 the duties of Dr F.W.A. Skae, inspector of the colonial lunatic asylums, were extended to public hospitals and charitable institutions. Skae only briefly survived his appointment but participated in at least one inquiry. While the position remained vacant, the work of the inspector was carried out by L.W. Loveday, who completed Skae's scheme for the first colonial survey of the hospitals.

The New Zealand Medical Association, as a guardian of professional standards, insisted that the new inspector should be a duly qualified medical practitioner and recommended that this should be made explicit by legislation. Although it approved of the appointment of

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30 NZH 31 January 1880.
31 PD 35 p 82, Hon W. Gisborne.
33 Bennett p 67. A fruitless inquiry into 'incorrect' diagnosis at Christchurch Hospital.
34 AJHR 1882 H23.
35 In an effort to form a colonial association, the Otago Medical Society changed its name to the 'New Zealand Medical Association' in 1878. The aim was more fully achieved in 1886, when the present association was formed. See NZMJ Vol I pp 5-7.
36 IA 1 82/1157 (80/2577) NZMA to Colonial Secretary, 7 June 1880. This recommendation was repeated the following year. IA 1 82/1157 (81/2256) 5 June 1881.
inspectors, the *New Zealand Times* considered that it would be impossible for them to police the system thoroughly and pressed for additional safeguards in the form of local supervision.\(^\text{37}\) With the failure of the bill of 1881, however, the matter was dropped and it was not until 7 November 1882 that a permanent inspector was appointed.

Dr G.W. Grabham's duties were to inspect the hospitals and lunatic asylums of the colony, but charitable institutions no longer came under the jurisdiction of his office. Grabham was a conscientious and able man, who realized that an inspector in the colony was essential to regulate hospital expenditure and induce some measure of uniformity into the 'system'. Unlike Skae he was widely versed in medicine and his professional standing combined with his 25 years' experience of hospital administration in England and Europe, commanded considerable respect.\(^\text{39}\)

\[\text{37 NZT 28 June 1881.}\]
\[\text{38 *N.Z. Gazette* 1882 Vol II p 1715. No charitable aid inspector was appointed.}\]
\[\text{39 Very little personal information on Grabham is available. A prolonged search brought to light no primary sources and he received no recognition in such secondary sources as G.H. Scholefield's Dictionary of New Zealand Biography. Most of the information on him is gleaned from his official reports. His short period of residence in the colony - four years - partly accounts for this paucity of information. It was not possible to make inquiries in Britain, to which he returned in 1886.}\]
HOSPITALS IN NEW ZEALAND 1881

SOUTH ISLAND

LEGEND
- Hospitals
() Number of beds

After a spate of building in the late 1870s, the number of New Zealand hospitals was steady at 37.40 With the exception of the sanatorium at Rotorua, no new hospitals were built until the late 1880s. Instead, attention was focused on improvements within the established hospitals.

The incidence of infectious diseases overseas, smallpox in particular, led to the construction of isolated fever wards in many hospitals. Enlargements, alterations and improvements during this period indicate the awareness of a need to consolidate the hospital 'systems'. A general improvement in surgical facilities, sanitary conditions and the preparation of food followed Grabham's first report. Items like comfortable bedding, furniture, ornaments, paintwork and convalescent materials, which came under the inspector's scrutiny, were constantly added to the facilities already employed in the hospitals.

Diversity was still a dominant feature of the hospitals, which found it difficult to shake off their provincial past. The largest town hospitals were situated in the four main centres, and in Timaru, Nelson and Hokitika. They were equalled in number by the country-town hospitals and a combination of these two categories was, in turn, numerically matched by the

40 See maps following pp 15, 23.
rural hospitals.  \textsuperscript{41}

Wooden buildings remained the rule, although some of the larger towns affected stone or brick. A few were adaptations of buildings erected for other purposes. Dunedin Hospital was established in a building that had been used for an exhibition. The hospitals at Blenheim and Riverton had been converted, with less success, from immigration barracks. Four cottages erected for immigration purposes at Palmerston North served as a 'hospital' in times of emergency and similar structures elsewhere served variously as storerooms, staff quarters, mortuaries or fever wards.

Other hospitals were originally poorly designed or had been unwisely extended. One of the newest, Ashburton, was 'badly planned and ill-constructed'. \textsuperscript{42} Wellington Hospital, opened in July 1881, was even more modern but displayed a front corridor 300 feet long, 13 feet wide by 18 feet high, which commandeered most of the available sunlight. As it formed the northern part of the building, the four main wards and their intervening courtyards were rather dull and gloomy. The architect had to plan for lavatory accommodation near (but outside) the wards and a garden for convalescents: as the entrance was from the north he felt

\textsuperscript{41} See Appendix C.
\textsuperscript{42} AJHR 1883 H3A p 2.
obliged to place the garden there and the latrines to the south. The imposing public front was criticised as being of little benefit to patients and, to make matters worse, the latrines were unsatisfactory and gave offence in the prevalent southerly winds.

The Auckland Hospital, opened in 1877, was the subject of a devastating report after Grabham's first visit:

'Vermin are said to abound; and I can well believe that this is the case, as I saw evidences of much neglect ... The rooms are not cleaned, as the rules (hanging on the walls) enjoin. Bath-rooms are littered with brooms, rags, boots, and clothing; window sills with medicines, papers, and dressings, for which no proper places are provided; and, worse than all, the beds of helpless patients remain unmade for days together ... The mort­uary is ill-arranged, and very foul-smelling.'

Some renovation was made essential by patients with 'filthy habits' and cases of delirium tremens. Although the buildings, generally, were in good repair, the whole interior required colouring and painting and the wood­work was 'particularly shabby'. On the other hand Grabham saw many excellent features in the building and thought it could make a model hospital under proper organization. The following year he was able to report

45 AJHR 1885 H78A pp 17, 19.
46 AJHR 1883 H3A pp 3-4.
47 Ibid.
that 'radical changes' had taken place in both staff and
management, producing a 'vast improvement' throughout
the hospital.\(^{48}\)

As a perusal of the other hospital reports reveals,
Auckland Hospital in 1882 had been the worst in the
colony and its tone a reflection of the worst features of
hospitals in the provincial period, rather than of the
standard of its contemporaries. Other large hospitals,
like Christchurch and Dunedin, received high praise for
their efforts. In a few hospitals, however, the staff
worked in poor conditions. At Picton:

'The floor \(^{\text{sic}}\) of the two lower wards are
worm-eaten and perfectly rotten. The
Matron recently had a narrow escape from
severe accident, while carrying a patient,
from this cause.'\(^{49}\)

Grabham's next report recorded that attention was obvi­
ously paid to his suggestions and repairs to both the
hospital and its approaches had been made.\(^{50}\)

Many hospitals were of good design and showed an
appreciation of the demands for sunlight and sanitation.
Hospitals such as those at Masterton, Reefton, Waimate,
Timaru, Arrowtown, Lawrence and Napier, consistently
received very favourable reports from the Inspector.
Particular attention was paid to the suitability of

\(^{49}\) Ibid p 15.
\(^{50}\) AJHR 1885 H18A p 11.
the staff and those who performed their duties well received warm commendation. At Timaru, for example, Grabham noted that:

"In this establishment the indefatigable Steward, Mr. Jowsey, has always some improvements in hand; he is now occupied in renovating and decorating the wards and adjoining rooms. One of the large wards, with its belongings, has just been finished; the floor is in splendid condition, and the walls are painted, stencilled and distempered in a most elegant manner; in fact, I cannot call to mind anything so pleasing and good of its kind, in the Old Country."51

Rural and small country-town hospitals were staffed by a doctor, who was permitted to conduct a private practice, a resident steward and his wife, the latter often assisting as a nurse or 'matron'. In country-town hospitals this arrangement was supplemented by the services of a nurse or two and a male assistant, whose duties included those of dispenser unless the hospital was large enough to justify the employment of another man in this capacity. The town hospitals retained a staff of nurses and wardsmen, usually supervised by the steward and the matron52 and a resident medical officer. An additional surgeon or physician could be appointed to assist the resident doctor, but this task was usually borne by an honorary or 'visiting' staff.

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51 Ibid p 16.
52 Many hospitals preferred the positions of steward and matron to be filled by a married couple.
The notion of an honorary staff - skilled practitioners rendering their services gratuitously - was derived from the voluntary hospitals of England. The doctors who held these positions not only made a personal contribution to the relief of the sick, but gained valuable practice in surgery and retained the goodwill of the wealthier classes from whom they drew their income. It was a mark of confidence in his ability for a doctor to be appointed to the honorary staff and there were often more applications than vacant positions. The knowledge and experience of honorary staffs undoubtedly advanced medical treatment in New Zealand, but this contribution was, to some extent, marred by the friction generated by disputed appointments and by disagreements between office-holders.

In the frequent internecine quarrels in the main hospitals, doctors were still inclined to charge their opponents with medical incompetence or the purchase of credentials. Such accusations occasionally contained more than a grain of truth. Yet some responsible positions were held by people who, despite unorthodox qualifications, had proved their ability before gaining office and discharged their duties efficiently. The number of these doctors declined with the growth of professional attitudes, and the principle of employing only registered practitioners was gradually put into
practice. This change was reflected in such resolutions as the following:

'It was agreed to request Dr. Mackellar, House Surgeon, to register himself under the Medical Practitioners' Act, if he had not already done so.'

The low wages and irksome duties of wardsmen and stewards deterred some of the most suitable types of men. Dismissals for rough conduct, drunkenness and inattention to duty were less frequent than they had been in provincial times, but still occurred. Late in 1879, the steward of New Plymouth Hospital was charged with criminally assulting a female patient and it was noted that, because only members of his family were employed at the hospital and there was no visiting committee, he reigned supreme and patients' complaints stood little chance of being heard or remedied.

Among the cases that came to the notice of the Colonial Secretary was the dismissal of a later steward of Taranaki Hospital on the charge 'Drunk and creating a disturbance in the Hospital!'. An inquiry into the conduct of a senior male assistant at Auckland Hospital who admitted drinking 'occasionally', was terminated when he tendered his resignation in return for the withdrawal of the word 'habitual', in the charge of,

53 NZH 20 March 1883.
54 Taranaki Herald 27 December 1879. See also PD 44 pp 647-648.
55 IA 1 81/3461 3 August 1881.
'habitual drunkeness and neglect of duty', preferred against him.55

Many stewards and wardsmen, however, proved to be capable workers who accumulated a fund of knowledge and skill that stood them in good stead when nursing their patients. A few were even able to perform minor operations. In the Inspector's reports many stewards received praise and constructive criticism, but if he found evidence of gross incompetence on the part of a hospital's steward, Grabham had little hesitation in recommending his dismissal and this advice was usually acted upon.

Most of the domestic tasks in the larger hospitals - laundry, cooking and cleaning - were the responsibility of a small staff of servants who, in time of stress, were obliged to carry out nursing duties. As a precaution against any dishonest inclinations they might have, the blankets at Auckland Hospital were to be numbered and a check was also to be imposed on food supplies, 'so that the servants could not supply themselves at the expense of the patients'.57

The treatment of patients, not surprisingly, varied from hospital to hospital. Discipline, as in

56 IA 1 83/3631 (82/5346) 13 December 1882.
57 AJHR 1877 H15 pp 2-3.
earlier times, was sometimes difficult to maintain and was one of the reasons for fencing the larger hospitals.

At Christchurch:

'Before the hospital was fenced patients often wandered out and went to the town. Sometimes they returned, sometimes not. They frequently brought back alcohol, on or in the person.' 58

An Auckland Committee stated that a good fence would assist in maintaining discipline59 and at Dunedin commendation was given to new gates which prevented 'forbidden articles' from being smuggled into the hospital. 60

Despite formal visiting hours, little control was exercised over the general public whose activities tended to subvert discipline in the main hospitals. The situation was worse at Wellington than at any other hospital:

'Frequent visits are made by ladies, and the public are admitted on Wednesdays and Sundays. This privilege seems to be greatly abused, and many go to the hospital out of mere curiosity. The names are not all entered in the Visitors' Book, yet I [Grabham] counted 108 for Sunday last, and as many as 250 have been registered in one day.' 61

Discipline and the control of visitors gradually improved as the Inspector made his presence felt and he

58 Bennett p 55.
59 AJHR 1877 H75 p 2.
60 AJHR 1884 Sess I H7A p 8.
61 AJHR 1883 H3A p 25. A letter to the Colonial Secretary 1883 - IA 1 83/3507 'As to interference with patients at Wellington Hospital by visitors' - has since been destroyed.
was pleased to note that at Dunedin:

'New rules have been made for the regulation of visitors, and for preventing the introduction of unsuitable articles of food and drink. It is certain that something was needed in these matters.'62

In the old English hospitals convalescent patients were traditionally required to assist in the wards63 and in some of the New Zealand provincial hospitals they had performed nursing duties. In several colonial hospitals a 'refuge case', usually an old man, was retained and allowed to live-in in return for doing light work around the hospital, such as tending the garden.

At Auckland in 1882, the Inspector found that female nursing was confined to the female wards and in the male fever ward nursing was carried out by an old patient.

'The nursing - if I can call it by that name - in the other male wards is of the most wretched description ... Such a system as this would not be tolerated at home, nor have I seen anything so bad at any other of the colonial hospitals.'64

Grabham also attacked the way that convalescent patients were made to do scrubbing and other onerous work, asserting that if they were able to do it without injury, they

63 Abel-Smith p 11.
64 AJHR 1883 H3A p 3. Wards one and three were in the charge of old men; in the other wards, assistance was confined to what the patients gave to each other.
should be discharged and if not, they ought not to do it. 65

This report was written only nine days after the hospital committee had reaffirmed its belief in the principle of work for convalescent patients, 66 but nevertheless it resulted in the termination of the old system.

The situation at Auckland was exceptional and at nearly all the other colonial hospitals Graham was able to report that the patients appeared to be comfortable and without complaints. At Christchurch:

'The condition of the wards was ... very creditable, and I formed a good opinion of the nurses. The patients appeared to be carefully and kindly treated.' 67

Female nurses were little more than elevated domestic servants and some, indeed, had been drawn from girls employed in that capacity in hospitals. That the work rarely attracted those of refined ways is perhaps indicated in the traditional expense of 'ale for nurses'. Their accommodation, when it was provided, consisted of attics, basements, or other crowded quarters considered appropriate for servants. They were untrained and gained any medical knowledge and skill they had through experience in the wards. The occasional individual

65 Ibid.
66 NZH 20 March 1883.
was, 'rough in her manner to the patients', but many were considerate and nursed the patients to the best of their somewhat limited abilities.

At New Plymouth, as in most other colonial hospitals:

'The nursing was done by elderly women, but neither in appearance or in their methods were they very like nurses.'

These semi-literate old nurses, with their haphazard 'training', were often incapable of effectively administering modern treatments and it became increasingly apparent that an element of professionalism should be injected into New Zealand's nursing system.

The influence of Florence Nightingale and her training school at St. Thomas' Hospital, spread to Australia in 1868 when six trained nurses, especially selected by her, arrived in Sydney and introduced her methods. Their success at Sydney and Melbourne was observed by the Auckland Hospital Commissioners as early as 1877. Three years later a Taranaki newspaper remarked that the Newcastle Hospital had secured the services of, 'one of Miss Nightingale's trained nurses' and advised the local hospital board to do likewise. The comment

68 Ibid p 27.
69 W.H. Skinner Pioneer Medical Men of Taranaki 1834 to 1880 p 145. This comment was made by the first trained nurse at New Plymouth, Mrs Bayley (nee Miss Blackley), appointed as Matron in 1886.
70 Australian Encyclopaedia Vol V p 3.
71 AJHR 1877 H15 p 2.
72 Taranaki News 10 January 1880.
of a Napier officer that:

'The want of properly trained female nurses has been much felt in our Hospital since its erection..."73

drew a favourable response from the Colonial Under-Secretary, who agreed that it would be well to import a number of trained nurses.74 In addition to opposition from some sceptical 'traditional' nurses, advocates of trained nurses had to contend with a few reactionary members of the public, who resented the introduction of female nurses of any description into male wards.

One such person wrote:

'I don't think that any female with the slightest pretence to modesty or self-respect would do such work, while there are plenty of men to do it, and whose work really it is.'75

In his second report Grabham gave his full support to the probationer system which had been successfully introduced at Wellington Hospital. Here, he said, nurses took the greatest possible interest in their calling which was not chosen for pecuniary motives. As well as producing dedicated and efficient nurses, the system proved economical as the salary of a probationer

73 IA 1 82/4632 J.A. Smith to Colonial Secretary, 23 September 1882.
74 Ibid.
75 AES 17 June 1880. Letter opposing the paper's support for female nurses.
was £25 a year and that of an ordinary nurse twice this amount. The probationers were often from a much higher class than the nurses of the previous generation. At Wellington and Auckland:

'...well-educated ladies may be seen serving their apprenticeship with other "probationers" ... The example so well set might with advantage be followed by others of the larger hospitals, whose present nursing arrangements are not in accordance, by any means, with modern ideas.' 77

Grabham predicted that trained nurses from these hospitals would be gradually distributed in other New Zealand hospitals, thereby raising the standard of nursing throughout the colony. The recruitment of qualified nurses from overseas complemented this scheme. The largest proportion of these nurses had been trained in England and many of them became 'lady superintendents' or matrons. An early, but typical, example was Miss A. Crisp who was appointed to supervise nursing at Auckland Hospital in June 1883, after ten years experience in both civil and military hospitals before coming to New Zealand.78 Grabham was pleased with the continued success of the system at Wellington Hospital, where interest in the work was produced by a system of healthy competition

76 AJHR 1884 Sess I H7A pp 20-21.
77 Ibid p 1. The training system at Wellington was firmly established but that at Auckland temporarily lapsed. See AJHR 1885 H18 p 1.
78 Rauch p 79.
Wellington Hospital in the 1880s.

Established at Newtown in 1880, the hospital was not free from architectural problems, but led the colony in its programme for training nurses.
between ward sisters. He was also able to observe the employment of superior education and training in another way:

'The dispensing of prescriptions is now almost entirely done (under the supervision of the Medical Officer), by a female nurse. I satisfied myself, by examining her, that she is competent for this duty; and the knowledge which she has gained of drugs and their uses is most creditable to her.'

As Grabham plainly saw, the reform of hospital standards at this level was vital to the improvement of medical treatment in New Zealand.

Contemporary faith in the medicinal qualities of alcohol was challenged by a number of men who saw it as a major cause of poverty. Its medicinal properties were doubted by a Dr J. Irving who, after commending a local temperance association said:

'I think it is the duty of the medical profession to raise its voice at all times, loudly and persistently, against the most pernicious vice of drinking; but more especially now, because I am certain that as it was so much the fashion for all medical men, as a rule, to recommend stimulants some 15 or 20 years ago, so a great stimulus was given to the consumption of all alcoholic drinks, especially among the better classes.'

80 Ibid.
81 These interests were represented in Parliament. For example, FD 29 p 675 R. Stout; FD 35 p 88 Sir W. Fox.
82 LT 24 July 1880.
This plea produced no immediate reaction, but its sentiments later received the Inspector's warm support.

From the time of his second report, Grabham conducted a campaign against what he considered to be the excessive consumption of alcohol in New Zealand hospitals. His reports on individual institutions show that he examined nearly all the books and papers and commented on any increase or reduction in alcohol expenditure. His attention to detail was revealed in the way he sometimes recorded the exact quantities of drink consumed at a hospital during the period of his inspection. At Christchurch, late in 1884, he remarked on the 'sudden diminution' in alcohol consumption after official attention was drawn to the large intake and concluded:

It appears strange that the laundress should require four ounces of brandy daily.'83

After widespread inquiries, Grabham had found that the hospital system of the Canadian province of Ontario was an appropriate model for New Zealand development.84 A recent survey had shown that about £431 was spent on wine, beer and spirits for the 6,032 patients of Ontario hospitals; for New Zealand's 6,056 patients about £2571 was required.85 This six-to-one ratio was made even less favourable by the fact that the population of Ontario

84 AJHR 1883 H3A pp ii - iii.
was much larger than that of New Zealand and its hospital patients, presumably, suffered illnesses of a more serious nature. The peak year for alcohol expenditure appears to have been 1883, the first year of Grabham's campaign. The following year brought a small reduction and the comment that:

'It is quite safe to assume that a much smaller consumption would meet the real wants of the patients.'

A significant decrease in expenditure took place over the next two years and alcohol now assumed a less important position in hospital budgets. Grabham's opinion on the matter was, as he said himself, very well known and it contributed to this decrease.

Out-patients services were provided in most New Zealand hospitals. Some of the out-patients were convalescents who had been subjects of hospital care, but most of them were poor people with minor ailments. Like hospital inmates, out-patients were supposed to be drawn from those classes unable to afford the services of a doctor. Hospital reports indicate that out-patients

86 Ibid.
87 AJHR 1885 H18 p 2.
88 See Appendix E. This is not related to developments in anaesthetics because there were no significant changes in this field from 1877 to 1892. See Bennett p 209.
89 AJHR 1886 H9 p 8.
probably outnumbered in-patients in a ratio of about three-to-two.90

As out-patients services constituted a more direct threat to the livelihood of general practitioners than hospital care, the circumstances of out-patients were usually thoroughly scrutinized. In England, failure to do this had led to widespread abuses and the notion that medical benefits were a form of dole. In some counties, the reaction to this abuse had led to unnecessary hardship for some genuine cases.91 New Zealand doctors were eager to avoid a similar situation in the colony and appear to have been successful in this aim.

The brief hospital report for 1885 indicates the rise in medical standards since the appointment of Grabham in 1882. There were still many improvements to be made, but these were generally of much less importance than those made in response to earlier problems. Large hospitals, such as Timaru and smaller hospitals, such as Waipukurau, were found to be in the best possible order.92

90 AJHR 1882-86. Out-patients generally numbered about 9,000, in-patients about 6,000. It is impossible to obtain accurate statistics on out-patients 1881-85 as some hospitals returned the number of patients treated, others the number of applications received (often several from one patient) and some made no returns at all. Returns made later in the decade were reasonably accurate. See Appendix I.
91 Abel-Smith pp 86, 101.
92 AJHR 1886 H9 p 7.
Forced to retire through ill-health, Grabham was able to say:

'... I look back with great satisfaction upon the contrast which is noticeable between the present state of the hospitals and their condition three and a half years ago.'

Obviously much of the credit for this change was due to the officials and staff in charge of the institutions who, Grabham said, were ready and willing to learn anything he could teach them:

'Everywhere I have been courteously received, and my criticisms taken in good part, and acted upon without delay...'

This minimizes some of the conflicts between the Inspector and various hospital authorities. Only after several years of exhortation, for example, were the hospitals at Christchurch (1885) and Wellington (1886) connected to their respective town drainage systems. However, if due allowance is made for restricted finance and bureaucratic limitations, Grabham's assessment appears to be valid.

93 R.C. Begg 'Public Hospitals in New Zealand' NZMJ Vol XXXI p 434 describes Grabham as a man of initiative and energy. His devotion to duties, for he travelled 17,260 miles by coach and vessel in his first three as inspector (1882-84), may have contributed to the breakdown in his health.

94 AJHR 1886 H9 p 1.

95 Ibid.
Until 1882, there was little progress within the hospitals. Grabham emancipated New Zealand hospitals by his perception of what could be done with them and, later, by his success in initiating the long process of their reform. As the Inspector himself was the most powerful force behind the dramatic improvements from 1882 to 1885, this period can be aptly termed 'the Grabham years'.

Charitable institutions were not so fortunate as their medical counterparts. As these institutions were outside his jurisdiction, Grabham confined his charitable aid activities to those aspects that also directly concerned hospitals. Thus charitable aid did not reap the benefits of Grabham's insight and energy and retained, instead, a close affinity with the situation of the hospitals prior to 1882.

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96 AJHR 1883 H3A pp 11, 23; H18A pp 7, 16.
III. PROVISION FOR THE DESTITUTE, 1877-85.

The abolition of the provinces changed some of the sources of charitable aid in New Zealand, but had little effect on its general form and distribution. This continuity is particularly noticeable in the provision of outdoor relief. Death, sickness and desertion of the family provider remained major causes of poverty.¹ A large proportion of those who received assistance, therefore, were adults with several dependents. In March 1878 about two thirds of the aid distributed in Canterbury and Auckland was received on the behalf of children.²

Fluctuating economic conditions produced a large number of unemployed and the most needy of these were sometimes given relief work by Charitable Aid Boards or relieving officers. The men employed were invariably those whose families would otherwise have become a charge on the charitable aid funds. In August 1877, for example,

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¹ About three quarters of the charitable aid distributed in Canterbury 1878-80 was granted for these reasons. IA 1 82/1157 (78/1324) J.E. March to Mayor of Christchurch, 20 March 1878, shows that of a total of 625 cases, there were 114 adults and 361 dependents in this category. LT 12 June 1880, indicates that the corresponding figures two years later were 116 and 334.

² IA 1 82/1157 (78/1324) J.E. March to Mayor of Christchurch, 20 March 1878; IA 1 78/1595 B. Maclean to Colonial Secretary, 27 March 1878. There are no precise returns from other districts.
the Canterbury Relieving Officer was empowered to provide relief work for all men of the 200 to 300 unemployed in Christchurch who had families. Continued depression in the 1880s made the able-bodied unemployed a common feature of New Zealand life.

Immigration was seen as a source of both unemployment and increased demands on charitable aid funds. The poor selection of immigrants meant that some were unhealthy and soon became a charge on government funds:

'Our colonial poverty arises ... in no small degree among those who have been brought to our shores at our expense in order to aid us in the settlement of the country ... emigration [is] a very different thing to what it was thirty or forty years ago. The diminution of the danger [associated with it] induces the feeble to venture out to us, and by the want of care exercised by agents, imbeciles and persons afflicted with chronic and hereditary disorders are intruded on us.'

The increase in able-bodied poor, too, was blamed on the system of immigration. Immigrants frequently found that there was little work available and, of that offered, much was unsuitable. Their discontent was expressed in no small degree among those who have been brought to our shores at our expense in order to aid us in the settlement of the country ...

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3 LT 9 August 1877. March was able to provide work for all who applied in mid-1880 - LT 12 June 1880.
4 Taranaki News 10 January 1880.
5 PD 24 p 159; 29 p 599. W. Rolleston and H.P. Murray-Aynsley. P 7 August 1877 reported a resolution of the Auckland unemployed for the stoppage of free immigration.
letters to England\(^6\) and the *Lyttelton Times*, sensitive to their plight, advocated their employment on what it considered to be essential public works.\(^7\)

\[\text{There was considerable diversity in the charitable aid arrangements of the colony. At Gisborne, Wanganui, Greymouth, Hokitika, Oamaru and Dunedin, charitable aid came under the auspices of the local benevolent society, which received a government subsidy on its subscriptions. Relieving officers distributed government aid at Auckland, New Plymouth, Nelson and Christchurch. In Wellington the Benevolent Society administered private relief and government aid was supervised by the Inspector of Police. At smaller centres, notably Picton and Napier, poor relief was administered by the hospitals.}\(^8\) In some rural areas there was little charitable aid distributed as such. Destitutes were cared for by private charity, or migrated to the towns and the aged poor were looked after by the local hospital.

The benevolent societies manifested the traditional belief in voluntary aid for the destitute. Their main concern was the distribution of general outdoor relief

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6 *LT* 24 July 1880.
7 *Ibid* 18 June 1881.
8 *IA* 77/4946 Charitable aid returns, 24 July 1877; *IA* 64/10 Charitable aid returns, 24 June 1878; *AJHR* 1884 Sess II H13 pp 1-4.
and the care of the aged.9 The number of societies grew when severe conditions brought an increase in poverty. Even at Christchurch, which was considered rather languid in voluntary aid schemes, a benevolent society was formed when the need grew acute and it supported a soup kitchen and distributed food, clothing and fuel.10

The principle of voluntary aid received strong government support. A meeting of Grey's cabinet reaffirmed that charitable aid:

'... should, in the opinion of the Government, be distributed through Social Voluntary Organisations, subsidised by the Colony in proportion to the voluntary subscriptions raised.'11

Later, the Hall ministry assured the House that, in their hospital and charitable aid schemes, great care would be taken to avoid interference with existing voluntary organisations.12 The class from which the administrators of the colony were drawn also provided the people who were chiefly responsible for the management of the benevolent societies and this may have promoted cooperation between the two.

The fortunes of benevolent societies varied with the amount of local interest and demand. Similarly, their criteria for providing assistance fluctuated

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9 In the four main centres they were also responsible for small female refuges.
10 LT 7-8 June 1880.
11 IA 178/1595 18 April 1878. Signed 'E. Fox, Secretary.'
12 PD 35 p 99; 38 p 83.
according to locality. In relatively good times they were inclined to give dubious applicants the benefit of the doubt and were open-handed in their charity.

This generosity, with funds partially derived from taxpayers, was naturally a target for criticism. One newspaper objected to the way philanthropy was frequently combined with a 'spirit of wastefulness'.\(^\text{13}\) In Parliament the charitable work of the societies was praised but their management of business affairs strongly criticized.\(^\text{14}\) The \textit{New Zealand Times} claimed that assistance was often given with little discrimination or inquiry and that the good nature of 'almoners of public bounties' indisposed them to keep stringent checks upon purse strings:

'This was excusable, perhaps, when the funds came in plentifully from the public treasury, and the people, themselves prosperous, gave liberally in the cause of charity, with little care how their gifts were applied. The altered circumstances of the colony now forbid that a systematic check to improper applications should be longer delayed ...'\(^\text{15}\)

The lack of system and the virtual absence of any form of inspection probably led to most of this abuse. Coordination between the various charitable bodies in large towns was often lacking, so that a vagrant could sometimes draw aid from several organizations, respectively supported by churches, benevolent societies and

\(^{13}\) \textit{Colonist} (Nelson) 30 December 1879.  
\(^{14}\) \textit{PD} 38 p 112.  
\(^{15}\) \textit{NZT} 28 June 1881.
the government. From the time of the abolition of the provinces no-one had sufficient authority to curtail misappropriations effectively.

This situation also existed in towns where charitable aid was controlled by a relieving officer. Under the provincial system they had been clearly responsible to the various provincial governments, but since abolition they had been in a nebulous position, with both local and colonial responsibilities. At Auckland the officer was competent and energetic, but was unable to check on the authenticity of many applications and was subjected to strong local pressures that he felt unable to resist. The existence of these pressures was corroborated by the Hon G.S. Whitmore, who also stated that while he was Colonial Secretary 'many scandalous cases' came to his knowledge.

The Colonial Under-Secretary admitted that the government was not sure that economy was being practised, but was unable to change the situation. At Napier, the absence of any properly constituted authority led to an

16 PD 38 p 598.
17 IA 1 78/1595 B. Maclean to Colonial Secretary, 27 March 1878.
18 PD 45 pp 125-126. Whitmore was Colonial Secretary from 18 October 1877 to 8 October 1879.
19 AJJC 1878 No 20 p 18.
arrangement whereby some members of the hospital committee issued orders on storekeepers for food, clothing and money for charitable aid applicants. These accounts were certified without question by the municipal council, which gained a monthly refund of the charges from the central government. This practice led to, 'enormous abuses' and the claim that:

'... nine tenths of the money is given to worthless and improper persons, without any previous inquiry as to their character ... matters go on without control or supervision of any kind whatever, ending in misdirected charity, waste, extravagance and encouragement to the idle and dissolute portion of the community.'

The only serious check on abuse came from the random campaigns of charitable aid committees and newspapers. Personal pride, too, contributed in that few liked it to be known that they were, 'on the charitable aid books'. The death of Skae, soon after his responsibilities were extended to cover charitable aid, dashed hopes for immediate reform in the system. His eventual successor, Grabham, was not officially expected to concern himself with charitable aid matters and indeed, his enormous task of reforming the hospital system largely prevented him from doing so.

There was a growing belief that many of the recipients of public charity were unworthy, their wants

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20 IA 1 82/4362 J.A. Smith to Colonial Secretary, 23 September 1882.
21 Ibid.
receiving attention because they were noisy and obtru­sive, while many needy cases shrank from the public view and were overlooked or comparatively neglected. The New Zealand Herald lamented:

'... that in a young country like this, founded within the memory of the present generation, we should be reproducing the pauperism and state charities which belong to the over-crowded countries of the Old World.'

and drew comfort only from the fact that the situation was much worse in Victoria and Tasmania, where pauperism had been 'reduced to a science'.

In contrast there were very few, if any, Maori recipients of charitable aid. They were little affected by the fluctuations of European society and their community life assured the individual of care when the need arose.

Traditional assistance in the colony, in the form of kindly neighbours and community collections, still provided substantial aid to the needy. Some funds were raised to return invalids to their relatives, both within New Zealand and overseas; others alleviated chronic distress, usually caused by the death of the family pro-

23 Ibid.
24 IA 64/10 Charitable aid returns, 24 June 1878. Eight of the twelve centres listed provided figures and an analysis was made of the recipients' countries of origin. The column headed 'Maori' is empty. The list is clearly headed by 'English' (699) and 'Irish' (502).
vider. These activities were more characteristic of, but not confined to, the rural areas.

An incident at Christchurch indicated the extent of public generosity. A petition for the support of five destitute and recently orphaned young children was left at a city hotel and soon raised £11.3.9. Inquiries, however, revealed it as gross misrepresentation on the part of two teenagers, whose father and brother were employed in other districts and the Press took the opportunity to commend the vigilance that prevented the success of the scheme, as well as the charity of those who made it possible.25

The friendly societies in New Zealand offered one form of self-reliance. Most of the 249 societies in 1877 belonged to the Manchester Unity Independent Order of Odd Fellows (105), the Ancient Order of Foresters (60), the Hibernian Australasian Catholic Benefit Society (27), the Independent Order of Rechabites (22) or the Independent Order of Odd Fellows (17).26 The combined membership of the 188 societies for which figures were available was nearly 14,000.27 By the end of 1884 there were 281 societies with a combined membership of just over

25 P 24 June 1880.
26 AJHR 1877 I19 p 2.
27 Ibid. The grant total for the colony, obviously, would be in excess of this figure by several thousand.
21,000. 28 Most of the lodges were fairly small 29 and the most significant feature of this aspect of the period was the spectacular growth of the United Order of Druids. 30

Throughout the colony the benefit of friendly societies was restricted because most of the poorer classes were outside their membership. 31 About one third of their members relinquished membership for reasons other than sickness - mainly because they were unable to maintain their payments. 32 Many other people did not even contemplate membership because of the relatively high weekly dues. 33

Some of the societies were, 'undoubtedly unsound' and combination of ignorance of basic actuarial principles and inadequate contributions had led to the insolvency of others. 34 At this time, therefore, a number of societies afforded only limited security to their members. The majority, however, were basically sound

28 AJHR 1886 H2A pp iv, 6.
29 Ibid p iv. 218 of the 281 lodges had a membership of less than 100 and the average membership was 75. 2.
30 Ibid p 5. From 1 society in 1878 to 31 by 1884.
31 P 10 February 1877 estimated that they provided protection for about one tenth of the population of Canterbury. In 1884 about 1 person in every 27 of the population was a member of a friendly society. (Note that the membership of the breadwinner provides protection for the whole family.)
32 W.B. Sutch Poverty and Progress in New Zealand p 95.
33 Sutch PP p 95. EP 20 June 1882 cited the case of an unnamed, but 'sound and prosperous', English society which lost nearly half of its membership through inability to maintain payments.
34 AJHR 1886 H1A p 1.
and were accorded support because they were seen as
an agency that fostered independence.\textsuperscript{35} The friendly
societies were, within limits, reasonably successful -
they assisted many who might otherwise have been
forced to seek public charity but, as a preventive
force, they were only a partial solution to the wide
problems of poverty.

The most significant forms of indoor relief were
still those provided in orphanages and refuges. These
institutions, like the hospitals, increased slightly
in number during the late 1870s and then concentrated
on internal improvements rather than further expansion.

From late 1876 to 1880, orphanages and industrial
schools were controlled by the Justice Department, but
generally continued to operate under local management as
in the provincial period. Government grants for com-
mitt ed children and those sent by relieving officers,
were paid from the charitable aid vote.\textsuperscript{36} The govern-
ment institutions were characterised by a lack of
finance and reluctance to provide even essential accom-
modation and amenities. Although it solicited suggest-
ions for improvements to these institutions the Depart-

\textsuperscript{35} Ibid; PD 38 p 108.
\textsuperscript{36} Whelan p 120.
ment had no constructive policy and seemed worried only by the possibility of adverse publicity.37

In 1880 control was transferred to the Education Department and a more effective system of management and inspection was introduced. The Neglected and Criminal Children Acts Amendment Act of 1881 authorised the transfer of such children to any part of New Zealand and inaugurated a truly colonial system of child welfare. One result of this was that the Roman Catholic authorities in Nelson were able to make better provision for a larger number of their co-religionists.38 Under the direction of Inspector Habens, conditions at the government institutions improved rapidly.39

A significant development was the introduction of the 'boarding-out' system, whereby children were cared for in foster homes, to which an allowance, usually about 5s0d per week, was granted. Provision for the system was made under section 34 of the first charitable aid bill and it received the very enthusiastic support of Dr. Wellis, who saw it as the only good part of the bill, '... the oasis in the desert.'40 With the demise of the bill, nothing more was achieved until 1880, when Habens was sent to Australia to observe the systems in

38 Ibid p 145.
40 PD 24 p 77.
operation there. His favourable report\textsuperscript{41} was reinforced by one which showed the excellent results achieved by boarding-out in Massachusetts and New York\textsuperscript{42} and a system of boarding-out was introduced into New Zealand in 1882. Under careful control, it proved widely successful and attracted strong public support.\textsuperscript{43} An unfortunate corollary was that in the industrial schools at Burnham and Caversham there was eventually a greater concentration of poorer quality inmates and the tone of the institutions suffered accordingly.\textsuperscript{44}

The Police Departments, invaluable because of their local knowledge, unobtrusively did much to ensure that circumstances in the foster homes were satisfactory. They also adopted, 'a kindly and quiet watch', over children placed out at service or entrusted to the care of relatives.\textsuperscript{45}

As the colony matured, the numbers of aged and infirm requiring charitable aid increased. Many had no relatives to support them. The few old peoples refuges in existence were similar to their provincial predecessors. A number were established in old immigration

\textsuperscript{41} AJHR 1881 E 6. Cited in Whelan p 153.
\textsuperscript{43} LT 25 July 1885; AES 2 October 1885.
\textsuperscript{44} Whelan pp 172-173. The 'family atmosphere' of these schools gradually disappeared and they took on more the character of reformatory institutions.
\textsuperscript{45} AJHR 1881 E6A p 2.
barracks or disused hospital buildings. In 1877 the old Auckland Hospital building was opened as a refuge and provided with a resident master and matron. 46 Although its interior, 'presented a clean appearance', it was admitted to be old and dilapidated and 'infested with bugs'. 47 In 1882, Napier asked the government to erect a new refuge and described the condition of the old one as:

'... so dilapidated, dirty, and unsuitable that it is a disgrace to the Colony' 48

The Armagh Street Depot in Christchurch was typical of the 'doss-house' type of refuge; men were permitted to sleep there for a few nights but were discouraged from permanent residence. Consequently some people slept out of doors, usually in parks or on river banks. Limited accommodation was available to old people in some benevolent institutions, 49 but was insufficient to meet the demand.

A few refuges provided excellent accommodation. The Ashburton Old Men's Home, established in 1878, maintained a fairly high standard of comfort and supervision in its early years. 50 As the Thames Refuge was operated as a part of the local hospital, Grabham felt

46 Rauch pp 112-113.
47 AJHR 1877 H15 pp 1-2.
48 IA 1877/4362 J.A. Smith to Colonial Secretary, 23 September 1882.
49 As the name implies, these were institutions established and managed by the benevolent societies and their supporters for the benefit of destitutes.
50 LT 6 October 1879.
obliged to inspect it. He found that it was well furnished and that good meals were served to the 12 inmates:

'Every part of this small establishment is in the most creditable condition — bright, cheerful and scrupulously clean. I could not help wishing that some of the hospital patients could be exchanged for its inmates, as the contrast between their respective surroundings is very great.'

After a visit to the same refuge, two years later, Grabham stated that it might well serve as a model for other towns, 'both as regards arrangements and comfort.'

In his first report, Grabham said that the few refuges in existence were quite inadequate for the reception of the large and increasing numbers of aged people. Many made a home of their local hospital and, with the chronic and infirm cases, made these institutions correspond:

'... very closely to the permanent pauper establishments of an English union workhouse.'

These patients impaired hospital efficiency and, in some of the larger towns, their occupation of whole wards excluded curable patients. As the cost of their maintenance in hospitals far exceeded that of 'properly appointed' refuges, their presence could be opposed on

51 AJHR 1883 H3A p 23.
52 AJHR 1885 H18A p 16.
53 AJHR 1883 H3A p ii.
grounds of economy as well as of efficiency.\(^{55}\)

By 1884, those towns without refuges were clearly indicated by the hospital reports. Of the 124 patients at Dunedin Hospital, 25 were refuge cases and a further 5 were boarded out, at a cost to the Hospital of 10s0d each per week. At Wellington Hospital 25 of the 77 patients were in this category and this prompted the Inspector to remark:

'Judging by the growth of this evil of late, it cannot be very long ere the whole hospital becomes a gigantic alms-house.'\(^{56}\)

Several smaller hospitals maintained a high proportion of old people - Wanganui, Picton, Timaru and Lawrence in particular. In his report on Greymouth Hospital, Grabham said:

'A number of "refuge cases" continue to encumber this hospital, and this class has a natural tendency to increase as the colony grows older.'\(^{57}\)

and a similar situation at Hokitika, Kumara and Westport illustrated the effect produced by the lack of a refuge in a large district.\(^{58}\)

Refuge cases, like the gratuitous treatment of pauper patients and the provision of outdoor medical relief, emphasized the link between hospitals and charitable aid in New Zealand. The contemporary attitude,

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\(^{55}\) AJHR 1883 H3A p ii; 1885 H18 p 2.  
\(^{56}\) AJHR 1885 H18A p 18.  
\(^{57}\) Ibid p 7. See Appendix A.  
\(^{58}\) AJHR 1885 H18A pp 7,8,19.
that the two were very closely associated, is reflected in many of the debates and discussions of the period. The two were also linked in administration and finance-aspects of social welfare in which there developed obstacles to the satisfactory operation of hospitals and charitable institutions in New Zealand.
IV. A DEARTH OF MANAGEMENT, 1877-85.

Both the administration and the finances of hospitals and charitable aid in the period 1877-85 left much to be desired. The abolition of the provinces created a vacuum which was only partially filled by a hazy and rather inefficient combination of central and local administration. This confusion was also evident in the finances of the period. The diverse financial arrangements of the colonial institutions were theoretically co-ordinated in 1878 by the recognition of two systems - one of colonial government control and the other of local finance combined with government subsidies. In practice, however, financial affairs remained somewhat arbitrary and complicated.

There were three main types of administration. Two of these - the Central Board of Health and the supervision provided by the inspector - involved the central government. The third, and probably most important, was that of the local committees which, in default of effective central control, assumed wide responsibilities.

The general health and physical welfare of the colony was entrusted, under the Public Health Act of 1876, to a Central Board of Health. Because health matters came under the auspices of his department, the

1 N.Z. Statutes 1876 No 60 p 380.
Colonial Secretary was always president of the board. The board's duties were not clearly defined—possibly to give it a flexibility in keeping with its position as the principal health authority. The relatively frequent meetings of the board's early years were primarily concerned with quarantine measures, which were clearly regarded as its main responsibility. ²

Another duty of the board was to supervise the activities of local boards and it was empowered to demand reports on conditions in the districts under their jurisdiction. ³ A survey covering the existence of infectious diseases, drainage and sewage facilities, water supplies and local board activities was made in 1877 ⁴ but was not followed up. After 1880, meetings were very infrequent and from about this time, the board seems to have been of very little significance. After extensive research, F.S. Maclean concludes that:

'During the 24 years of its existence the Central Board of Health, by any standard, failed dismally to fulfil the task for which it was established.' ⁵

The local board of health was usually the local

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² N.Z. Central Board of Health, Minutes 1876-1900.
³ N.Z. Statutes 1876 No 60 pp 382, 391. The local boards were also appointed under this act.
⁴ IA 19/1 Returns from Local Boards of Health to the Central Board of Health, 1877.
⁵ F.S. Maclean Challenge for Health p 119.
county or borough council. As most schemes for health improvements had to be provided from their own funds, they were often subject to restraint from ratepayers who, naturally, were primarily interested in keeping expenditure to a bare minimum. Apart from exercising some control over local epidemics and quarantine cases, they were generally inactive.

An 'outstanding exception' however, was the Christchurch Drainage Board, which constituted the city's local board of health from 1876 to 1885. A significant drop in the local death rate—from about 30 per 1,000 of population in 1875 to about 14 per 1,000 in 1882—is ascribed largely to the activities of the board and its tireless medical officer, Dr C. Nedwill. Unfortunately most local boards existed more on paper than in fact. Like their parent body, they rarely used their authority to protect their localities from hazards to health.

Although the machinery of the 1876 Act was largely ineffective, hospital administration, at least, was partially coordinated by the Inspector from 1882. Grevhem was directly responsible to the Colonial Secretary and his recommendations, particularly those included in

6 Maclean p 151.
7 Ibid p 137. This was before the board was able to persuade the hospital, which discharged its drainage into the Avon, to connect with the city system. This task completed in 1885, marked a further contribution of the board to the health of Christchurch. See Bennett pp 51, 65-66, 69-74.
8 Maclean p 151; Sutch PP pp 85-87.
the individual hospital reports, were responsible for many improvements in the colonial institutions. As early as 1884 he was able to say:

'... the favourable manner in which the local Committees and Medical Officers have received and carried out my suggestions has been very gratifying, and has certainly greatly exceeded my expectations. We have now many establishments which, in their arrangements, order, and comfort, will bear favourable comparison with any of the numerous European hospitals with which I am acquainted; and a spirit of emulation has sprung up in the colony which cannot fail to have a wholesome effect.'

Grabham had surprisingly few official powers to enforce his directions. He relied upon contemporary respect for official inspections and apprehension of the consequences of adverse reports. The publication of these reports and inter-district rivalry often led to local pressure for improvements. The ultimate sanction was Grabham's power of appeal to the Colonial Secretary, but it was rarely used. The best managed hospitals were those which were the subjects of local interest and support, but the Inspector also found that these elements could be a major obstacle to his attempts to reform the colonial system.

Largely because of the gold rushes, the South Island had an extensive hospital network, with approximately double the capacity of North Island.
hospitals. Although the total number of hospital beds in New Zealand remained almost static over the years 1881-85, there were pronounced changes within the hospitals themselves. This was mainly due to population changes and internal consolidation measures. In this period, 8 of the 12 North Island hospitals and 9 of the 25 South Island hospitals increased in size. Decreases in size affected 12 in the South Island and only 4 in the North.\(^\text{11}\) The overdevelopment of the South Island, appear to be mainly responsible for these changes.\(^\text{12}\)

To increase efficiency in the colonial hospital system, Grabham recommended the closure of at least six hospitals. He also proposed the modification of seven others to form branch institutions, or small cottage-hospitals, attached to larger neighbouring hospitals.\(^\text{13}\) Improvements in communications, especially railways, meant that these institutions were redundant and Grabham's scheme could have been implemented, 'without inflicting any great hardship'.\(^\text{14}\)

Local interests, naturally, were opposed to either the closure of the hospitals or the surrender of their management to other districts. The hospitals were in existence largely because of local efforts; they

\(^\text{11}\) Four hospitals, all in the South Island, remained unchanged.
\(^\text{12}\) See Appendix C.
\(^\text{13}\) AJHR 1885 H13 p 2; H18B p 1. 9 of the 13 hospitals affected were in the south island.
\(^\text{14}\) Ibid H18B p 1.
Waipukurau Hospital in the Mid-1880s.

Opened in 1879, this rural hospital developed rapidly to attain the status of a country-town hospital by 1885. Grabham's proposal to make it a branch hospital linked to Napier was defeated by local opposition and government inaction. The proof copy of this photograph bears the date '1879', but the new ward on the left of the photograph appears to be that built in 1884.
were usually a subject of pride and represented a measure of security and convenience that a distant hospital could not provide. Such hospitals were also a means of retaining, partly at government expense, resident medical practitioners. 15

Grabham was unable to defeat this parochialism. The government realized that his suggestions were designed to benefit the colony as a whole, but in the face of such strong opposition, it declined to risk political repercussions by implementing them. The Inspector was well aware of his limiting powers, but his repeated requests for the more 'direct and efficient authority' of the Ontario system bore no fruit. 16

At the base of hospital and charitable aid administration were the local boards or committees. Hospitals and charitable aid affairs were sometimes dealt with by separate bodies, but in many districts they came under jurisdiction of a single committee. As the committees controlled internal policy, they were largely responsible for the standards of care in the institutions under them. Their wide powers included the regulation of staff, patients and applicants, as well as general facilities and financial affairs.

15 Ibid H18 p 2.
16 AJHR 1883 H3A p iii; 1885 H18B p 2.
The composition of the hospital committees varied considerably, but depended largely on their sources of income. In most of the districts where voluntary subscriptions formed an important part of the income, elections by subscribers were the rule, but there was little uniformity in the franchise, frequency of elections, or number of positions to be filled. This kind of management was typical of the 'goldfield' hospitals. A few hospitals were managed by local bodies, a development which, for obvious reasons received strong government support. In the larger hospitals, where the government provided most of the funds, committees were generally appointed by the government. In a number of districts some combination of these three elements could be found, the most common being that of subscribers and local body representatives.

These various bodies often controlled charitable aid as an adjunct of hospital administration. Government-appointed boards of large hospitals maintained a close liaison with the local relieving officer. Benevolent societies elected their own committees of

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17 AJLC 1878 No 20. Despite this, the total figure for local bodies contributions towards hospitals maintenance remained fairly low.

18 Exceptions to this were Napier and Thames.

19 IA 64/10 Hospital and charitable aid returns, 24 June 1878; AJHR 1882 H23 pp 3-6; AJHR 1884 Sess II H13 pp 1-2.
management, usually in an election by subscribers. Despite its complexities, local management was fairly effective - probably because of its proximity to the institutions with which it was concerned. Its apparent efficiency was the reason why local control was favoured by a wide spectrum of political opinion. 20

The hospital and charitable aid accounts of the period were a financial jungle. Charitable aid returns were rarely compiled by the central authorities and were usually incomplete. 21 Grabham observed the absence of any regular system of bookkeeping in the colonial hospitals in his first report. 22 His frustration at this state of affairs was evident two years later when he described the tables of hospital receipts and expenditure as 'very imperfect'. 23

The sources of error are best seen in hospital accounts for the simple reason that there were more of them produced than their charitable aid counterparts.

20 PD 24 pp 83 Gisborne(Totara,Wd), 95-96 Ballance (Rangitikei,Wn), 443 Whitmore(MLC,HB); 44 p 650 Dick(Dunedin West,O); 50 p 475 Stout(Dunedin East,O).
21 IA 64/10 Charitable aid returns, 24 June 1878. Returns were occasionally published at the request of members of parliament. According to Speight(Auckland East,A), the accounts of benevolent societies required some attention, PD 38 p 112.
22 AJHR 1883 H3A p 11.
23 AJHR 1885 H18 p 2.
Often information from important hospitals was not supplied. There is no apparent reason for this, but the state of their books may have led some hospitals to withhold information, or put them in a position where they were unable to supply it. In some cases no figures at all were supplied; in others a few items or categories were omitted. In both cases totals were distorted and the value of the data impaired.

Another common defect was incorrect classification. Individual items may have been placed under inappropriate categories, but this cannot be checked. The more obvious flaw was the tendency to combine two or three categories to produce one figure. The most frequent combination was that of 'provisions' with 'wine, beer and spirits'. 'Drugs and dispensary' and 'surgical instruments' were also common victims of the practice. This method of accounting was probably traditional in most of the hospitals that employed it, but may have been a convenient way of concealing unwarranted expenditure. The adverse effects of this procedure were generally restricted to expenditure accounts.²⁴

The most disconcerting feature of the hospital accounts is the presence of numerous arithmetical

²⁴ See, for example, the accounts in Appendix B.
errors. Printed accounts which showed final analyses should have been faultless: to check their accuracy was a simple operation, yet this was obviously not carried out. In the worst case the grand total, notwithstanding two minor errors, was £140 short of the correct figure. Such elementary inaccuracies bring into question the competence of the officers responsible, as well as the dependability of the system of bookkeeping and audit. Confidence in other aspects of the hospital returns is also undermined.  

Finally, two apparently reliable records of government grants to hospitals are difficult to reconcile. A review of government aid, compiled in 1888, gives figures quite different from those of the annual reports. This is partly because the annual reports employed the calendar year and the later survey the financial year, but the discrepancy cannot be fully explained and the contemporary documents made no attempt to do so. On the other hand, the charitable aid figures of the 1888 survey correspond exactly with those for the three years in which annual reports on charitable aid are available.  

25 Income for 1882.  
26 See Appendix D.  
27 Ibid.
The contemporary accounts, though not unimpeachable, are important in that they present a general outline of financial affairs and indicate the relative value of various items and sources. Some analysis of hospital and charitable aid income is essential as it was the income of these institutions, rather than their expenditure, which was the subject of much dispute.

Hospital and charitable aid income was derived from three main sources - the government, local bodies and the general public. The latter source was subdivided into voluntary subscriptions, donations and payments on account of patients or inmates. Subscribers gained satisfaction from the knowledge that their regular contributions helped the sick and needy. An added incentive was that those who contributed a fixed sum, usually 10s per year or more, were often entitled to vote for members of the controlling committees. Furthermore in a number of districts subscribers to the local hospital were entitled to free treatment for themselves or their nominees. A parallel charitable aid development was that relief was often readily available to those who had the recommendation of a subscriber. In some areas, the collection of subscriptions was vigorously carried out, in others virtually nothing was done. 28

28 AJHR 1883 H3A p ii.
Donations, which differed from subscriptions in that they were not given on a regular basis, were a significant source of funds. Bequests, on the other hand, were generally confined to a few fortunate institutions. Money was also raised by such voluntary activities as fetes and 'charity Sundays'.

Although hospital facilities were supposed to be reserved for the destitute, they were often used by other sections of the community. Destitute people were treated free of charge and those patients who were able to pay for treatment were expected to do so. Only one survey, completed in 1882, gave details on this aspect of hospital finance. It revealed that about one quarter of the patients in the 29 hospitals which returned figures for this item, paid sums between 2s 6d and £2,2.0 per week, for hospital treatment. Payments were made for over half the patients in the hospital at Arrowtown, Charleston, Cromwell and Naseby and for almost exactly half of those at Ashburton.

This suggests that both the obligation and the capacity to pay for treatment were strongest in the rural areas.

29 On 'charity Sunday,' which was generally an annual event, the proceeds of church collections were given to charity. LT 8 November 1884 states that 'charity Sundays' were inaugurated in Christchurch in 1882.
30 AJHR 1882 H23 pp 3-6.
In his early reports on individual hospitals, Grabham noted the care or otherwise with which patients' payments and subscriptions were collected. He discovered grounds for both praise and criticism in this respect and was clearly surprised by the class of 'destitutes' treated in New Zealand hospitals:

'On visiting the hospitals a new-comer cannot fail to be struck with the presence of many patients who, if in England, would be treated at home by their private medical attendant ... The provision of free board and medical attendance during illness for those who ought to be able to pay for them must have a very bad influence in fostering habits of improvidence; injustice is done also to medical practitioners.'

Medical men were well aware that they suffered some loss of income because of the charitable inclinations of some hospitals. The New Zealand Medical Association in particular was concerned that these institutions were:

'... abused by many persons in comparatively good circumstances.'

In his third report the Inspector expressed grave misgivings about the situation:

'A large proportion of the patients treated in the hospitals are not proper objects of charity. Legislation regarding the collection of maintenance-money is defective, and the machinery inefficient. Payment, on recovery of health and income from employment, should be insisted on.'

31 AJHR 1883 H3A p ii.
32 IA 7 82/1157 (80/2577) NZMA to Colonial Secretary, 7 June 1880.
33 AJHR 1885 H18 p 2. The legislation to which Grabham refers is the Destitute Persons Act of 1877.
This was a case where, through the lack of a colonial system, practice was rather at variance with theory. Grabham represented the traditional view on payments by patients. The practice had grown up in some hospitals that, after payment of their annual subscription, patients received free medical treatment. A small number of hospitals did not demand a subscription or fees and, in these circumstances, a few people even regarded free treatment as their right. Most hospitals, however, managed a compromise solution. Those able and willing to pay did so; the remainder were given accounts for their treatment but little effort was made to enforce payment.

The equivalent source of charitable aid income was from relatives of those receiving institutional care. Few detailed accounts are available but it seems certain that the proportion whose care was paid for in charitable institutions was considerably less than in the hospitals.34

Local bodies were an integral part of the hospital and charitable aid system. At least nine hospitals were, at some time during this period, completely controlled

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34 AJHR 1884 Sess II H13 p 2. For the financial year 1883-84 about one-tenth of the expenditure of Thames Orphanage and a lesser proportion at Lyttelton Orphanage, was recovered from parents. No details of church orphanages were given.
by the local council, and local bodies were often represented on the committees of other hospitals. Local bodies were able to influence the administration of benevolent societies and, though not directly associated with charitable institutions, some local bodies contributed to their maintenance from ordinary rates.

The Financial Arrangements Act of 1876 empowered the government to deduct money for hospitals and charitable aid from the subsidies then paid to counties and boroughs. Those local bodies which failed to pay their proportionate share of the expenses thus made their contribution indirectly. In the Financial Arrangements Act of 1878 two systems of management and finance were recognised. One provided for control by the government of those institutions it supported, much of the cost being deducted from local body subsidies. The other system was based on local control with governments subsidies, generally £1 for £1, on local body payments as well as voluntary contributions. Intended as a temporary measure, this arrangement became the basis of hospital and charitable aid finance for seven years.

35 Patea, Wanganui, Nelson, Blenheim, Reefton, Ashburton, Waimate, Dunstan and Cromwell.
36 N.Z. Statutes 1876 No 48 p 203.
37 IA 64/10 Treasury circular re financial adjustments relative to subsidies paid for charitable purposes, 14 February 1878.
38 N.Z. Statutes 1878 No 46 p 272.
Wanganui Hospital in the 1880s.

Perhaps typical of the older country-town hospitals, Wanganui Hospital was managed by the local bodies of the districts it served.
After 1882 government subsidies to local bodies ceased and this means of indirect revenue was lost. The refusal of many counties and boroughs to contribute directly resulted in a significant drop in income from these sources.\(^{39}\)

The central government inherited responsibility for the maintenance of numerous institutions, as well as the provision of charitable aid, from the provincial governments. The central government wholly maintained 15 hospitals, 2 orphanages and 3 industrial schools. A further 22 hospitals and 6 orphanages, besides a number of refuges and benevolent societies, received government subsidies.\(^{40}\) There was a steady rise in government expenditure on hospitals and charitable aid: with the exception of 1879-80 it increased every year from 1877 to 1885.\(^{41}\) This heavy load on the government was increased by the abolition of local body subsidies. Few counties or boroughs were prepared to pay for hospitals and charitable aid when their counterparts obtained similar benefits without incurring burdens and were able to divert their funds elsewhere.

In 1883, the first year that recoveries could

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\(^{39}\) See Appendix D.

\(^{40}\) See Appendix E.

\(^{41}\) AJHR 1888 H9 p 3.
not be made from local bodies, the financial statement showed a distinct increase in government expenditure. 42

The Colonial Treasurer, the Hon H.A. Atkinson, said:

'Some districts, recognizing the truth that it is more blessed to give than to receive, still continue to subscribe to local hospitals and benevolent societies; but the general tendency, I am sorry to say, is to more and more throw the whole burden of relieving the poor upon the State.' 43

In the Upper House, the Hon J.W. Barnicoat disputed Atkinson's claim as to the lofty motives of those local bodies that still subscribed. He pointed out that, because of pressure from ratepayers, local bodies were more inclined to receive than to give. He claimed that local bodies contributed only because they supposed they were under an obligation to do so. 44 A gradual realization of the true position would account for the falling off in local body payments and, to some extent, increases in government expenditure. 45

The demands of the various local bodies and the rising cost of hospital maintenance were major reasons

42 PD 44 pp 221-222.
43 Ibid p 222.
44 PD 45 pp 124-125.
45 See Appendix D. In AJHR 1885 H18 p 2, Grabham commented: 'Extravagance in the management prevails in the hospitals, and will continue to do so while the locality benefits by the expenditure of Government money.'
for the appointment of a government inspector. He was able to assess the requirements of the numerous institutions in partially and attempted, often with little success, to curtail extravagance.

What was possibly the most outstanding failure of hospital and charitable aid finance was, however, outside the jurisdiction of the inspector. This was the very high charitable aid expenditure in Canterbury. In a typical year, 1883-84, direct payments of charitable aid in the colony totalled £14,776.7.1. Of this Canterbury received £9,664.13.7. Auckland, with a grant of £2,931.5.10 was the only other province to receive over £1,000 in direct aid. Subsidies paid to local institutions amounted to £19,872.10.11 and were distributed more evenly. Although Otago, Auckland, Wellington and Nelson all received over £3,000, Canterbury, at £4,617.13.7 led its nearest rival by about £1,300. Canterbury received about 40% of the

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46 NZH 30 January 1880; see also J.P.S. Jamieson 'The New Zealand Hospital System' NZMJ Vol XXXIII p 260.
47 Skae was empowered to examine the aspects of charitable aid administration, but pressure of other duties and his inexperience with the subject, prevented him from doing so. Grabham, technically at least, had no power to investigate charitable aid matters.
49 AJHR 1884 H13 p 4. The figures for this year tally exactly with those of the 1888 survey.
total expenditure, a proportion that was characteristic of its receipts throughout the period.\textsuperscript{50}

The reasons for this apparently incongruous state of affairs and for the tolerance of other provinces received scant attention in contemporary records. The somewhat parochial \textit{Lyttelton Times} implied that Canterbury had a right to its payments because the central government had inherited the province's substantial land fund. In the days of provincial government this had been a source for charitable aid payments and, therefore, the liability for such payments, in the papers' view, remained with whoever administered the fund.\textsuperscript{51}

The key to the situation lay in the activities of the provincial government, which had a significant effect on Canterbury's attitude to charitable aid. Largely because of its prosperity, the somewhat paternalistic provincial government maintained a sizeable

\textsuperscript{50} Accounts for the period as in \textit{AJHR} 1888 H9 pp 18-22, as well as other sources, suggest that this is an accurate representation of Canterbury's position. IA 64/10 Charitable aid returns, 24 June 1878, and \textit{AJHR} 1882 B22 show that, while local body subsidies were in operation, the largest deductions were from those due to Canterbury boroughs and counties. According to V. Pyke, PD 44 p 648, the amount of government charity per head given for 1882-83 was about 5\textsuperscript{1}d for Otago, 1s3d for Auckland, 1s6d for Wellington and 2s3d for Canterbury.

\textsuperscript{51} \textit{LT} 20 July 1883. Canterbury had by far the largest land fund. See \textit{AJHR} 1877 C2; \textit{P} 14 October 1878.
charitable aid department, which was the least parsimonious agency of its kind in the colony. An unfortunate corollary of its relatively generous benefits was that the small private benevolent societies of the churches disappeared and the recipients of charitable aid tended to look upon their benefits as a right. Grabham's successor, in a review of the situation, asserted that the ease with which aid was obtained in Canterbury attracted 'a large proportion of thriftless people', many of them immigrants of poor quality.

After the abolition of the provinces, Canterbury received large sums for charitable aid. This was largely because no specific allocations were made for the central government's charitable aid vote. The Treasury, therefore, employed the appropriations of the previous year to allot this sum to the provinces. As Canterbury had spent easily the most on charitable aid in provincial days, it qualified for the lions' share of the vote.

The expenditure of the province was often attacked in parliament, yet little was done to curtail it.

52 PD 44 p 652 Thomson (Christchurch North, C).
54 IA 64/10 Treasury circular re financial adjustments relative to subsidies paid for charitable purposes, 14 February 1878. This flaw, apparently not remedied until 1885, was applicable only to direct payments. £1 for £1 subsidies were unaffected.
55 PD 24 p 82 Atkinson (Egmont, T); 35 p94 De Latour (Mount Ida, C); 44 p650 Dick (Dunedin West, O); 50 p475 Walker (Ashburton, C); 52 p 29 Fergus (Wakatipu, O).
This was probably because, except in times of political turmoil, it often seemed that the government was about to legislate on hospitals and charitable aid and thus remedy the situation. Until such a time parliament was expected to tolerate such anomalies as Canterbury's position. None could have foreseen that it would take nine years to pass such a reform and, after several years, the frustration of some members became evident in the increased frequency of their attacks on the arrangement that afforded Canterbury such licence.\(^{56}\)

Canterbury politicians, although they generally refrained from criticism of charitable aid in their own province,\(^{57}\) were also very dissatisfied with the lack of a satisfactory hospital and charitable aid system. Indeed, some of the, E.C.J. Stevens and W. Rolleston in particular, were in the vanguard of the movement for colonial reform. To some extent their concern was based on humanitarian ideals. They also realized that the existing arrangements were essentially of a temporary character\(^{58}\) and hoped to assist in the evolution of a

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56 Ibid.
57 For exceptions, see PD 24 pp 99-100 Murray-Aynsley (Lyttelton), 146 Bowen (Kaiapoi), 164 Stafford (Timaru); 44 p 652 O'Callaghan (Lincoln); 50 p 475 Walker (Ashburton).
58 PD 29 p 597 Turnbull (Timaru).
system consistent with their own beliefs. Provincial discontent with six years of legislative sterility was succinctly expressed by the Canterbury Times:

'Year after year the Government has promised to devise a satisfactory system, thereby preventing other people from taking up the matter. Year after year the Government has broken its promise.'

Most ministries were eager to remove the anomalies of poorly coordinated administration and inequitable financial practices, but found themselves confronted with problems which they were unable to overcome. In tackling the question of future hospital and charitable aid arrangements, one of the prime difficulties that faced the various ministries was what principles, in the face of pressure from many groups, to adopt.

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59 Canterbury Times 2 December 1882 p 16.
V. PRINCIPLES OF PUBLIC AID, 1877-85.

That hospitals and charitable aid were in need of reform was undisputed. The abolition of the provinces made the introduction of a colonial system essential:

'Hitherto the poor have been provided for by the provinces, but provincial institutions having been abolished, it is the duty of the Legislature to take the matter in hand.'

But the establishment of a general system raised questions which could not be evaded and there was considerable disagreement on the form of legislation to be adopted, and the principles it was to embody. The basic principles of poor relief, as well as the merits and faults of various systems, were extensively discussed in the first charitable aid debate.

Fundamental considerations were the causes of poverty, the value of overseas experience and the role of voluntary charity. The suggestion of a poor-rate and the alleged possibility of the 'pauperization of the colony', in conjunction with the other issues, led to a prolonged appraisal of the state's role and the rights of paupers.

There was general agreement on the main causes of

1 PD 24 p 73 Reid (Teieri, O). See also P 9 February 1877.
2 'Charitable aid' included institutions for the cure of disease. See PD 24 p 76 Wallis (Auckland City West, A).
poverty: old age, sickness, death of the father of a family, unemployment and 'social delinquency', which covered personal weaknesses such as desertion and drink. More obscure causes, however, also had their protagonists. R.M. Turnbull, for example, claimed that machinery caused unemployment, and hence destitution, an opinion which was refuted by W.R. Russell who asserted the opposite was true.

Other members took the opportunity to adduce causes of a more political nature. Legislation was seen as both a cause of and a cure for, poverty. The landed estates were bitterly attacked and Grey, in particular, cast much of the blame for poverty on the system of taxation. Politics appear to have changed Grey from a man of initiative in hospital affairs, for he was instrumental in founding some of the earliest colonial hospitals, to an

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3 The term is borrowed from J.B. Condliffe The Welfare State in New Zealand p 291.
4 A prolonged search did not bring to light any detailed analyses of the causes of poverty in the 1880s. An analysis made in the following decade shows the major causes in the order listed here, AJHR 1897 H22 p 38. For a typical contemporary appraisal, see PD 24 pp 79-80 Stevens (Christchurch City, C).
5 PD 38 pp 98-99. A similar opinion was expressed by some English authorities until the end of the century. See, for example, H.V. Mills Poverty and the State p 105 and J.A. Hobson Problems of Poverty passim.
6 PD 38 p 105.
7 PD 24 pp 155-156 Stout (Dunedin City, O); 30 p 1176 Rolleston (Avon, C); 35 p 86 Barron (Caversham, O).
8 PD 24 pp 146 Grey (Thames, A), 156 Stout (Dunedin City, O); 38 p 99 Turnbull (Timaru, O).
9 PD 24 p 146; 35 p 91; 38 p 94. This was also criticized by W.L. Rees (Auckland City East, A), PD 24 pp 85-86.
opportunist who, despite his exhortations, appeared to be more concerned with political advantage than social reform. The activities of some politicians, notably Atkinson in the 1880s, were influenced by their beliefs as to the causes of poverty. In many cases, however, the exposition of the 'causes' of poverty was merely an attempt to make political capital out of hospital and charitable aid debates.

Overseas precedent was sometimes examined in the search for a solution to the colony's welfare problems and was also employed to support a number of schemes. Hall, for example, cited the sources of charitable aid finance in 12 advanced countries and states when he introduced one of his bills. English practices drew most attention because they were, to many politicians, the most familiar. This influence was partly countered by some members who considered that the difference between the two societies, both in form at that time and in future needs, was so great as to make English experience of little relevance to the New Zealand situation.

The progressive states of Massachusetts and New

10 PD 24 pp 142-147; 36 pp 89-91; 36 pp 265-267; 38 pp 93-96; 42 pp 192-197.
11 PD 35 p 76.
12 PD 24 pp 73 Reid (Taieri, O), 85 Rees (Auckland City East, A), 154 Bastings (Waikaia, O); 38 p 98 Wakefield (Geraldine, O).
York developed systems that aroused the interest of English legislators and this, in turn, led to a few exponents of American methods coming forward in New Zealand's parliament. Australian colonies were not frequently mentioned in hospital and charitable aid debates, possibly because they, like New Zealand, drew largely on English experience and had not evolved satisfactory systems of their own. Attention to Australian institutions was generally restricted to those of Victoria and New South Wales.

A basic principle of the English system was its emphasis on voluntary charity. In New Zealand, the English influence in this respect had been strong in the early years of the colony, but declined in some areas so that the future of voluntary aid became one of the most contentious issues of hospital and charitable aid finance.

There were many strong advocates of a dependence on voluntary contributions. Some of these argued from

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13 J.J. Henley Report on the Poor Laws of Certain of the United States. In his introduction Henley refers to a report made by a fellow officer, Longley, in 1871 and to reports obtained from the United States by the British Legation in 1872. Henley was an English government inspector and his 92 page report deals comprehensively with the subject.

14 E.C.J. Stevens showed the most interest in American methods. As Henley's report was not published until August 1877, the book Stevens refers to in PD 24 p 80 was probably a copy of Longley's report. His interest in Massachusetts was shared by Rolleston, PD 30 p 1176.

15 AJHR 1877 H15 pp 1-2; PD 24 pp 75 Rolleston (Avon, C), 167 Reid (Taieri, O); 29 p 596 Rolleston; 38 pp 86 Murray (Bruce, O), 89 Shephard (Waimea, N); 44 p 644 Fish (Dunedin South, O).
from a moral viewpoint:

'... I am sure there is nothing more healthful to the moral life of a man than to have the springs of generosity, benevolence and charity stirred and opened within him.'

Such an opinion reflected humanitarian and religious attitudes inherited from England. Protagonists of this view felt that, if levies for charitable aid became compulsory, contributions would become mechanical and result in a lost of '... the wholesome effect of natural free-born charity'. Another popular outlook was that voluntary subscriptions and donations had worked well in a faulty system and should again prove their worth when it was reformed.

A Christchurch member, Stevens, objected to leaving charitable institutions to voluntary support, not because he opposed it as such - on the contrary, he shared the views of the moralists - but because he felt that it was not a source which the government should have taken upon itself to invoke. Another member termed maintenance by fund-raising activities, such as raffles and bazaars, 'a system of pious frauds' and strongly opposed voluntary contributions on the grounds that men ought to be compelled to do their duty.

16 PD 24 p 96.
17 PD 45 p 125 Whitmore (MLC, HB).
18 PD 24 p 80. This view was also expressed by E. Wakefield (Geraldine, C), PD 24 p 92.
19 PD 24 p 153 Swanson (Newton, A).
This was the dilemma of the legislators - private charity was a good principle, but if men were not 'compelled to do their duty', the financial burden was laid solely upon those willing to help and many who could easily afford to give escaped altogether.\(^{20}\) According to one member of the House, those who could least afford it were the most willing contributors.\(^{21}\) As a rule, voluntary contributions, produced least when funds were most needed because the contributors, like the intended recipients, were feeling the effects of depressed conditions.\(^{22}\)

Voluntary assistance to both hospitals and charitable institutions was often enthusiastic at the time of their foundation, but gradually declined as these institutions became a settled part of community life. An example of this tendency was the support for Oamaru Hospital, which soon after its foundation received annual voluntary contributions in excess of £300. Five years later the annual voluntary contributions totalled £45.\(^{23}\) A similar process took place at New Plymouth.\(^{24}\) In the opinion of a Taranaki newspaper, individual generosity was 'too intermittent and uncertain' to meet colonial requirements.\(^{25}\)

\(^{20}\) PD 29 pp 598 Feldwick (Invercargill, O), 599 Saunders (Cheviot, O).
\(^{21}\) PD 38 p 105 Swanson (Newton, A).
\(^{22}\) Taranaki News 3 August 1877.
\(^{23}\) PD 24 p 100 Shrimski (Waitaki, O).
\(^{24}\) Ibid p 84 Kelly (New Plymouth, T).
\(^{25}\) Taranaki News 10 January 1880.
The New Zealand Herald appreciated the moral advantages of voluntary contributions but felt that funds should have been drawn from all members of the community and therefore supported the idea of a poor-rate. A rate seemed equitable and it gained limited support in the House.

A form of poor-rate suggested by the Press in 1877 was considered and rejected by members of Atkinson's cabinet. After he had dealt with minor objections to a poor-rate, the Hon D. Reid indicated to the House what he considered to be the chief obstacle to its introduction - the problem of 'settlement'. English experience had shown that many complications could arise from settlement - the assessment of responsibility for the maintenance of destitutes who migrated from parish to parish or county to county. Responsibility, which depended on birthplace and period of residence, was often complicated and produced much needless litigation and ill-feeling. The problem was of particular significance to New Zealand because of the colony's...

26 NZH 31 January 1880.
27 PD 29 pp 596 Gisborne (Totara, Wd), 598 Feldwick (Invercargill, O), 599 Murray-Aynsley (Lyttelton, C); 35 p 73 Pyke (Dunstan, O).
28 P 9,10,12 February 1877.
29 IA Im 1 77/170 Memorandum, filed 23 February 1877.
30 PD 24 p 73.
31 Ibid.
frequent new arrivals and shifting mining population, and settlement difficulties were adduced by some opponents to the introduction of a poor rate.

A more potent objection to the introduction of a poor-rate was that, in contemporary minds, it was often linked with a poor law system and its attendant evils. Such a system had provided at least a partial impetus for many colonists to leave England. Numerous contemporary English writers condemned the poor laws because they seemed to increase pauperism rather than cure it:

'... as regards the Poor Laws, there is an almost universal concurrence of opinion among those who have studied the subject, that the influence of these laws ... is to foster pauperism and discourage providence.'

This idea was also expressed in maxims:

'... The degree of indigence and misery is exactly in proportion to the assistance given to the poor in rates.'

Its association with poor laws was a reason for opposition to the introduction of a poor-rate in New Zealand. The term 'poor law' was occasionally employed as a smear tactic, sometimes in a subtle manner, sometimes not. By the identification of the English

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32 AJHR 1885 H183 p 2.
33 PD 29 p 599 Saunders (Cheviot,C); 35 pp 75-77 Hall (Selwyn,C).
34 F. Peek Social Wreckage p x.
35 J.R. Pretyman Dispauperisation. The maxim appears on the title page and is attributed to Arthur Young.
36 PD 24 pp 95 Ballence (Rangitikei,Wn), 102 Burns(Roslyn, O); 29 p 443 Whitmore (MLC,HB).
37 See, for example, PD 38 p 92 Ballence (Rangitikei,Wn); 44 p 222 Atkinson (Egmont,T).
poor law with their opponents' poor-relief schemes, politicians could use criticisms of the English system to justify their own standpoint. Reid's conclusion - that the more liberal the provision, the more pauperism increased - was openly drawn from the English situation.38

Similar sentiments were voiced by W. Barron:

'If we legislate for paupers, we are apt to create them... It is against the interests of the colony that we should pass anything which may be called a poor-law.'39

Speaking of advocates of this view in a later debate,40 the Lyttelton Times noted that:

'The great bugbear which some of the Opposition speakers profess to be afraid of is the establishment of a pauper class...'41

and refused to take sides in the dispute.

The notion that poor relief created a pauper class, whose incentive to work was completely removed, produced concern in some quarters.42 Even Grabham went so far as to claim that practically gratuitous hospital treatment was 'pauperizing the population to an alarming extent.'43 In his proposals submitted to the Colonial Secretary, an Auckland officer indicated his awareness

38 PD 24 p 165.
39 PD 35 p 86.
40 PD 38 pp 85 Moss (Parnell, A), 92 Ballance (Wanganui, Whn), 107 De Latour (Mount Ida, O).
41 LT 18 June 1881.
42 PD 37 p 71 Whitmore (MLC, Hawkes Bay); 38 p 107 De Latour (Mount Ida, O).
43 AJHR 1885 H18 p 2.
of the prejudice against some relief schemes:

'I know that objection will be taken to poor laws and to what is termed pauperising the Colony, but the question is pressing itself into public notice, and call it by what name we may, we cannot get rid of it, and therefore, it has to be met on its own ground.'

Politicians, too, recognized that the connotations of the term 'poor law' were unfortunate and felt that to ignore the need for some measure of this kind in New Zealand was unrealistic. Swanson dismissed the 'odium' of having a pauper act on the Statute Book as 'the greatest claptrap possible'. Others approved of such methods of poor relief on the grounds that they were the most equitable and efficient means of supporting all forms of charity.

A basic issue, at the root of many of the principles debated, was the role of the state in hospital and charitable aid proposals. Although private charity had made significant contributions to the relief of suffering and distress, government aid was also a fundamental part of New Zealand's early systems:

'...both education and social welfare devolved upon the provincial governments in default of any adequate alternative.'

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44 IA 1 78/1595 B. Maclean to Colonial Secretary, 27 March 1878.
45 PD 24 p 75 Rolleston(Avon, C). See also PD 29 p 596.
46 PD 38 p 105.
47 PD 24 pp 76-77 Wallis (Auckland City West, A); 86 Rees (Auckland City West, A); 109 Hodgkinson(Riverton, O).
48 Condliffe p 280.
The extent of government involvement in charitable aid varied from province to province. The extremes were probably best represented by Otago and Canterbury. Otago encouraged voluntary organizations to deal with the matter, virtually confined itself to providing subsidies and induced a pride in this system in its citizens. The government of Canterbury, on the other hand, dominated hospital and charitable aid arrangements in the province with extensive grants and altruists generally performed their good works under its auspices. Most other provinces appear to have leaned towards the system of comprehensive government aid but, because of pecuniary difficulties, tended to adopt a middle course.

Conflicting attitudes on this issue were reflected in the dispute on the 'right' of destitutes to receive state aid. Politicians from Auckland and Canterbury favoured explicit recognition of such rights:

'That there should be institutions ... for the purpose of the aged and infirm is very proper and very necessary. I think that mankind generally - except the honorable gentleman who moved the second reading of the Bill - will acknowledge that those people have a real right, and an inalienable right, in their old age and poverty, to be supported by the State or by the Government.'

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49 PD 24 p 76.
Stevens claimed that it was a public duty to hold out 'the strong hand of the State' to the unfortunate and his remarks were endorsed by other speakers. Similar comments by Rolleston were described by the Premier as 'a species of communism', a charge which was repudiated by Rolleston, but supported by the Attorney-General.

Although he was generally opposed to the government, R. Stout, representing Dunedin, concurred with the ministerial viewpoint:

'I think it would be a dangerous principle for this colony to affirm that any man has a right to go to the State and demand relief whenever he pleases.'

The final phrase obscured the issue, but Stout's declaration, in opposition to Auckland and Canterbury attitudes, illustrates, to some extent, the influence of their home province on the opinions of some of the leading men.

As government aid had become an integral part of social welfare in New Zealand, it was generally accepted that state aid must play some part in the provision of assistance for the poor and sick. The extent and consequences of such aid, however, were objects of

50 Ibid p 80.
51 Ibid pp 75 Rolleston (Avon, C), 152 Swanson (Newton, A).
52 Ibid p 75.
53 PD 24 pp 82-83 Atkinson (Egmont, T).
54 Ibid p 157.
55 Ibid p 160 Whitaker (Waikato, A). Whitaker, however, accepted Rolleston's denial.
56 PD 24 p 156.
57 Even Atkinson, a strong supporter of voluntary charity, was unequivocal on this point. See PD 24 p 83.
Christchurch Hospital in the early 1880s.

Christchurch Hospital was the principal hospital in Canterbury, a province which was strongly in favour of state-aided institutions. Part of the original hospital of 1862 and the additions of 1867 are to the left of the picture. The creek, which discharged hospital drainage into the River Avon until 1885, runs across the centre of the picture and is marked by the white footbridge on the left of the picture. In his report of 1883, Grabham praised the siting of the hospital and also noted that a boat was kept on the river for the use of convalescent patients.
dispute. This involved a revision of accepted practice:

'In New Zealand we have been accustomed to look to the Government to do everything for us. It is time that was changed...' 58

Changes, obviously, depended largely on the role assumed by the state. A state poor-rate was suggested as a basis for a uniform financial system which eliminated the problem of settlement. 59 On the other hand, it was argued that poor-rates, state or local, were detrimental to voluntary charity. 60 It would dry up because, once contributions were made compulsory, donors would feel that responsibility for the institutions lay solely with the supervising authorities. Local interest, indispensable to the efficient management of institutions, would thus decline. 61

The state was also important in that it could affect the extent of poverty by its immigration and public works policies, as well as the amount it provided for poor relief. Whatever its precise role, the state was intimately involved in the social welfare of New Zealand. Members of parliament, many of them with personal experience of the problems involved, were forced to consider carefully what principles to adopt in framing the

58 PD 24 p 91 Trevers (Wellington City, Wn).
59 Ibid p 93 Wakefield (Geraldine, C).
60 PD 38 p 39 Shephard (Waimate, N); 51 p 613 Pyke (Dunstan, O); 52 p 29 Fergus (Wakatipu, O).
61 PD 24 p 83; Gisborne (Totara, Wd); 29 p 443 Whānau (MLC, Wd); AJHR 1883 R9A pl.
legislation which was to coordinate hospitals and charitable aid in the colony. From the time of the abolition of the provinces some measure was clearly necessary, but conflicting attitudes and interests, within parliament and in the colony as a whole, were to make this legislative process a very difficult one.
VI. POLITICS OF A SOCIAL ISSUE, 1877-85.

The problem of producing satisfactory hospital and charitable aid legislation plagued colonial politicians throughout the period 1877-85. Atkinson's bill of 1877, which stressed the role of voluntary contributions, failed to meet the realities of the situation. This failure, however, did not pave the way for a more practicable solution. From 1878 to 1880, the House of Representatives became preoccupied with the idea of providing funds from a source that made fewer demands on New Zealand's citizens - land endowments.

The unsuccessful proposals of Ballance and Hall extended over the period of 1878-81 and included a sharing of the responsibility for hospitals and charitable aid between the government and local bodies. In 1882, Atkinson presented a scheme which he claimed would reduce poverty to socially manageable proportions, but was unable to gain popular approval for it. Public interest in the scheme waned in 1883. The Stout-Vogel ministry, confirmed in office in September 1884, supervised the measure which eventually received the approval of Parliament and assumed a place in the Statute Book as the Hospitals and Charitable Institutions Act of 1885.
The first charitable aid bill was presented to the House by the Hon D. Reid on 27 July 1877.\(^1\) It reflected cabinet opinion, with a strong emphasis on the principles of voluntary charity and local control. The bill was largely based on the experience of Otago where voluntary contributions, supplemented £1 for £1 by the provincial government, had been the main source of funds for hospitals and charitable aid. The success of this system induced the central government to support a similar scheme designed to meet colonial needs.\(^2\) An important modification of the Otago system was the provision of additional government grants for the building of new institutions and the extension of existing ones.

Under the bill, local control was closely associated with the voluntary contributions. If 50 or more people each subscribed not less than £1 a year (or £10 in one donation) to an institution, they were entitled to apply for registration as a corporate body. The subscribers who undertook this course of action were entitled to elect their own board of management and thus wielded considerable power.

The bill laid down that all institutions under it were subject to annual inspection, but otherwise central control was reduced to a minimum. The general administration of the bill was left in the hands of one of the

\(^1\) PD 24 pp 73-74.
\(^2\) Ibid pp 74, 82.
ministers of the Crown, normally the Colonial Secretary and the Governor was empowered to modify the measure by such regulations and orders as he deemed necessary to carry out its objects more effectively.

Not aspects of the bill were subjected to severe criticism. A number of members opposed the scheme's dependence on voluntary contributions. It was argued that such a financial basis was both insecure and inequitable. There was also dissatisfaction with the method of appointing boards of management. Rolleston saw this as a means whereby private contributors could gain control of a public institutions and its government subsidized funds '...perhaps not solely in the interests of the institutions themselves'. Australian experience had shown that large boards of subscribers were sometimes incapable of providing satisfactory management of hospitals.

On the other hand, local boards were a means of maintaining community interest in hospitals and charitable aid. Their supervision of funds, which depended mainly

3 See Chapter V for details.
4 FD 24 p 75. See also pp 77 Wallis (Auckland City West, A), 79 Stevens (Christchurch City, C), 89 Swanson (Newton, A) for speeches supporting Rolleston. One of the activities he probably had in mind was an old English practice whereby valuable hospital contracts were let to members of the committee, or their friends, with little regard for competitive prices.
5 P 12 February 1877; AJHR 1877 H15 p 1; FD 24 p 75 Rolleston (Avon, C).
on local efforts, seemed to some members to be the best method of maintaining the institutions efficiently.  

A further objection to the bill was that it did not make explicit provisions for those institutions which did not fulfil the requirements for incorporation. The sudden increased demand on voluntary contributors to support local institutions was one which most large towns would have found very difficult to meet. The immediate future of these institutions, therefore, seemed very uncertain.

Much criticism was levelled at the form of the bill. The unintentional effect of one clause was to restrict incorporation to the original body of subscribers and complicate the position of later contributors. The detailed provisions for elections, as drafted, could restrict the activities of philanthropists. Several members were critical of the power given to the Governor, a practice which they regarded as a somewhat dubious means of compensating for the faulty composition of the bill.

6 PD 24 pp 83 Atkinson (Egmont, T), 96 Ballance (Rangitikei, Wn), 100 Murray-Aynsley (Lyttelton, C), 111 Fox (Wanganui).
7 Ibid pp 91 Travers (Wellington City, Wn), 93 Wakefield (Geraldine, C), 103 Fisher (Heathcote, C), 149 Manders Wakatipu, O. J.T. Fisher pointed out that Canterbury was expected, under this system, to raise the enormous figure of £14,500 in voluntary contributions.
8 3 August 1877.
9 PD 24 p 78 Wallis (Auckland City West, A).
10 Ibid pp 78 Wallis (Auckland City West, A), 86-87 Rees (Auckland City East).
One member spoke of the 'utter inadequacy' of the measure, another of 'this patchwork, this apology for a system of government,' and a speaker in favour of the bill thought that the government were dealing with the matter 'in a very slipshod manner.' The *Lyttelton Times* was also critical of the government's presentation of the bill:

'This is a fair sample of the legislation submitted by Mr. Donald Reid ... either he drafts his Bills himself, or he keeps a draftsman of his own of remarkable incapacity.'

In May 1877, the government had signified its intention to legislate on hospitals and charitable aid, but had found itself 'without authentic information' on existing arrangements in the colony. A limited amount of material had been collected by 11 July, but further information requested by Reid later in the month, was not available. For drafting and presenting the bill, therefore, Reid had to depend on incomplete returns and his personal knowledge of the Otago system. He seems to

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11 *Ibid* p 79 Stevens (Christchurch City, C).
12 *Ibid* 87 Rees (Auckland City East, A). For similar views see also pp 74 Rolleston (Avon, C), 76 Wallis (Auckland City West, A), 89 Travers (Wellington City, Wn).
13 FD 24 p 156 Stout (Dunedin City, O).
14 *LT* 4 August 1877.
15 IA 1 77/3324 circular no 24, 9 May 1877.
16 IA 1 77/3324 indicates that returns from about 17 hospitals were shown to Reid on 11 July. IA 1 77/4946 (77/3958) shows that the Colonial Secretary's office was unable to comply with Reid's request of 24 July. The file he hoped to use was not completed until the end of August.
have used reports on public charities in England and
the Australian states as secondary sources. 17

Two government supporters criticized Reid's intro-
duction of the bill and his failure to provide infor-
mation on the situation of hospitals and charitable aid
in New Zealand and overseas. 18 Reid countered that he
had not wanted to 'trouble the House' with tedious
statistics. 19 Furthermore, like an investigating officer
in New South Wales:

'I was placed in a position of
difficulty and embarrassment, because no data
had been left me by my predecessors, and that
I had scarcely had proper means of communication
with the institutions in connection with which
I was collecting information.' 20

Responsibility for the bill in the House of Rep-
resentatives had been thrust upon Reid because the
Colonial Secretary, under whose auspices hospitals and
charitable aid came, was a member of the Legislative
Council. The Colonial Secretary, the Hon D. Pollen,
was in Auckland in early July 21 and thus unable to assist
directly in formulating the bill. That Reid himself

17 PD 24 pp 165, 167.
18 Ibid pp 111 Fox (Wanganui,Wn), 164 Stafford (Timaru,
O). One opposing speaker, Rolleston (Avon,C), raised
this point, p 157.
19 PD 24 p 167.
20 Ibid.
21 IA 77/3324 Brief instructions were telegraphed to
the Under-Secretary, G.S. Cooper, by Pollen.
was unable to spare staff for a thorough analysis of hospital affairs indicates that he was probably working under considerable pressure. This, allied with the limited information at his disposal, accounts for the apparent haste and imprecision with which the bill was drafted.

Nevertheless, the vagueness of the bill was turned to advantage by the government. After three attacks which followed the introduction of the bill, Atkinson made some explanations of the measure. The most important of these was a pledge that the government would continue to manage those institutions not immediately brought under the bill, until they could be incorporated into the system. Atkinson's manoeuvre drew only limited support and weakened the bill as a means of quickly producing a uniform system in the colony.

Opinion for and against the bill was fairly evenly divided and its fate was obviously in jeopardy until the third day of the debates. The speech of the Attorney-General, the Hon F. Whitaker, 'clarified' the functions

22 IA 1 77/3324 D. Reid to G.S. Cooper, 11 July 1877.
23 PD 24 p 82.
24 Ibid p 85. T. Kelly (New Plymouth, T) was converted by Atkinson's explanation and the opinions of some other members who did not speak were probably influenced in a similar fashion.
of the bill and swung opinion clearly into the government's favour. He interpreted the bill as dealing solely with those institutions which, supported by subsidized voluntary contributions, wished to come under its auspices. 25

Virtually all members of the House had been under the impression that the bill was designed to incorporate, in time, all the institutions of the colony. This interpretation was clearly refuted by Whitaker who stressed the absence of compulsion in the bill. 26

Speakers who followed Whitaker expressed irritation that this explanation was not given sooner:

'I E.W. Stafford feel very great regret that the explanation which the Attorney-General has given was not afforded earlier by some member of the Government, and put in such a shape that the House might understand the principles of the measure which it has been discussing for the last few days.' 27

C.A. Fitzroy said that many members had been under the wrong impression and blamed Reid for this situation:

'...had the honourable gentleman who introduced the Bill given the same lucid explanation which we have just heard from the Attorney-General this debate, instead of lasting two or three days, need not have lasted more than the same number of hours.' 28

Whitaker's speech achieved its aim; the main point of the opposition was removed and most members declared

25 PD 24 pp 160-161.
26 Ibid.
27 Ibid p 163.
28 Ibid, p 4 August 1877 deplored the lack of candour on the part of the government as well as the timing of its manoeuvre.
themselves reasonably satisfied with the measure. One of the speakers influenced by Whitaker's explanation was A. Brandon, who said:

'If I vote for the second reading of the Bill it will be on the understanding that in Committee it will be reduced to the innocent measure described in, and its principles made in accordance with, the explanation given by the Attorney-General.'

The bill had become a completely permissive measure: its lack of compulsion had already drawn strong criticism and the statement that hospitals and charitable institutions were able to remain outside its jurisdiction, if they so desired, removed any remaining semblance of power from the bill. Some discrepancy between the statements of Reid and Whitaker, however, remained.

The precise nature of the bill was put further in doubt by members politically unsympathetic to Atkinson, but in favour of the bill. Most speakers in this category expressed intentions of modifying the bill in committee. The government, therefore, gladly agreed to Fox's suggestion that a commission be appointed to investigate the matter during the recess, thereby making the bill

29 PD 24 p 164.
30 Ibid pp 74 Rolleston(Avon,C), 80 Stevens(Christchurch City,C), 85 Rees(Auckland City East,A), 90 Trevers (Wellington City,Wn); P 3 August 1877.
31 LT 4 August 1877.
32 LD 24 p 167; LT 4 August 1877.
33 LD 24 pp 83 Gisborne(Totara,Wd), 96 Bellence(Rangitikei, Wn), 157 Stout(Dunedin City,O), 163 Bryce(Wanganui,Wn), 165 Brandon(Wellington County,Wn).
34 Ibid p 112.
under discussion merely a tentative measure.35

The bill easily passed its second reading with 42 votes in favour and 11 against.36 Those sympathetic to both Atkinson's government and the bill numbered 37. Of the 20 opposed to the bill, 19 were inclined to political opposition. Stevens was the exception. Non-political considerations appear to have affected the vote of 25 members generally opposed to Atkinson: 12 voted for the bill and a further 13 abstained.37

The role of political allegiances in forming opinions on the matter was disputed in the debates themselves. W.L. Rees and Grey, opposed to both the ministry and its bill, claimed that the subject was a party question.38 Grey's attempt to infuse a political element into the debate did not go unnoticed:

'...the eloquent speech of the honourable member for Thames [Grey] almost assumed a political aspect, whereas this is peculiarly a social question.'39

Government supporters and those whose opinion of the bill did not match their political allegiance, asserted that the subject was divorced from politics.40

35 Ibid pp 161 Whitaker(Waikato,A), 166 Reid(Taieri,O); P and LT 4 August 1877.
36 PD 24 p 168.
37 These figures include nine pairs. See Appendix F for details.
38 PD 24 pp 87,142.
39 Ibid p 149 Russell (Napier,HB).
40 Ibid pp 81 Stevens (Christchurch City,O), 149 Russell (Napier,HB), 154 Joyce(Wallace,O), 157 Stout(Dunedin City,O).
Country members, whose hospitals were often already managed under arrangements similar to those proposed by the government, were generally strongly in favour of the bill. They noted that most of the opposition came from the centres of population, where hospitals and charitable institutions had been extensively supported by the provincial governments. 41

The strongest opposition to the bill came from Auckland and Canterbury, where attitudes to social welfare were generally contrary to those promoted by Atkinson. The voting of Taranaki, Hawkes Bay and Nelson–Malborough members reflected their political sympathies. Wellington, Westland and Otago, however, were generally anti-Atkinson in tone but, because of their hospital and charitable aid arrangements, were inclined to support the bill strongly. Otago, in particular, showed a marked swing in the government's favour. 42

41 Ibid pp 101 Woolcock (Grey Valley, N), 163 Kennedy (Grey Valley, N). Of those generally opposed to Atkinson but sympathetic towards the bill, the country members were more inclined to vote in favour of it and those from the towns to abstain.

42 See Appendix F. Because their province had been the model for the bill, most Otago members realized that it would be relatively simple for their institutions to meet colonial requirements. ODT 4 August 1877 appreciated that the bill was faulty, but thought it was basically sound. Of the eight main newspapers, only ODT, P and LT expressed editorial opinions on the 1877 bill.
Dunedin Hospital, about 1880.

The hospital building had served as an exhibition building in 1865 and was converted into a hospital the following year. Dunedin was the only hospital in Otago to be wholly supported by government funds in the period 1877-85.
Once the government had, thanks to Whitaker's speech, extricated itself from an awkward position, the bill assumed the role of a weathercock. A fair representation of colonial opinion had been presented in a far-ranging debate, in the light of which the government had decided to postpone the task of making full provision for hospitals and charitable aid until the next session:

'The House has plenty to do during this session, and this is not a pressing question, because it can be dealt with until next session as it has been dealt with hitherto, and by the end of another year we shall be in a better position to legislate upon it.'

Ten weeks after this decision the fall of Atkinson's government brought with it the demise of both the charitable aid bill and the promised investigating commission.

The establishment of land endowments as a source of funds was an aspect of hospitals and charitable aid which received parliamentary attention over the next few years. First suggested as a colonial scheme by two speakers in the 1877 charitable aid debate, it was reviewed with favour the following year. Precedent

43 PD 24 p 162 Whitaker (Waikato, A).
44 Ibid pp 77 Wallis (Auckland City West, A), 149 Manders Wakatipu, 0).
was set by overseas practice, the existence of colonial education reserves and the examples of Otago and Auckland, which had established small land endowments for hospitals and charitable institutions before the abolition of the provinces. 45

Early in 1878, C.C. Bowen put a motion to the House:

'That it is expedient that the Government should make reserves of waste lands of the Crown, in every district throughout the colony, for hospitals and other charitable purposes.' 46

The Minister of Lands, Stout, mentioned that the central government, of which Bowen had been a member, had refused to sanction a similar proposition when it had been made by the Otago provincial government. Stout said he now felt it was too late to institute any system of land endowments. 47 Bowen deplored the minister's introduction of party squabbles and gained the sympathy of the House which passed his resolution by 34 votes to 21. 48

Two days later, Stout was accused of attempting to defeat the resolution by a 'sidewind'. 49 Two of his Otago colleagues, J.C. Brown and H. Feldwick, introduced private bills, ostensibly to provide endowments for

45 PD 29 p 676 Murray (Bruce, O), Rolleston (Avon); 36 pp 709-110 Swanson (Newton, A), 263 Macandrew (Port Chalmers, O), 269 Stevens (Christchurch City, O).
46 PD 29 p 675.
47 Ibid.
48 Ibid p 677. See Appendix G for details.
49 PD 30 pp 730-731 Murray (Bruce, O).
their local institutions. Members from both sides of the House objected strenuously to such individual grants, which they saw would lead to a chaotic scramble for endowments. This was contrary to the spirit of Bowen's motion and, in the heated debate that followed, several members charged that Brown and Feldwick were in collusion with Stout. 50 A comprehensive system of colonial endowments was advocated as a more orderly and equitable procedure and, as opposed to this, the individual land endowments were rejected by 40 votes to 21. 51

The matter received little further attention until July 1880, when Stevens introduced a private member's bill, which proposed to endow hospitals and charitable aid with 1,000,000 acres of public lands. 52 The Premier, Hall, thought that the proposed area was too ambitious and hoped for a considerable reduction in committee. In all other respects he accorded the bill his full support 53 and it passed the second reading without a...
diversion. In committee, Hall's proposal, that the area to be set aside should be 200,000 acres rather than 1,000,000, was narrowly defeated.\(^5^4\) A move to block the bill was unsuccessful and it was read a third time the following week.\(^5^5\)

The main body of opinion in the Upper House thought of land as security for overseas loans and claimed to oppose endowments because they would undermine the colony's credit.\(^5^6\) Two members, the Hon G.S. Whitmore and the Hon J. Menzies, raised the bogey that fostering such schemes was tantamount to introducing a poor law into New Zealand.\(^5^7\) The Hon H.J. Miller and the Hon T. Fraser of Otago pleaded on behalf of the bill in vain and it was defeated by 30 votes to 6.\(^5^8\)

Despite further affirmations of support in the House of Representatives, Stevens was discouraged by this failure and abandoned his project.\(^5^9\) The task of pressing for land endowments was assumed by W. Barron who constantly reminded the various ministries of the

\(^{54}\) Ibid p 435. 24 votes to 23.  
\(^{55}\) PD 36 pp 435, 595.  
\(^{56}\) PD 37 pp 70-73.  
\(^{57}\) Ibid pp 71, 73.  
\(^{58}\) Ibid p 75. Although NZH 31 January 1880 had expressed the view that land endowments were of little benefit and most papers reported the progress and demise of the bill, no daily newspaper commented editorially on the subject. It was left to the Canterbury Times 7 August 1880 p 77 to rebuke the Legislative Council for its decision.  
\(^{59}\) PD 38 pp 85 Wallis(Auckland City West, A), 93 Johnston Manawatu, W, 101 Gisborne(Totara, Wd), 102 Pitt(Nelson City, N), 106 Russell(Whanganui, HB), 139 Barron(Geoversham, O).
importance of the subject. These exertions did not go unrewarded. Because of the House's acceptance of the idea, land endowments for the benefit of hospitals and charitable aid were incorporated into the 1885 Act, with the stipulation that they should not exceed an area of 250,000 acres. It was a little ironic that provision for land endowments was finally made under an act supervised by Stout, the earliest opponent of the idea.

One of the main reasons for the parliamentary preoccupation with land endowment schemes was that attempts to secure the cooperation of local bodies in hospital and charitable aid affairs seemed fruitless. Voluntary contributions alone were insufficient to maintain the institutions and the central government was reluctant to support them indefinitely. Furthermore, the government control which accompanied the complete dependence of some institutions on state finance was an anathema to most districts. Local bodies, therefore, could be considered a logical major source of funds. When it was drafted, the 1876 arrangement, whereby local bodies contributed either directly or from their subsidies,
was regarded as essentially a temporary one. The provision of a scheme to replace it, however, proved more difficult than had been anticipated.

Because the Colonial Secretary was a member of the Legislative Council, the Hon J. Ballance assumed the responsibility for hospital and charitable aid affairs in the House of Representatives. In a circular to the local bodies he said:

'The Government on taking office found that the hospitals and charitable institutions throughout the colony were being managed upon no fixed principle or system, and that it was absolutely necessary to place them on a more satisfactory footing.' 62

Ballance proposed that the local bodies assume responsibility for hospitals and charitable aid on the understanding that the government would contribute £1 for £1 on both subscriptions and money from local body funds. The government hoped that the individual obligations of the various local bodies controlling the institution would be negotiated among themselves. This scheme promised not only the advantages of local control, but guaranteed a permanent government subsidy in place of the 'temporary' one in operation and 'no deductions whatever' were to be made from ordinary local body subsidies.63

62 AJHR 1878 H 31 p 1.
63 Ibid pp 1-2.
A model of Ballance's aspirations evolved in Central Otago, where the Vincent County Council, in conjunction with the borough councils of Clyde and Cromwell and the municipal corporation of Alexandra, undertook the control of the Dunstan (Clyde) and Cromwell hospitals. The existing committees were to manage the hospitals and collect the government-subsidized subscriptions as before, but any deficit was to be made up by the contributing local bodies and the government. By mutual consent, the local body contributions were drawn from the localities in proportion to the value of rateable properties within their respective boundaries. 64 A similar, but less harmonious, system was brought into operation in Westland. 65

Elsewhere the reaction to Ballance's suggestions was generally unfavourable. Many local bodies refused to cooperate or made their support conditional on such vital aspects as further government support or the reactions of other councils. 66 Their attitudes to the maintenance of hospitals and charitable aid was a principal item on the agenda of two colonial conferences - of boroughs and counties respectively - held in Wellington.

64 Ibid p 2.
65 AJLC 1878 No 20 pp 12-16.
in late July and early August 1878. Government hopes proved barren and the Colonial Secretary described the local bodies attitude as:

'Do anything you like, but do not ask us to pay the money.'

Ballance and Whitmore felt the time was not ripe for the introduction of a comprehensive measure and confined themselves to a modification of the existing state of affairs in the Financial Arrangements Act of 1878. A hospitals and charitable aid bill introduced in July 1879 lapsed with the fall of the Grey ministry a few months later.

As chairman of the county with the largest charitable aid expenditure in the colony, the Hon J. Hall had taken a particular interest in hospital and charitable aid affairs. A fortnight after they had taken office, Hall's ministry introduced a bill which proposed to divide the colony into a number of small hospital and charitable aid districts. Like the preceding bill it explicitly incorporated hospitals in its title to

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67 PD 28 p 47 Whitmore (MLC,HB).
68 PD 28 pp 220, 264; 29 p 442, 595.
69 PD 30 pp 1175-1177.
70 PD 31 p 60.
71 IA 1 82/1157 (78/1423) Hall to Colonial Secretary, 28 March 1878. See IA 1 64/10 Charitable aid returns, 24 June 1878 and AJHR 1882 B22, for examples of expenditure in the county of Selwyn.
72 PD 32 p 428.
eliminate any doubts on its jurisdiction and removed the resentment, felt by some medical men, against the classification of hospitals as charitable institutions.\textsuperscript{73} Owing to the pressure of other business, however, the bill was not carried any further.\textsuperscript{74}

In a brief survey of newspaper opinion available in January 1880, the Colonial Secretary's Office found that one paper strongly favoured the bill as it stood, two gave it qualified support and one opposed it.\textsuperscript{75} More directly concerned were the local bodies which received copies of the 1879 bill together with a request for their opinions on the matter.\textsuperscript{76}

The replies to this inquiry encompassed a wide range of subjects and attitudes. Most returns covered items of particular interest to the localities concerned: common topics included patients' payments and other sources of funds, local body representation on controlling boards and the size of the proposed districts.\textsuperscript{77}

\textsuperscript{73} PD 24 pp 76 Wallis (Auckland City West, A), 158 Rolleston (Avon, C).  
\textsuperscript{74} IA 1 82/1157 (80/262) Circular to local bodies, 12 January 1880.  
\textsuperscript{75} IA 1 80/669 Under-Secretary's memorandum, 13 January 1880. Of the newspapers in the four main centres and Napier, New Plymouth, Nelson and Hokitika, only four expressed editorial opinion on the bill at this time. Taranaki Herald 3 Jan 1880 favoured the bill; Colonist (Nelson) 30 December 1879 and NZH 31 January 1880 supported it with amendments and \textsuperscript{76} P 6 January 1880 approved it with regard to hospitals, but strongly objected to the application of its provisions to charitable aid.  
\textsuperscript{76} IA 1 82/1157 (80/262) Circular to local bodies, 12 January 1880.  
\textsuperscript{77} IA 1 82/1157 Local body returns, February–June 1880.
Although a number of local bodies gave guarded approval to the bill, most remained opposed to it. Because their institution might be reduced to a branch establishment or closed down altogether, a number of communities were opposed to any system which incorporated large districts. Opposition to any reduction in their hospital's status was explicitly stated in several local body returns.\(^78\)

The financial proposals were the most common reason for opposition to the bill: local bodies were generally unwilling to rate themselves for the sake of hospitals and charitable institutions, a tendency perhaps more characteristic of the larger centres of population than elsewhere.\(^79\) The possibility of political repercussions was made clear in the reply of the Taranaki County Council:

'Your Committee disapprove of the Bill as it stands and recommend that a Memorial be put to the Members for the Provincial District of Taranaki urging upon them to support only such a Bill as shall provide for the maintenance of Hospitals and Charitable Aid out of the Consolidated Fund of the Colony.'\(^80\)

\(^{78}\) IA 1 82/1157 (80/1793) Return of 13 Westland local bodies, 19 April 1880; (80/2523) Maniototo County Council, 29 May 1880; (80/2627) Naseby Borough Council, 1 June 1880.

\(^{79}\) IA 1 82/1157 (80/1405) Christchurch City Council, 25 March 1880; (80/2670) Auckland City Council, 40 June 1880 and (80/2752) Dunedin City Council, 16 June 1880, objected to the proposed changes. Wellington City Council did not reply.

\(^{80}\) IA 1 82/1157 Taranaki County Council, 7 June 1880. This attitude was not confined to the poorer provinces.
In his introduction of the revised bill, Hall admitted that the government had failed to win the support of the local bodies, but hoped the House would be constructive in its criticism and assist in the solution of what he regarded as a very difficult social problem.\(^{81}\) Although a number of speakers supported the bill and offered advice on the problem of local body opposition,\(^{82}\) the debate was inconclusive.

The influence of the local bodies was illustrated by the opposition speeches of S.E. Shrimski and C.A. De Latour, whose opinions accurately reflected those expressed by the local bodies of their respective districts.\(^{83}\) W.J. Speight also noted that local body inquiries had shown a preference for existing arrangements over those proposed in the bill.\(^{84}\) In the light of this situation the bill was read a second time and later withdrawn by Hall.\(^{85}\)

In June 1881, Hall introduced a bill similar to that of 1880 except that it was more explicit in

\(^{81}\) PD 35 pp 75-77.
\(^{82}\) Ibid pp 79 Shephard(Weimes,N), 80 Montgomery(Akaroa,C), 83 Sutton(Napier,HB).
\(^{83}\) Ibid pp 83, 94; IA 1 82/1157 (80/1592) Waitaki County Council, 9 April 1880 and (80/2627) Naseby Borough Council, 1 June 1880.
\(^{84}\) PD 35 p 95.
\(^{85}\) Ibid p 99. Begg p 432 claims that the opposition of the local bodies was so strong that the government would have been in danger had the bill been pressed. His statement that the 1879 bill was withdrawn after its first reading is correct, but he is mistaken in ascribing this order of events to the bill of 1880.
favouring large districts. Small districts, Hall said, led to too great a diversity and produced prolonged conflicts over the question of settlement. 86 He also remarked on the difficulty of persuading local districts of the advantages of a uniform system. As in 1880, the power of creating hospital and charitable aid districts was left in the hands of the Governor-in-Council, to give the bill flexibility and avoid disputes which could hamstring it. 87

An element of confusion was introduced by protagonists of local government reform, who used the debate as a platform for what they considered to be a more important principle. 88 The Lyttelton Times said the debate was one where wild talk, crude opinions and utter failure to grasp the subject prevailed and hoped this could be remedied in committee. 89 This hope proved in vain: the bill, which had been described in the House as, 'too comprehensive ... of too ambitious a character,' 90 failed to gain wide support and suffered the same fate as its predecessor. 91

86 PD 38 p 82.
87 Ibid p 117.
88 Ibid pp 86 Moss (Parnell, A), 90 Shrimski (Waitaki, C), 95 Grey (Thames, A), 110 Kelly (New Plymouth, T). LT 23 June 1881 commented that the debate on the bill '... must have taught Mr. Hall by this time that local government is a question of serious importance.'
89 LT 18 June 1881.
90 PD 38 p 84 Wallis (Auckland City West, A).
91 Ibid p 120.
As a member of the Whitaker ministry, which took office in April 1882, Atkinson was able to exert an increased influence over hospital and charitable aid affairs. Unlike Hall, the new Premier was not a member of the House of Representatives and had no particular interest in the subject. T. Dick, the Colonial Secretary, likewise washed his hands of the problem, so the way was left open to Atkinson, who had declared his support for schemes of 'self-reliance' over anything that could be construed as a 'poor law'.

The idea of compulsory national insurance, designed to make provision for the sick, widowed, orphaned and aged, was introduced by Atkinson in his financial statement of June 1882. He realized the enthusiasm of others might not match his own, but declared that even if his proposal led only to 'dispassionate discussion' of the subject, some advance towards a solution of the problem of poverty would have been made.

The following month, the scheme itself was presented to the House. Basically, it provided for a central fund to which all citizens would contribute. From this, those in poor circumstances, through no fault of their own, would draw an allowance. A payment of 15s per week was

92 IA Im 1 77/170 Cabinet memorandum, 14 February 1877; PD 24 pp 82-83.
93 PD 41 p 535.
to be allotted to sick people who were single and between the ages of 18 and 65, 22s 6d to married men and 7s 6d to married women. After the age of 65, an annuity of 10s per week was to be paid. Widows with one child were to receive 15s per week, the amount rising to a ceiling of 30s per week, according to the size of the family. As in the case of orphans who were allotted 10s per week for their first three years and 6s per week thereafter, these allowances were to remain in operation until the children concerned reached the age of 15 years.94

For the protection against the difficulties of sickness and old age, all citizens between the ages of 16 and 23 were to pay into the fund between 2s 3d and 3s 3d per week, to achieve a total contribution of about £41.95 To qualify for orphans' and widows' benefits payment of about 2s per week for a further five years was necessary, bringing the total payment for benefits to about £66 per person. Proposals were also made to incorporate those outside the statutory age groups when the scheme was inaugurated.96

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94 PD 42 p 185.
95 People making contributions between the ages of 16 and 23 were to pay 2s 3d per week. Those contributing from 18 to 23 were to pay 3s 3d and in both cases there was to be a discount for payment in a lump sum.
96 PD 42 pp 185-186.
Atkinson's project was based on a series of essays by an English vicar, Rev. W.L. Blackley. The idea was not new. Similar schemes had frequently been mooted in England where public debate on the subject reached a peak with Lord Carnarvon's introduction of it into the House of Lords in 1880. No practical action, however, resulted from the movement. Even in New Zealand, the adoption of compulsory insurance for civil servants was suggested by two speakers in the debates on the 1877 charitable aid bill. The attraction of compulsory national insurance was that it provided an alternative to any form of poor law, appeared to encourage self-reliance and channelled some of the money normally dissipated in early manhood into a worthwhile investment.

The most significant modifications Atkinson made to Blackley's suggestions were in the amounts of money involved in payments and benefits. In the English scheme compulsory contributions totalling £10 were to be drawn from those between 18 and 21 years of age. Benefits were to be 8s per week in case of sickness and annuity of

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98 LT 8 June 1880; ES 6 August 1880.
99 PD 42 p 203 Hutchison(Wellington South); NZH 21 March 1883.
100 PD 24 pp 102 Burns(Roslyn, O), 152 Swanson(Newton, A).
101 PD 42 pp 190-191 Montgomery(Akaroa); EP 20 June 1882;
LT 24 June 1882.
4s per week after the age of 70. 102

Under Blackley's system a man might insure himself for an amount far in excess of £10 if he so desired - this figure was merely set as a compulsory minimum. Although the high minimum payments of Atkinson's scheme produced comprehensive benefits, they were also an obstacle to public support for the plan.

Public interest was aroused by Atkinson's scheme, which was closely scrutinized both inside and out of Parliament. The Evening Post thought that:

'Major Atkinson has effectually succeeded in setting people thinking over the great problem of poverty and he has also given them a theoretical remedy, or rather a future preventive, to consider.' 103

Parliament was generally hostile to the scheme. Newspapers generally endorsed the aims of the proposal, but could not envisage it in practice and were not reluctant to give their reasons for this conclusion.

The large amount of capital involved and the difficulties of administering payments and benefits, put a significant proportion of public and private funds at risk:

'It might fail. Our opinion is that it would eventually fail. And if it did it would do a hundred times more harm than can possibly be attributed to the poverty which it is expected to remove.' 104

102 ES 6 August 1880; EP 18 June 1882.
103 EP 17 July 1882.
104 F 22 March 1883.
The heavy burden of payments could cause hardship and perhaps handicap the poorer members of the community who were supposed to benefit by the scheme. Because of the mobility of the youthful population and unemployment caused by economic fluctuations, the collection of payments seemed to pose a problem. The compulsion associated with these payments was rejected as alien to the colonial character. Grey was vehement in his denunciation of this aspect of the scheme and expressed his views in characteristically extravagant terms:

'I say it is a blow at Christianity itself. It is a blow at the family. It is an attempt to make every single individual a part of a great communistic society.'

Payments were seen as an unfair tax from which the contributor might never derive advantage. The Australasian thought that:

'...the most serious difficulty would be the collection of annual premiums, and the compelling of every person to come in and join the great financial feast. The proposal amounts, in short, to a heavy poll-tax... We fear that there are many people who would object to be done good to on such terms.'
Similar sentiments were expressed in the House of Representatives and Atkinson's scheme received little further publicity until March 1883.

To stimulate public interest in the problems of poverty and present his views on other political matters, Atkinson undertook what was popularly termed a 'stumping tour' of the colony. The tour opened in Christchurch, where a capacity audience attended two lively meetings. Large audiences also attended his Dunedin meetings, after which he spent nearly three weeks in the smaller towns of Otago and Canterbury. Much to the chagrin of Aucklanders, Atkinson's North Island schedule was drastically curtailed to incorporate only Wellington and his home province, Taranski.

Atkinson was careful not to antagonize the friendly societies: he proposed that citizens who were members of friendly societies should be exempt from compulsory membership of the national insurance scheme. This nullified one potential source of opposition and representatives of friendly societies in both Christchurch

111 PD 42 pp 192 Montgomery(Akaroa, C), 199 Moss (Parnell, A), 203 Hutchison(Wellington South) 205 Sheehan(Thames, A).
112 P 20-21 March 1883. Topics discussed at the first meeting were the constitution, taxation and land tenure. The second night was devoted to national insurance.
113 ODT 3-11 April 1883; P 12-23 April 1883.
114 NZH 25, 28 April 1883.
115 PD 42 p 189. Blackley p 16 proposed to override any objections from friendly societies.
and Dunedin endorsed the scheme.\footnote{LT 22 March 1883; P 6 April 1883, G.H. Scholefield, Notable New Zealand Statesmen p 140 claims, 'The friendly societies were of course hostile to the scheme', but offers no evidence to support his statement.} With this exception, Atkinson was unsuccessful in securing support for compulsory national insurance.

A series of discussions, which arose in the wake of his tour, lashed the scheme. Important faction leaders, such as Montgomery and Stout, were joined by a number of other politicians in their condemnation of Atkinson's proposals.\footnotemark{117} The \textit{Press} commented:

'The Colonial Treasurer has been a perfect Godsend \textit{sic} to the Opposition speakers, with his scheme of National Insurance. If they have nothing of their own to speak in favour of, they can always bang away at that ...'\footnotemark{118}

Two years before Atkinson's introduction of his scheme the \textit{Evening Star} had expressed the view that national insurance was, 'predestined to remain a philanthropic dream'.\footnotemark{119} By 1882 it was recognized that some social reforms might be made, but those on the scale of Atkinson's were reserved for the distant future.\footnotemark{120}

\footnotetext[116]{LT 22 March 1883; P 6 April 1883, G.H. Scholefield, \textit{Notable New Zealand Statesmen} p 140 claims, 'The friendly societies were of course hostile to the scheme', but offers no evidence to support his statement.}
\footnotetext[117]{P 30 March 1883; QDT 14, 16 April 1883. Of the other politicians, J. Holmes, M.W. Green and R. Turnbull were the most active. \textit{NZH} 25 28 April 1883 claimed that the lack of support for his mission in the South Island had influenced Atkinson to curtail his arrangements for a North Island tour.}
\footnotetext[118]{P 25 April 1883.}
\footnotetext[119]{\textit{ES} 6 August 1880.}
\footnotetext[120]{\textit{PD} 42 p 203 Hutchison(Wellington South); \textit{EP} 17 July 1882; \textit{Australasian} 5 August 1882, reprinted in \textit{EP} 17 August 1882.}
Even Atkinson's colleagues were unsympathetic and one, J. Bryce, was reported as saying Atkinson was, '... a little premature - a century too soon perhaps.' Few people took Atkinson's 'best known "fad'' seriously and the reason for his failure to achieve any immediate action was evident to at least one contemporary writer:

'It is not a scheme that is calculated to evoke any enthusiasm of a popular character, and in the absence of this feeling it is impossible for it to become law. There is no class in the colony to whom it appeals with anything like the force required to carry so sweeping a proposal.'

After an effort to rekindle interest in it in June 1883, Atkinson's public advocacy of the scheme appeared to have been finally abandoned.

The activities of Atkinson stimulated interest in conventional hospital and charitable aid proposals and led to increased demands for legislation on the matter. On 10 September, one week after he was confirmed in office, Vogel was faced with the issue. He considered it an 'exceedingly important' subject and, though unable to deal with it immediately, promised to attend to the

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121 PD 42 pp 183-207. Only one of the seven members who spoke on national insurance supported Atkinson.
122 NZH 28 April 1883.
124 Ibid 21 March 1883.
125 PD 44 p 222.
matter as soon as possible. His colleague, Stout, confirmed that investigations designed to produce 'a better system' would be carried out during the recess.

The debate on the hospitals and charitable institutions bill opened on 23 June 1885, four days after its first reading. Vogel pointed out that the need for legislation had been felt since the abolition of the provinces and in the intervening years 'difficulties and incongruities' had mushroomed for the lack of a uniform system.

His 'essential conditions' for a successful bill were centred on administration and finance. Committees of management were to be essentially local and amenable to public opinion by being made elective. Expenses were to be 'somewhat localized' and the government was prepared to meet a reasonable proportion of the cost, but refused to be the last resort of local committees in financial difficulty.

Under the bill, the sources of finance comprised rents and endowments, voluntary contributions, grants

126 PD 48 p 223.
127 PD 50 pp 148, 475.
128 PD 51 pp 58, 100. The measure was called the 'hospitals and charitable aid bill' until after the second reading, when it assumed the title of 'hospitals and charitable institutions bill'.
129 PD 51 p 100.
130 Ibid p 101.
from local bodies and a government subsidy of 10s for £1, drawn from the consolidated fund. \textsuperscript{131} Local bodies were empowered to pay their contributions from either ordinary funds or a special rate for the purpose. \textsuperscript{132}

The colony was divided into 12 districts, each supervised by a district board of administration. These boards were elected annually by the contributing local bodies and had control over all institutions in their district. To encourage voluntary contributions and a measure of autonomy in those institutions that were independently minded, provision was made for 'separate institutions'. The committee of any institution administered under the decree were permitted to apply for incorporation if they were able to present a list of names of at least 100 people who had signified their intention to contribute, in annual sums of not less than 5s each, a total of not less than £100, the money to have been paid in advance. \textsuperscript{133}

The committees of management for 'separate institutions' were elected directly by the subscribers. Although ultimate power still lay with the district boards, internal control of the institution was in the hands

\textsuperscript{131} Ibid p 102.  
\textsuperscript{132} PD 52 p 318.  
\textsuperscript{133} P 18 September 1885.
of the committee of management. 134 This system was basically the one adopted for Dunstan and Cromwell hospitals in 1878 and was not purely experimental: special provision had been made for Auckland Hospital to become a 'separate institution' in 1883, a move that proved both popular and successful. 135

A generally favourable reception greeted the bill in the House, though many speakers hoped for minor changes in committee. The point 'which most speakers seemed to attack with great strength', 136 was the smallness of the subsidy. It alienated a number of potential supporters and seemed to threaten the passage of the bill. After consultation with his colleagues, Vogel offered to pay a £1 for £1 subsidy. 137 Despite the delaying tactics of Atkinson, the bill was soon read a second time and committed. 138

The most significant development in committee was a large increase in the number of hospital districts - from 12 to 28. All but three of these amendments were passed on voices. Personal compacts were evident in

134 Members of the committee of management were often referred to as the 'trustees' of the institution.
135 Rauch p 16.
136 LT 16 July 1885.
137 PD 52 p 33.
138 Ibid pp 34-37, 39, 287. In the division on the bill's committal Atkinson, Newman and Pearson appeared in both the voting lists and in the pairs. The correct division on the matter was 58 ayes and 14 noes, not 59 to 16 as printed. There were two pairs.
Auckland Hospital in the 1880s.

Although opened only five years, the hospital was lashed for its low standards by Grabham's report of 1882. The hospital facilities and administration had improved dramatically by the following year and, soon after this change, it became the first 'separate institution' in the colony.
the five divisions on the creation of separate districts and on three occasions ministers went into opposing lobbies to honour their agreements with the members concerned.

Hospital districts were often amalgamated to form 'united districts' for charitable aid purposes. Eighteen hospital districts, in combinations of two and three, formed eight 'united districts'. Ten districts retained the same boundaries for both hospitals and charitable aid.

The government obtained a 55 to 21 vote of support at the third reading. After discussions which traversed the ground of earlier debates, the Legislative Council approved the bill and it was finally passed on 14 September 1885.

A number of diverse influenced affected members' feelings towards the bill and, of these, political alignments and town-country allegiances were probably the most powerful. Of the 94 members, the votes of 42 concided with their political affiliations of the previous year. As in 1877, the small provinces of

139 Four of the five members who brought forward amendments always voted for their colleagues. The fifth, Hirst, voted for three of the amendments but abstained twice. Members whose districts were directly affected, such as Buchanan, voted with this group.
140 PD 52 pp 614-615; LT 12 August 1885.
141 N.Z. Statutes 1885 No 46 pp 175-177.
142 PD 53 p 13.
144 See Appendix H.
Taranaki and Hawkes Bay voted with some consideration for politics, a trait also noticeable in Westland. The only other province where voting on the bill correlated closely with political inclinations was Canterbury, which favoured the government and the bill they had produced.

Political affiliations were not allowed to dominate voting on what most considered to be a social question. Of those who had favoured Stout and Vogel in the previous year, 16 voted against the bill or abstained. On the other hand, 30 members politically unsympathetic to the ministry voted for the bill or abstained. 'Greyites' of the previous year voted in opposition to their leader and members of the so-called 'Middle Party' were evenly divided on the subject.

Town versus country rivalry assumed some significance in members' speeches, despite an earnest plea that it be excluded from the debate. Ever since the 1877 bill, country members had complained that town hospitals should not be fully dependent on government support while their own institutions merely received a £1 for £1

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145 Ibid. Of the six members who came into the House after the ministerial crisis, three favoured the bill, two opposed it and one abstained.
146 Cadman, Fraser, T. Thompson, Tole, Smith, Seddon and Joyce.
147 LT 30 July 1885. Ormond and Fisher opposed the bill, G.F. Richardson and Dargaville supported it.
148 PD 51 p 608 White (Sydenham, C).
subsidy. Town members replied that the sick and poverty-stricken gravitated to the larger towns and superior amenities which could only be maintained with extensive government support.

Country members were, naturally, inclined to support any bill designed to introduce a uniform system in the colony. Their limited support for the 1877 bill and alliance with the local bodies in opposition to the proposals of 1879-81, was based on two fears. They were wary of any move to close down local institutions or reduce them in status and also apprehensive of being forced to surrender a large amount of local control.

Under the 1885 bill, there was little chance of either of these fears being realized. The Hon P. A. Buckley, who framed the measure, had referred to Grabham's report which advocated a reduction in the number of colonial hospitals, but had not dared to incorporate any such move into the bill. The significant increase in the number of hospital districts left the way clear for a strong local element in the management of institutions. The provision for separate

149 PD 24 pp 101 Woolcock (Grey Valley, N), 149 Manders (Wakatipu, O), 163 Kennedy (Grey Valley, N); 44 p 643 Pyke (Dunstan, O); 51 p 603 Brown ("Mopaka, O); Buchanan (Wairarapa South, Un).
150 PD 44 p 644 Fish (Dunedin South, O), 51 pp 606 Newman (Thorndon, Un), 608 Gore (Dunedin South, O), 611 Reese (Stanmore, O).
151 PD 53 p 459.
institutions' also operated in favour of rural interests which, with the realization that their fears were groundless, afforded the bill considerable support.  

Town opinion was mollified by the knowledge that all districts using an institution had to contribute to its maintenance. The eventual approval of a £1 for £1 subsidy secured support for the bill for some members who had earlier been critical of it as harmful to their constituencies. As one observer noted, however, it was men such as Peacock, Newman and Gore, who represented large towns, that remained most strongly opposed to the bill. A large proportion of those who voted against the third reading were town members. Country members, who for political or other reasons opposed the bill, were more inclined to abstain from voting.

An analysis of sectional interests indicates that voting was roughly aligned to the town-country cleavage. Proportionately, contractors, lawyers and merchants were inclined to oppose the bill and some town uneasiness was revealed in a relatively high proportion of abstentions.

152 PD 51 pp 608 Guinness (Greymouth, Wd) Brown (Tuapeka, O), Buchanan (Wairarapa South, Wn), 615 Joyce (Awarua, O).

153 PD 52 p 38 Holmes (Christchurch South, O).

154 PD 51 p 608 Guinness (Greymouth, Wd).

155 Grey, W.J. Hurst, Moss, Ormond, Fisher, Newman, White, Hislop, Gore, Macandrew and Stewart could be classified as town members because of the proximity of their constituencies to large town hospitals. H. Hirst and R. Hursthouse qualified as country-town members. The remaining eight members opposed to the bill were country representatives. See Appendix C for the basis of classification.

156 Of the 18 who abstained, 11 were country members.
among journalists and lawyers. On the other hand, the wider classification of 'other professional men' favoured the bill.

The measure also received very strong support from farmers and secured moderate approval from estate owners. The voting of businessmen reflected the overall distribution of votes in the House. 157 Although sectional interests probably played some part in securing votes, political and wider town-country considerations appear to have dominated the issue.

The Otago Daily Times pointed out that the Otago members were placed in something of a dilemma, with their political affiliations favouring the government and their social convictions inclined to fault the bill. 158 In the third reading 11 Otago members supported the bill, 7 opposed it and 6 abstained. Thus the political allegiance of the province and its dissatisfaction with the bill were both made clear.

Credit for drafting the bill was given largely to the Colonial Secretary, Buckley. 159 However, his experienced Under-Secretary, G.S. Cooper, was probably of considerable assistance. Cooper, described as 'a fine type of civil servant' 160 showed an insight into hospital

157 See Appendix H.
158 ODT 28 September 1885.
159 TD 51 p 100 Vogel (Christchurch North, C).
and charitable aid affairs as early as 1877\textsuperscript{161} and the additional knowledge he had accumulated since that time may well have proved invaluable to Buckley.

Stout and Vogel proved themselves astute in piloting the bill through the House. The \textit{Lyttelton Times} noted their willingness to compromise where they thought it justified:

'In their treatment of the Bill, the Government have behaved with commendable good sense. When firmness was possible, they have been firm; when it was necessary, in the public interest to give way, they have given way.'\textsuperscript{162}

Their most significant concessions, of course, were those concerned with the number of districts and the size of the government subsidy. Some interpreted this as a severe blow to the bill - the \textit{Otago Daily Times}, for example, said that it passed in a 'mangled state.'\textsuperscript{163}

Stout and Vogel, however, drew on the experience of others. The division of the colony into hospital districts was drawn from the proposals of Ballance and Hall. The idea of 'separate institutions' closely resembled aspects of the 1877 bill and Ballance's suggestions to local bodies. The success of Auckland Hospital as a 'separate institution' made the incorporation

\begin{footnotes}
\footnote{161 IA 1 77/3324 Memo to Colonial Secretary, July 1877.}
\footnote{162 LT 20 July 1885.}
\footnote{163 ODT 24 September 1885. See also \textit{P} 16 September; Begg p 435.}
\end{footnotes}
of the idea in the bill politically possible.

With the experience and fate of their predecessors behind them, it is difficult to believe that Stout and Vogel really expected the House to accept a bill which allowed for only 12 hospital districts and granted a subsidy of merely 10s for £1 — half the amount of the lowest government subsidy in the period 1877-84.

It seems more likely that Stout and Vogel deliberately set both the subsidy and the number of districts at a low figure in the anticipation of some conflict over these items. By virtue of their opening bids, they were able to make concessions which satisfied a majority of the House. Although not particularly desirable from a colonial point of view, the increased number of districts at least encouraged local management. The reduction of colonial assistance to a £1 for £1 subsidy achieved the goal of drastically reducing government expenditure.164

Stout and Vogel appreciated that all demands would not be satisfied,165 but produced an apparently uniform and equitable system. Operating in their favour was the frustration of the colony, which had been without a uniform system since the abolition of the provinces.

164 See Appendices D and E.
165 PD 52 p 39 Vogel (Christchurch South, C).
Unsuccessful demands for a comprehensive colonial system had been made in parliament since 1877, and this feeling of frustration was reflected in some newspapers. By 1880, for example, the New Zealand Herald felt that:

"If there is any one thing of which more than another this colony should be ashamed, it is the lack of a uniform system with regard to our charitable institutions."

Some people felt that any hospital and charitable aid system would have defects which could only be found and remedied by putting it into practice. This argument secured some support for early bills and again appeared in 1885. The Legislative Council, in particular, supported the passage of the bill in order to make a start at reform. Such an attitude introduced flexibility into the bill and made a variety of material alterations possible in the future.

Despite some loss of public interest, caused by years of legislative dispute, an air of optimism

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166 PD 24 p 73 Reid(Taieri,0); 23 p 457 Stevens(Christchurch City,0); 29 p 442 Hall(Selwyn,0); 44 p 643-644 Sutton(Napier,HB).
167 Taranaki News 10 January 1880; IT 5 June 1880, 24 June 1882.
168 NZH 31 January 1880.
169 PD 24 32 Atkinson(Egmont,T), 111 Fox(Wanganui,Wn), 154 Joyce(Walae-o,0); ODT 4 July 1877.
170 PD 52 pp 31-32 Cowan(Hokonui,0).
171 PD 53 pp 171-172 McLean(Otago), 457 Stevens(Canterbury), 468 Richmond(Nelson).
172 IT 20 July 1885.
accompanied the bill. It was the start of a new era in the social welfare of the colony and newspapers generally applauded the passage of the bill, which came into operation as the **Hospitals and Charitable Institutions Act** on 1 October 1885.

173 ABS 29 September 1885; NZT 23, 29, 30 September 1885; LT 20 July, 24 September 1880. ODT 24 September, 1, 2 October 1885 tended to be neutral and P 16, 18 September was unenthusiastic. ES, EP and NZH made no editorial comment, but the general tone of the latter two from 1877 to 1885 favoured a measure along the lines of the 1885 bill.

VII. BIRTH OF A COLONIAL SYSTEM, 1886-92.

The legislators of 1885 had expected the Hospitals and Charitable Institutions Act to produce faults which they would be called upon to remedy. Accordingly, amendments to the Act were made in 1886, but thereafter most politicians regarded the subject as settled on a reasonably satisfactory basis. The politics of hospitals and charitable aid in this period thus palled somewhat beside those of the nine years prior to the passage of the Act.

In the hospitals, the work of Grabham was continued. MacGregor, the new inspector, was also active in charitable aid affairs which, under the 1885 Act, came under his jurisdiction. With the resolution of the major sources of hospital and charitable aid income, attention was largely diverted to income and expenditure at the local level: economics now became more closely aligned with the social, rather than political aspects of hospitals and charitable aid. By the early 1890s a colonial system, closely related to that of modern times, was in operation in New Zealand.
The Hospitals and Charitable Institutions Act had been passed on the understanding that any amendments, found by its operation to be necessary, would be made in subsequent legislation. On 14 June 1886, the government announced its intention to amend the Act and this was done by 11 August. The primary concern of the government was the encouragement of voluntary contributions, which were gradually declining. The main provisions of the amendment were an increased government subsidy on voluntary contributions - £1.4.0 for £1 - and the strengthening of separate institutions by an increase in the power of their boards. Minor points included the provision of advances to boards awaiting local body payments and the provision of salaries and travelling allowances for board members.

A notable feature of the debate was the revival of a certain amount of town-country rivalry. Some of those members whose districts had experienced an increase in rates, to pay for hospital and charitable aid facilities, complained of the extent of their burden. They generally represented the interests of the smaller hospitals and were in favour of increasing the number of districts in order to reduce their financial burden.

1 PD 54 p 474 Buckley (MLC, Wn).
2 PD 56 p 640.
3 Subscriptions and donations declined in proportion to other sources of hospitals' income from 1884 to 1886. See Appendix D.
4 N.Z. Statutes 1886 No 36 pp 235-244.
obligations. Other members pointed out that seasonal labourers employed by the country were often supported by the towns where they congregated when unemployed. Furthermore, most serious accident cases were treated by town hospitals and the attempts of the wealthy districts to avoid being coupled with the poor contravened the spirit of the Hospitals and Charitable Institutions Act.

The debate, however, was not as intense as any prior to the passage of the Act. Indeed, one member found the speeches unedifying and wearisome and expressed the hope that the 'blowing', done only to 'get into Hansard', would stop. According to a parliamentary correspondent:

'The discussion was rather a review of the working of the charitable aid system established last year than addressed to the merits of the Bill or its amendment. It was exhaustive and pretty complete. That it did not last longer nearly four hours is a proof that the system has not after all so much fault as the House and country anticipated last year.'

An estate-owner and avowed advocate of the country districts, W.F. Pearson, later moved a resolution that rating be extended to all forms of property, rather than be largely confined to land. This suggestion opened

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5 PD 55 pp 354 Walker(Ashburton,C), 359 Buchanan(Wairarapa South,WN), 361 Steward(Waimate,C), 363 Buckland (Franklin North,A), 365 McMillan(Conberidge,O).
6 Ibid pp 357 O'Conor(Buller,N), 304 Reese(Stanmore,C).
7 Ibid p 362 Kerr(Waimea,N).
8 LT 8 July 1886.
9 PD 55 pp 520-524; 56 p 556.
up a measure of town-country rivalry and political squabbles.\textsuperscript{10} Considerable distaste for the current rating system was reflected in a division, which the government lost by the Speaker's casting vote - an action he took to encourage a more satisfactory solution to the problem.\textsuperscript{11} Opposition speakers, however, could not agree on an acceptable alternative and the matter lapsed.

When the bill reached the committee stage, the government supported an amendment to separate Auckland and North Auckland districts and successfully opposed five amendments for the separation of other districts.\textsuperscript{12} In the next debate, W.C. Buchanan and J.B. Whyte again tried to secure separation for their districts, but were defeated by Montgomery's support for the government and Stout's threat to withdraw the bill altogether.\textsuperscript{13}

That personal compacts were important in hospital and charitable aid affairs was indicated by an open dispute between J.B. Whyte and A.J. Cadman over the terms of their lobby agreement.\textsuperscript{14} The Legislative Council noted that Whyte's amendment was rejected by only one vote and inserted a clause transferring Pisko

\begin{itemize}
\item \textsuperscript{10} PD 55 pp 520-534.
\item \textsuperscript{11} Ibid p 535.
\item \textsuperscript{12} PD 56 pp 332-333. The amendment of Dargaville(Auckland West,A) was successful. Others which were unsuccessful were put forward by Whyte(Waikato,A), Buchanan(Wairarapa South,Wn), Walker(Ashburton,C), Steward(Waimate,C) and Grace(Tauranga).
\item \textsuperscript{13} Ibid pp 552-555.
\item \textsuperscript{14} Ibid p 556 Whyte(Waikato,A), Cadman(Coromandel,A).
\end{itemize}
from Thames to the Waikato district. By its acceptance of the amendment, the House made Whyte the only representative to achieve separation for his district against the government's will.\textsuperscript{15} Generally, the House was sympathetic to the government's policy of retaining large districts. The bill was passed after Whyte's success and, as the \textit{Hospitals and Charitable Institutions Act 1885 Amendment Act, 1886}, became law on 17 August 1886.\textsuperscript{16}

After the passage of the Amendment Act, Parliament was basically satisfied with hospital and charitable aid arrangements. In its second year of office, the Atkinson ministry contemplated modifications to the hospital and charitable aid system.\textsuperscript{17} This policy, however, was not accorded a high priority and seems to have lapsed in the face of questions of retrenchment and political survival, which demanded the government's attention.\textsuperscript{18} No important hospital and charitable aid bills were brought forward by the ministry, which suggests that the operation of the Act had proved much more successful than the pessimistic Atkinson had predicted.\textsuperscript{19}

A number of local bills, for the separation of

\textsuperscript{15} Ibid p. 640.
\textsuperscript{16} Ibid; \textit{N.Z. Statutes 1886 No 36} p 235.
\textsuperscript{17} \textit{PD 63} p 426 Walker (Ashburton, C); \textit{AJHR 1889 N3} p 1.
\textsuperscript{18} Bassett pp 140-143.
\textsuperscript{19} \textit{PD 53} p 756.
various districts, were introduced in the House during the period 1887-90. They indicated that a few districts were dissatisfied with the rating arrangements. Most of these bills, however, were dropped after their first reading, which suggests that the members concerned were making a token gesture, mainly for the benefit of their constituents. Parliament, not inclined to further reductions in the size of districts, rejected the few bills which were debated. This action, combined with the general absence of parliamentary activity, indicates that most legislators were satisfied with the operation of the 1885 Act or, at least, could propose nothing more acceptable.

On 1 April 1886, Dr D. MacGregor was appointed inspector of hospitals and charitable institutions under the Hospitals and Charitable Institutions Act. Like his predecessor, he was a highly qualified man whose capabilities commanded respect. After distinguishing himself at three Scottish universities, he was appointed to a chair at Otago University at the age of 28. Stout, who was Premier at the time of MacGregor's appointment as colonial inspector, had been a student under the

20 In AJHR 1889 p 4 MacGregor warned against yielding to this pressure.
22 N.Z. Gazette 1886 Vol I p 403.
23 Carmalt Jones pp 43, 59.
professor, as had other lawyer-politicians such as Hislop, Stewart and Pitchett. In 1873 MacGregor became inspector of Otago lunatic asylums and was appointed as superintendent of the Dunedin Asylum in 1876.

In many aspects of medicine MacGregor was a progressive man. His most significant early contribution to colonial medical facilities was the introduction of antiseptic techniques to Dunedin Hospital. He took a keen interest in the medical school and was a firm advocate of courses which would be recognized by reputable overseas institutions. He also supported the employment of trained female nurses in all colonial hospitals.

Like Graham, he drew extensively on overseas experience in his efforts to improve the New Zealand system. His inquiries often met with a generous response. In 1888, for example, his request for material on the main hospital and charitable aid systems of the United States resulted in a shipment of 152 volumes on the subject.

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24 Scholefield DNZB Vol II p 16.
25 Ibid.
26 See page 13.
27 Carmalt Jones p 49.
28 IA 1 88/1635 Correspondence of D. MacGregor, F.D. Ball and S.J. Phelps (U.S. Legation, London), 29 September 1887 - 6 April 1888. These were employed in the hospital report of the following year, AJHA 1889 F3 pp 2-3.
In some respects however, MacGregor was conservative. His attitude to charitable aid, in particular, reflected his Scottish background and his close association with the Otago situation. Despite the growing colonial antipathy to voluntary contributions, he firmly believed that they had a vital role to play in the hospital and charitable aid system. He also believed in the provision of 'bare subsistence and no more' for state paupers to prevent 'pauperization' of the people. 29

In a series of articles written in 1876, MacGregor claimed that New Zealand had experienced a form of 'natural selection' and, because of this, could avoid the evils of British poverty. 30 Later, he blamed Vogel's immigration and public works policy for the extensive poverty which appeared in the colony. 31 Determined to prevent any further deterioration in social life, MacGregor advocated stringent control of charitable aid and supported the traditional notion that hospitals were primarily for the treatment of destitute people.

At a time when New Zealand's hospital and charitable aid system was acquiring a distinctive character of its own, MacGregor provided a beneficial steadying

29 AJHR 1888 H9 pp 2-8. Some classes of old people, widows and sick people were exempt from MacGregor's classification of 'state paupers'.
30 D. MacGregor 'The Problem of Poverty of New Zealand' New Zealand Magazine 1876 Nos I-III.
31 AJHR 1888 H9 pp 6-8.
force. Because of his attitude, some aspects of MacGregor's reports tended to stress the faults of the system and, indeed, appear to have been part of his campaign to keep it at a high level of efficiency.

Probably because of retrenchment in expenditure, enforced by economic conditions, few new hospitals were built to deal with the increasing number of patients. This was beneficial to the hospital system because the resources of existing hospitals were more fully utilized — an effect which Grabham had tried to achieve by his recommendation of a reduction in the number of hospitals.

Both of the new hospitals of the period were established in centres which had long felt the need for an institution and had, for a short time at least, supported small cottage hospitals. Hamilton possessed a small hospital for a few months in 1878 and established a permanent one in 1887.\textsuperscript{32} Five immigration huts which had served Palmerston North as an emergency hospital in the 1880s were replaced by a 'commodious and well designed hospital', on which work was begun in 1889, but not completed until 1893 because of drainage problems.\textsuperscript{33}

 Strong local support for the hospital was reflected in


\textsuperscript{33} AJHR 1888 H9 p 15; 1893 H23 p 16.
substantial contributions towards the cost of its erection.\textsuperscript{34}

The improvements in the quality of the hospital staff of the mid 1880s extended into the 1890s. The Otago Medical School was able to offer a complete degree course from 1885 and was accorded the status of a faculty in 1890.\textsuperscript{35} MacGregor encouraged the link between the medical school and the Dunedin Hospital, which, because of this association, acquired the best medical and surgical arrangements in the colony.\textsuperscript{36} The professional standing of the medical profession was enhanced by the activities of the New Zealand Medical Association which was re-established, on a fully colonial basis, in 1886.\textsuperscript{37}

MacGregor, like his predecessor, strongly favoured well-educated, trained nurses.\textsuperscript{38} Those at Wellington impressed the Inspector:

\begin{quote}
'...The nursing-staff struck me as being particularly satisfactory. They are well trained, intelligent, and ladylike, being evidently drawn from a class very much superior to the old-fashioned hospital-nurse of former times.'\textsuperscript{39}
\end{quote}

The training of nurses in the mid 1880s was generally informal, but by the end of the decade, recognized courses were instituted or contemplated in the four main hospitals.

\textsuperscript{34} Ibid.
\textsuperscript{35} Carmalt Jones pp 58, 56.
\textsuperscript{36} AJHR 1887 H9 p 7; 1888 H9 p 10.
\textsuperscript{37} NZMJ Vol I pp 5–7. The NZMJ was founded the following year.
\textsuperscript{38} AJHR 1889 H3 pp 9–10.
\textsuperscript{39} AJHR 1887 H9 p 23.
After a training course in 1883, Wellington Hospital awarded its first certificates in 1889. Auckland's first full course was instituted in 1889 and certificates were awarded in 1892. A two year course of formal instruction for nurses was begun at Christchurch in 1891. Some instruction was available to Dunedin nurses in 1889 but, as the Dunedin Hospital employed a lower ratio of female nurses than the other main hospitals, formal training was not instituted there for a further four years. The new professional standards of nursing were disseminated by nurses from the training schools who took up appointments in other hospitals of the colony.

The change was not accomplished without some conflict between the different generations of nurses. MacGregor's support for the modern nurses and the demands of new medical techniques, however, ensured the eventual demise of the old order. By 1892, New

40 Wilson pp 76-78.
41 Rauch p 80.
42 Bennett pp 96-97.
43 AJHR 1889 H3 P 10; Carmalt Jones p 38, H. Maclean Nursing in New Zealand p 265 gives the following foundation dates for the respective training schools: Wellington 1884, Auckland and Christchurch 1891, Dunedin 1893. In the case of Wellington, she appears to have confused the introduction of the 'probationer' system with the institution of a recognized course of instruction.
44 Twelve years after its foundation, the Christchurch school claimed to have trained the matron of every hospital in the South Island except one, Bennett p 104.
45 Bennett p 97.
Zealand was following the path set by other countries with progressive nursing systems. Nine years later, the colony confirmed its belief in the standard training and examination of nurses in 'the first sole nurses' registration act in the world.'46

The number of patients treated in New Zealand hospitals increased steadily during the period 1886-92.47 This was partly due to the increase in population and to the larger proportion of old people in a colony which was shedding its frontier way of life. Much of the increase, however, appears to have been due to a popular appreciation of the benefits of improved hospital treatments.

Payments by patients more than kept pace with the increase in numbers. Prior to 1885, this source of income formed about 6% of the colonial hospitals' income. After 1886, however, payments by patients rose steadily and, by 1892, formed about 12% of the hospitals' income.48 This proportionate increase, in a period of severe depression, can hardly have been the result of careful administration alone. It seems likely that it was largely due to the admission of more patients able to pay for their treatment to the hospitals of the colony.

47 See Appendix I.
48 See Appendix D for detailed accounts.
In the relatively pragmatic and egalitarian society of New Zealand, class distinctions in the use of hospitals became blurred. Hospital treatment, which had never really been confined to the poor, was available to all who could benefit from it. After the passage of the 1885 Act, New Zealand citizens were supporting the hospitals through government taxes and local body rates and those classes which had rarely used the hospitals now felt entitled to do so.49

In contrast to in-patients, the number of out-patients from 1886 to 1892 was generally static.50 This was mainly because the hospitals were usually careful to ensure that the out-patients they treated were genuinely destitute, otherwise general practitioners would have been deprived of their legitimate income. Out-patient services, in fact, were virtually unaffected by the 1885 Act. The honorary staff of each hospital often acted in the capacity of a local watchdog and, at the colonial level, private doctors' interests were guarded by the New Zealand Medical Association and the colonial inspector.

There was still some variation in the criteria applied to regulate the admission of out-patients.

49 This applied primarily to the middle classes. Generally the rich still preferred to be treated at home.
50 See Appendix I.
In this respect, Dunedin and Wellington were more liberal than the hospitals at Christchurch and Auckland. Out-patient arrangements, however, were not allowed to be widely at variance with those followed by other hospitals in the colony. A case of this nature arose after a new system was introduced at Thames Hospital in 1886. The hospital report for 1888 described the situation:

'...the Trustees have thrown open the outdoor department of the hospital to all persons whatsoever, whether rich or poor, who are willing to pay 5s. per week for advice and medicine. The result is that the general body of taxpayers of the colony have, through the Government subsidy, to contribute towards giving cheap medical advice to the Thames people, by enabling the Trustees to undersell the local medical men by the competition of a salaried officer...'51

Although the poorer classes still formed the majority of patients, the relatively cheap out-patient facilities were also utilized by wealthier members of the community:

'...well-to-do farmers farming their own free-holds; mine managers, mining speculators; ladies who have been seen driving up in their own buggies, including one whose husband boasts he is worth £10,000...'52

The number of out-patients treated at Thames Hospital jumped from 430 in 1886 to 1,339 in 1887,53 and the local doctors were affected, 'most injuriously from a pecuniary point of view.'54

51 AJHR 1888 H9 p 1.
52 NZHJ Vol II p 45.
53 AJHR 1887 H19 p 39; 1888 H9 p 1.
The Inspector, surprisingly quiet on the tendency for indoor patients of some means to make use of hospital facilities, was disturbed by the misuse of a government-subsidized institution and its staff as a source of cheap medical assistance. The problem was compounded by the attitude of the local administration:

'The Thames Board, convinced that they were in the full current of the spirit of the age, became propagandists of their idea, and endeavoured to get other hospitals to see the admirable simplicity and beauty of the system.'

The board was put under pressure to abandon its system: local doctors boycotted the hospital and MacGregor urged the board to abandon the system, a recommendation which received the support of the New Zealand Medical Association. As a result of this pressure, the Thames board reverted to its earlier arrangements and out-patients, which had numbered 1,020 in 1888, fell to 559 in 1889 and 228 in the following year.

The threat to the livelihood of general practitioners posed by the Thames Hospital system was averted

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54 NZMJ Vol II p 44 Dr M.H. Payne to NZMA, 28 July 1888.
55 AJHR 1889 H3 p 3.
56 NZMJ Vol II p 44.
57 IA 1 89/931 (88/270) D. MacGregor to Thames Hospital Board, 9 August 1888.
58 IA 1 89/931 NZMA to Colonial Secretary, 8 April 1889.
59 AJHR 1889 H3 pp 3,37; 1890 H11 p 23; 1891 H7 p 30.
and state-subsidized medical treatment for all was recognized as somewhat premature in New Zealand's developing hospital system.\textsuperscript{60} Fluctuations in the numbers of out-patients of other hospitals in this period were primarily due to local conditions, such as minor epidemics and the attitudes of the resident medical officers.

Despite his interest in the problems of poverty, MacGregor found that his appointments as inspector of both lunatic asylums and hospitals kept him from a close examination of the subject until 1887. In July of that year he was able to study outdoor relief at first hand and felt:

'...committed to the duties of a sort of Poor-law Inspector for the colony from my conviction of the urgency of this great evil...'.\textsuperscript{61}

Few officers of the charitable aid boards had an intimate knowledge of the character and circumstances of their charitable aid recipients and it soon became apparent that outdoor relief in many districts had lacked competent administration since the days of the provincial governments.

\textsuperscript{60} MacGregor realized that the system might appeal to Parliament, AJHR 1889 H3 p 3. Nothing, however, came of this.

\textsuperscript{61} AJHR 1888 H9 p 3.
In Auckland, MacGregor felt that if he wanted to know the facts, he must ascertain them for himself. Accordingly, he engaged the services of an ex-detective Strathiearn and made a thorough examination of cases of outdoor relief:

'...I made a house-to-house examination of all the cases of outdoor relief in the most populous parts of the city, and found that, during the period when the General Government provided most of the money, a state of things had grown up that in a young country like this was simply dreadful.'62

MacGregor discovered that a number of people who were in good circumstances received charitable aid. Many other recipients had prosperous relatives who were liable for their support and besides these there were numerous imposters. About 100 people were struck off the list after the Inspector's visit.63

MacGregor was directly responsible for a reduction of about 50% in charitable aid expenditure in Auckland and Napier over the next few months. Lax administration at Masterton had led to blatant abuse of charitable aid in the district.64 The Inspector was reasonably satisfied with the efforts of other controlling boards, which made the best they could of a difficult situation.

Abuse of the increased subsidy for voluntary contributions was found even in districts where outdoor

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62 Ibid.
63 Ibid.
64 Ibid. pp 3-4.
relief was well administered. Sums donated by friends or relatives of destitute people sometimes passed through the books of the local benevolent society so as to obtain the government subsidy. In one case noted by MacGregor, the local benevolent society took over a widow's pension of 10s per week, received the government subsidy on it as a voluntary contribution and gave the woman 15s per week, clearing £18.4.0 by the transaction.

MacGregor conducted a successful campaign against inefficiency in charitable aid administration. He noted that sterling efforts had been made to reduce charitable aid expenditure in Canterbury and received cooperation from most boards in the colony. In some cases, MacGregor avoided antagonizing boards by suggesting that they appoint their own inspectors. In 1891, at MacGregor's prompting, the Dunedin trustees sent an inspector to check on their country recipients and the 'remarkable disclosures' which resulted were reminiscent of the state of affairs at Auckland in 1887.

Although the economic situation of the colony

<table>
<thead>
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<th>Pension of widow</th>
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<tr>
<td>Government subsidy</td>
<td>31. 4. 0</td>
</tr>
<tr>
<td>Amount received by society</td>
<td>37. 4. 0</td>
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<tr>
<td>Allowance to widow</td>
<td>39. 0. 0</td>
</tr>
<tr>
<td>Profit</td>
<td>78. 4. 0</td>
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65 Ibid p 5.
67 AJHR 1888 H9 p 6.
68 ODT 31 December 1891.
promoted care in charitable aid administration, it was also responsible for an increase in the numbers of people seeking relief.\textsuperscript{69} The situation was not as harsh as that experienced by some overseas countries, but was serious by New Zealand standards.\textsuperscript{70} The depression was severe in the period 1834-88\textsuperscript{71} and, by the latter year, the 'down and outs' of the colony were in a pitiable state:

'... in these days of depression there is much misery; homeless people sheltering under trees and hedges in parks and gardens and unoccupied town sections, kennelling in barrels, iron tanks, anything that will cover their poor foodless bodies from the damp air of the night.'\textsuperscript{72}

The charitable aid system provided the poor with sufficient means to survive, but did not exclude additional assistance from private charity.\textsuperscript{73} In Christchurch, for example, the Roman Catholic Church undertook the building of a charitable institution\textsuperscript{74} and a refuge for vagrants was erected through the efforts of a local philanthropist, T. Herrick.\textsuperscript{75} Although some people gained charitable aid under false pretences, there were also many genuine cases of hardship.

\begin{flushright}
69 LT 20 August 1836.
70 EP 1 October 1885.
72 Canterbury Times 8 June 1888 p 21.
73 LT 20 August 1886; AJHR 1888 $9$ pp 8-9.
74 LT 17 February 1886.
75 R.C. Lamb Street Corner pp 32-34.
\end{flushright}
The economic situation, combined with MacGregor's campaign, encouraged a careful administration of funds: 'In consequence of the great movement towards economy which of late years has arisen all over the colony, Charitable Aid Boards have begun to look very sharply at their expenditure.'\textsuperscript{76}

The care of destitute children suffered because of this parsimonious outlook. A few local authorities tried to throw the whole burden of child care on the central government and children were sometimes boarded-out with charitable aid recipients.\textsuperscript{77} Theoretically, the allowance received for this service prevented such people from making further demands on the charitable aid authorities.

MacGregor was disturbed by the situation, for he believed that destitute children should have been given a good upbringing in responsible homes, preferably in the country:

'I am convinced it is mistaken economy to deal in this way with the young. Be as hard as you like with the adult beggar; but it will save a great deal of future expense...if we deal generously with the children.'\textsuperscript{78}

The following year he recommended that the state assume the whole cost of caring for neglected children, but there was little response to the suggestion.\textsuperscript{79} There were few changes in the institutional care of children in this period.

\textsuperscript{76} AJHR 1891 H7 p 28.
\textsuperscript{77} Whelan pp 169-170; AJHR 1891 H7 p 28.
\textsuperscript{78} AJHR 1891 H7 p 29.
\textsuperscript{79} AJHR 1892 H7 pp 2-3. The idea received the support of Dr A.G. Purchas, Medical Officer of the Auckland District, AJHR 1893 E3 p 4.
Old people received considerably more attention in the late 1880s than they had prior to the passage of the 1885 Act. Much of the cost of Auckland's Home for the Aged and Needy, opened in April 1890, was met by a large bequest from E. Costley, who also endowed other public institutions in the city. The insanitary old refuges, which had served Auckland as a collective hospital until 1877, were deliberately burnt down soon after the opening of the Costley Home.

At Hamilton, a refuge was established in 1888 — only one year after the foundation of the hospital. The Jubilee Home at Christchurch (1887) provided accommodation of a very high standard and at Dunedin the Benevolent Society, which maintained the largest refuge in the colony in 1891, cared for 167 old people. By the early 1890s there were 12 government-assisted homes for the aged in the colony and all districts, with the exception of Westland, were reasonably well served in this respect.

The progressive side of MacGregor's outlook was demonstrated in 1892 when he recommended, in his official

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80 Rauch pp 143-144.
81 NZH 21 October 1890. Old hospital buildings, which harboured vermin and germs, were usually purged by burning. Eleven years later, a similar fate befell the Taranaki Old Men's Home, which had also once served as a hospital.
82 Norris p 174.
83 AJHR 1891 VII p 28.
84 Ibid pp 27-28. As in the period 1877-85, the hospitals at Westport, Greymouth and Hokitika also acted as old men's refuges.
Taranaki Old Men's Home, 1887-93.
(Used with the permission of Mr R. Allan,
Director of the Taranaki Museum.)

This building served New Plymouth as a hospital from 1867 to 1887 and was then used as an Old Men's Home. A new home for old people was built in the early 1890s and, when the last group of old men was moved from the old building at the end of the decade, it was 'purged' by burning.
report, the introduction of old age pensions in New Zealand.\textsuperscript{85} English proposals and legislation in Germany and Denmark prompted him to comment favourably on the rise, in a number of countries, of:

'...a strong public sentiment in favour of a more sympathetic and discriminating treatment of the aged poor.'\textsuperscript{86}

The Inspector had been aware of the plight of this class for several years\textsuperscript{87} and recommended the adoption of Denmark's 'state pensioner' system in the colony.\textsuperscript{88} Pensions became an issue in the election of 1893 and received considerable public attention before they were introduced to Parliament in 1896.\textsuperscript{89} MacGregor's recommendations were largely embodies in the \textit{Old Age Pensions Act}, which became law in 1898.\textsuperscript{90}

Although the \textit{Hospitals and Charitable Institutions Act} was successful in its aim of producing a colonial system, the Inspector found several imperfections in the early years of its operation. From his point of view, the most serious was the Act's failure to promote voluntary contributions. Separate institutions, set up under the Act, were also designed to encourage public assistance, but often failed to achieve this aim.

\begin{footnotesize}
\textsuperscript{85} AJER 1892 H3 p 3.
\textsuperscript{86} \textit{Ibid}.
\textsuperscript{87} AJHR 1888 H9 p 8.
\textsuperscript{88} AJHR 1892 H3 pp 3-4.
\textsuperscript{89} Condilffe pp 296-297.
\textsuperscript{90} N.Z. Statutes 1898 No 14 pp 47-59.
\end{footnotesize}
Voluntary charity had been declining for at least two years before the passage of the 1885 Act. Several members of parliament expressed the view that, by enforcing payments towards hospitals and charitable aid, the Act would 'dry up the springs of charity'. A few members denied this, but a more common attitude was that dependence on voluntary contributions was outdated because they produced least when most needed and, at the best of times, constituted only a small fraction of hospital and charitable aid income.

Stout and Vogel seem to have had little faith in voluntary contributions as a substantial source of income, but paid lip-service to the idea. To bolster the falling rate of subscriptions and donations, they offered an increased subsidy on voluntary contributions in the 1886 amendment. This produced no appreciable change in the situation.

In his first report, MacGregor claimed that the 1885 Act might reduce voluntary charity in some districts.

91 AJHR 1883 H3A p ii; 1885 H18 p 2.
92 PD 51 p 613 Pyke(Dunstan, O); 52 p 29 Fergus(Wakatipu, O); 53 p 172 Pollen(MLC, A), 471 Reynolds(MLC, O).
93 PD 53 pp 173 Shrimski(MLC, N), 459 Buckley(MLC, Wn).
94 PD 53 pp 461 Barnicoat(MLC, N), 467 Whitaker(MLC, A); 55 p 359 Newmnan(Thornndon, Wn); LT 20 July 1885; ODT 1 October 1885. See pp 96-99 for a fuller discussion on the role of voluntary contributions.
95 PD 55 p 521 Vogel (Christchurch North, O).
96 N.Z. Statutes 1886 No 36 p 239.
97 AJHR 1887 H19 p 1.
A few years later he wrote:

'One of the chief aims of the existing Act was to leave nothing undone to encourage the voluntary contributions for charitable purposes that so honourably distinguished some districts of the colony; but, unfortunately, here, as elsewhere, a poor-law /1885 Act/ dries up the springs of charity.'

Voluntary contributions certainly dropped in the period 1886-92, but this was merely the continuation of a well-established trend. In 1881 subscriptions and donations formed about 14% of hospitals' income, by 1886 the figure was approximately 10% and by 1892 it had declined to 6%. The decline was a gradual one and there is no evidence to show that it was closely linked with the passage of the Act which registered, rather than caused, the 'drying up' of private charity. MacGregor and other staunch supporters of voluntary charity were unable to see that the only 'failure' of the Act in this respect was that it did not arrest the current trend of declining voluntary contributions.

However, the Act was unsuccessful in one aspect which was related to voluntary charity - the general application of the idea of 'separate institutions'. There were 22 hospitals and 7 charitable institutions registered as 'separate institutions' in 1886.

98 AJHR 1889 H3 p 4.
99 The decline was partly attributable to economic conditions, ES 17 August 1886.
100 N.Z. Gazette 1886 Vol I passim. This includes Auckland Hospital, first registered in 1883.
In some districts they proved successful, but often the public support, upon which they ostensibly relied, was eroded within a few years of their foundation. 101

Although voluntary subscribers to 'separate institutions' were permitted to elect a large proportion of the trustees, 102 they often did not do so unless a controversial issue arose. There seemed to be a case for legislative reform and some institutions reverted to local body control. 104 Parliament, however, did not regard the problem as serious enough to warrant immediate attention. 105

The multiplicity of local bodies associated with hospitals and charitable aid sometimes hampered the administration of the system and made MacGregor a firm supporter of local government reform. 106

101 AJHR 1888 H9 p 4. Voluntary contributions to the North Wairarapa Benevolent Society amounted to £222.18.9 from over 100 people in 1885 and £913.0 from 11 two years later.
102 N.Z. Statutes 1886 No 36 p 243.
103 AJHR 1889 H3 p 4.
104 Ibid; IA 1 88/3154 Auditor-General to Colonial Secretary, 19 September 1888.
105 A number of 'separate institutions' were abolished in the 1900s and, under the Act of 1909, only nine 'separate institutions' remained in existence. See N.Z. Statutes 1909 No 11 pp 92, 106.
106 AJHR 1889 H3 p 4; 1892 H3 p 1.
In most other respects, however, the 1885 Act was successful. It produced an equitable and uniform colonial system of hospitals and charitable aid to replace the chaotic arrangements of 1877-85. Although MacGregor rarely commented on the good points of the system he administered, he was particularly proud of the responsibility assumed by local bodies:

'...it is unquestionably the most statesmanlike step which has yet been taken in any of our Australasian Colonies in dealing with this question. What we possess owing to this law is at this moment the despair of New South Wales and Victoria. The old and incurably vicious system which prevailed here before 1885, under which political importunity was found to be successful in making up for the shortcomings of local charity, is still in full swing with them.'

By 1892, the New Zealand hospital and charitable aid system was well-established. Lack of appropriate finance and management was largely a thing of the past and the internal arrangements of the colonial institutions could have borne comparison with those of other progressive countries. The problems which now arose were small by comparison with those of 1877-85. In its first seven years of operation, the Act proved itself worthy as a cornerstone of New Zealand's public health and welfare system.

107 AJHR 1888 H9 p 6.
108 AJHR 1892 H3 p 1. The lack of local bodies in the Australian states was a principal factor in their failure to produce satisfactory hospital and charitable aid systems.
VIII. CONCLUSION: GENESIS OF THE WELFARE STATE.

The period 1877-92 was one in which the hospital and charitable aid arrangements of New Zealand's provinces were transformed into a single comprehensive system. Developments in medical knowledge and facilities, as well as in aspects of charitable aid, produced a relatively high standard of welfare services in the colony.

Because there was little government involvement in the internal affairs of hospitals and charitable institutions from 1877 to 1885, the diversity engendered in the provincial period remained a feature of the country's welfare arrangements. The anomalies of the system were widely tolerated because it often seemed that the government was about to legislate on the subject. On several occasions, however, ministries showed that they preferred to postpone the issue rather than assume responsibility for its resolution. General indifference to the situation was epitomised in the popular attitude towards patients' financial obligations: those who were willing and able to pay for their treatment did so and the remainder were given accounts, but rarely forced to honour them.

Prior to 1877, some effort had been made to support hospitals and charitable aid from private charity but, with the relatively meagre resources of early New Zealand
society, social welfare was usually supported by the various provincial governments. These financial responsibilities were inherited by the central government, which employed the 'temporary' administrative machinery of the 1876 and 1878 Financial Arrangements Acts to manage the system for nine years.

Dependence on the state increased as voluntary charity decreased in the face of economic recession. The notion that the state was obliged to provide some assistance for the unfortunate became widespread and a few people even regarded free treatment as a right.

In an effort to exert some control over the situation, the government appointed an inspector. This largely arrested the decline in hospital management and produced a significant rise in the standards of colonial institutions.1 Parliamentary activity to complement this improvement took nearly a decade to come to fruition - it was not until 1885 that the Hospitals and Charitable Institutions Act was passed.

The Act, which drew support from many shades of opinion, provided a firm basis for a colonial hospital and charitable aid system. Although labelled by some of its opponents as a 'poor law', the measure bore

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1 The depression possibly contributed to the decline in hospital management. However, it was also responsible for the retrenchment measures which supported Grabham's demands for a more efficient system.
little resemblance to English legislation. A codification of a system which had proved successful in some parts of New Zealand since 1878, the Act served as a curb on abuse rather than a source of it.

By making allowances for voluntary charity, the Act and its amendment acknowledged traditional theory. It was, however, primarily concerned with the growing feeling that dependence on voluntary charity was inappropriate in a uniform and equitable hospital and charitable aid system, and balanced state assistance with local finance and administration.

In some spheres, the effect of the Act was felt only gradually. This was particularly true of charitable aid, which was subject to little government control from 1877 until MacGregor took an interest in it in 1888. MacGregor's preoccupation with the difficulties of restricting abuse in outdoor relief, however, meant that his reports tended to overlook satisfactory aspects of the system. Of particular merit was the 'boarding-out' system for orphaned and neglected children, introduced in the early 1880s and the considerable attention devoted to the problems of the aged later in the decade. 2 Grabham's work in the hospitals was continued by MacGregor,

who proved a worthy guardian of professional standards. By the early 1890s, the colony possessed a hospital network which, combined with its charitable aid arrangements and judged by contemporary standards, formed a creditable state-directed system.

Once New Zealand's system for the cure of sickness and poverty was firmly established, attention was partly diverted to means of prevention. Most schemes were centred on the idea of state involvement. The state already played key roles in education and social welfare, and Vogel's public works and immigration scheme had heralded the possibility of state socialism. 3

The Hospitals and Charitable Institutions Act, passed in a period of depression:

'...took a long step towards the public provision of hospital service and poor relief as a right of citizenship.' 4

a notion which had long been recognized in practice 5 and one which was accepted by the majority of New Zealanders by 1892. 6

State assistance in the bringing up of families was occasionally suggested in the mid-1880s. 7 In his

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3 Scholefield NNZS p 130; Armstrong pp 24-26, 32.
4 Condliffe p 294.
5 This is also noted by J.E. Le Rossignol and W.D. Stewart State Socialism in New Zealand p 179.
6 AJHR 1892 H3 p 2.
7 LT 8, 9, 11 September 1885; PD 55 p 365 Levestam (Nelson, N).
Invercargill Hospital, about the turn of the century.
The hospital attained 'town' status in the mid-1880s and was second largest of the nine hospitals which served Otago.
report of 1888, MacGregor expressed concern for the aged, the widowed and the sick who, he thought, deserved a measure of state assistance to keep them from poverty.8

Public opinion was receptive to such ideas. Earlier in his 1888 report, MacGregor spoke of:

'...the good-nature of our people, at any rate so far as extravagance in vicarious charity is concerned. Our sensitiveness to suffering has been greatly stimulated by the comparative absence from our towns of those sights of misery and squalor that deaden the feelings by familiarity...'9

The era was one in which the public conscience was awoken. A similar movement in the U.S.A. a few years later was labelled, 'the new philosophy of the dawn of the twentieth century': 10

'This new philosophy studies causes as well as symptoms and it considers classes as well as individuals. On the practical side it tries to improve conditions...it seeks for prevention as well as cure.'11

Attention became focussed on the plight of the aged poor and a pensions scheme, designed to ameliorate this distress, was suggested by MacGregor in 1892. Interest in the prevention of this aspect of poverty had been aroused by the work of the friendly societies,

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8 AJHR 1888 H9 p 8.
9 Ibid p 5.
10 AJHR 1897 H22 p 1.
11 Ibid.
Atkinson's much-publicized national insurance scheme of 1882-83 and discussions on the role of the state in social welfare. This body of opinion was reinforced by considerable agitation before the question of old age pensions was raised in Parliament, a fact that W.P. Reeves appeared to have forgotten when writing his account in England:

'...the proposal to pass an Old Age Pensions Law, unexpectedly as it came from the Government in 1896, found public opinion in the colony quite ready to entertain the question.'

A similar sentiment, as J.B. Condliffe points out, is expressed in Reeves' claim that:

'...the Government, boldly moving in advance of public opinion, suddenly brought down a Bill containing a pensions scheme.'

The Liberals were generally reluctant to acknowledge the debt to their predecessors in social welfare; Seddon, for example, employed the abuse of outdoor relief in some districts in an attempt to discredit the whole charitable aid system.

Yet the difference between the Liberals and their predecessors was merely one of emphasis. In the period of transition, the colony was primarily concerned with the evolution of a comprehensive hospital and charitable

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12 W.P. Reeves State Experiments in Australia and New Zealand Vol II p 244.
13 Condliffe p 297.
14 Reeves p 244.
15 PD 95 pp 624-625.
aid system. Once this was satisfactorily achieved, New Zealand became more concerned with preventive measures. By overseas standards this was a radical development but, viewed in the light of colonial developments, it was firmly based on previous legislation. This continuity in social welfare developments had its parallel in the political and economic life of New Zealand.16

The Liberal legislation of 1891-94 was framed in an era of continued depression and could not take its full effect until better times returned after 1895. The Old Age Pensions Act, passed in an atmosphere of economic recovery, was the most spectacular endorsement of this policy, which was gradually extended to protect widows, orphans and the disabled, and culminated in the Social Security Act 40 years later.

A stable hospital and charitable aid system and a sympathetic body of public opinion were vital prerequisites to state experiments in the care of the less fortunate members of the society. In the period 1877-92, the basic elements of social welfare in the colony were fused into a comprehensive system which constituted, in substance, the genesis of the welfare state in New Zealand.

16 See Armstrong pp 273,303.
APPENDIX A.

Ages of Patients in the Hospitals of the Colony, 1884–85.

There are few statistics of patients' ages available, but those for 1884–85 probably indicate trends typical of the period.

1884

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<td>6268</td>
</tr>
</tbody>
</table>

1885

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>-5</td>
<td>41</td>
<td>24</td>
<td>65</td>
</tr>
<tr>
<td>5-15</td>
<td>316</td>
<td>161</td>
<td>477</td>
</tr>
<tr>
<td>15-25</td>
<td>809</td>
<td>503</td>
<td>1312</td>
</tr>
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<td>25-35</td>
<td>1062</td>
<td>282</td>
<td>1344</td>
</tr>
<tr>
<td>35-45</td>
<td>991</td>
<td>232</td>
<td>1223</td>
</tr>
<tr>
<td>45-55</td>
<td>917</td>
<td>173</td>
<td>1090</td>
</tr>
<tr>
<td>55-65</td>
<td>574</td>
<td>89</td>
<td>663</td>
</tr>
<tr>
<td>65-</td>
<td>247</td>
<td>28</td>
<td>275</td>
</tr>
<tr>
<td>Unspecified</td>
<td>17</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Totals</td>
<td>4974</td>
<td>1497</td>
<td>6471</td>
</tr>
</tbody>
</table>

In both cases —

The median age is about 35.

The age groups 15–45 and 45–55 are the heavily represented. Numbers tail off rapidly at both ends of the scale, a smaller decrease being registered in the older age groups. Males always outnumber females and the disproportion increases with age.

Differences between the two tables —

There are significant increases in the numbers of the 55-65 age group, both male and female, which probably
produced increased pressure for more old people's homes.
The large drop in the number of 'unspecified' perhaps reflects the results of Inspector Grabham's stress on the need for complete and reliable returns.

Sources: AJHR 1885 H18 p 5.
AJHR 1886 H9 p 9.
APPENDIX B.

Expenditure on Alcohol in New Zealand Hospitals.

Statistics on alcohol expenditure in New Zealand hospitals 1881-86 are not particularly reliable. Some hospitals, deliberately or otherwise, concealed their consumption by including it with other items, usually 'provisions' or 'drugs and surgical instruments'. Others, for various reasons, provided no information for their balance sheets and the absence of these figures distorts the colonial totals. Several hospitals supplied a blank return on this item alone; in many of these cases there was possibly no consumption of alcohol, but in a few, the cost appears to have been borne by another item. An example of the former is Coromandel, which presented a NIL return for the years 1881-83 and 1886 and an expenditure in only one year, 1884, when the cost of alcohol was 13/-.

Dunstan, on the other hand, returned NIL for the year 1882 but explicitly combined the previous year's total with 'drugs and surgical instruments' and expended £26.9.6 on alcohol the following year. Although this latter figure was reduced in subsequent years it is hard to believe that no alcohol was purchased at Dunstan in 1882. 'NIL' should be treated as 'no details available'.

Unfortunately no figures on alcohol expenditure are available for the crucial year 1885. The following table shows the annual expenditure on alcohol at eight of the larger colonial hospitals and the official total figure for the whole colony.

<table>
<thead>
<tr>
<th>Year</th>
<th>£</th>
<th>s</th>
<th>d</th>
<th>£</th>
<th>s</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1881</td>
<td>235</td>
<td>1</td>
<td>0</td>
<td>235</td>
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<td>5</td>
</tr>
<tr>
<td>1882</td>
<td>No Inf</td>
<td></td>
<td></td>
<td>367</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>1883</td>
<td></td>
<td></td>
<td></td>
<td>370</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>1884</td>
<td>260</td>
<td>5</td>
<td>6</td>
<td>276</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>1885</td>
<td>147</td>
<td>9</td>
<td>1</td>
<td>147</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>1886</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>107</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1887</td>
<td>127</td>
<td>17</td>
<td>0</td>
<td>106</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>1888</td>
<td>143</td>
<td>18</td>
<td>0</td>
<td>No Inf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1889</td>
<td></td>
<td></td>
<td></td>
<td>288</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL All Hospitals</td>
<td>2,241</td>
<td>10</td>
<td>3</td>
<td>1,644</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>1884</td>
<td>1886</td>
<td>1890</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Auckland</td>
<td>114</td>
<td>7</td>
<td>11</td>
<td>81</td>
<td>11</td>
<td>7</td>
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<tr>
<td>Christchurch</td>
<td>350</td>
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<td>0</td>
<td>160</td>
<td>15</td>
<td>6</td>
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<tr>
<td>Dunedin</td>
<td>392</td>
<td>4</td>
<td>0</td>
<td>164</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Greymouth</td>
<td>No Inf</td>
<td></td>
<td></td>
<td>137</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Hokitika</td>
<td>175</td>
<td>18</td>
<td>0</td>
<td>154</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Napier</td>
<td>248</td>
<td>8</td>
<td>6</td>
<td>36</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Timaru</td>
<td>108</td>
<td>16</td>
<td>9</td>
<td>78</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Wellington</td>
<td>No Inf</td>
<td></td>
<td></td>
<td>210</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL All Hospitals</td>
<td>1,997</td>
<td>9</td>
<td>5</td>
<td>1,525</td>
<td>5</td>
<td>11</td>
</tr>
</tbody>
</table>

A - Including drugs and surgical instruments.
1. 1881. Excluding Wangenui and Westport.

'Nil' at Akaroa, Arrowtown, Coromandel, Invercargill.

6 hospitals explicitly included alcohol expenditure with 'drugs and surgical instruments,' and 1 with 'provisions.' The total expenditure excluding these hospitals is £1,981.16.2; and including the figures of those included with "drugs and surgical instruments" is £2,402.4.6. Other sources were probably used by departmental officers to present what seems to be a fairly accurate total for this year.

2. 1882. Excluding Auckland, Greymouth, Patea, Wellington and Westport.

'Nil' at Coromandel, Dunstan, Gisborne, Naseby. The exclusion of Auckland, Greymouth and Wellington figures obviously distorts this total considerably. The expenditure of these three hospitals the previous year had been well in excess of £400, and in the following year was £776.2.8. It seems likely, therefore, that this year's total would be in excess of £2,000.

3. 1883. Excluding Patea and Westport.

'Nil' at Coromandel, Gisborne. This total is probably fairly accurate because the return is virtually complete. Significant rises occur at Christchurch and Napier, and possibly at Auckland and Wellington. The total increase, however, is not as significant as it first appears.


'Nil' at Greytown, Masterton, Queenstown. Considerable increases at Dunedin and Hokitika. This total is distorted by the absence of Greymouth and Wellington which, combined, had spent £408.10.0 the previous year. The annual report on Wellington Hospital states that 'The consumption of stimulating alcoholic liquors is very large.' (AJHR R18A p 18.) The true total here would be well in excess of £2,000. Grabham notes that this decrease in expenditure might be more apparent than real.

AJHR 1885 R18 p 2.

1885. No figures.

5. 1886. All returns registered.

'Nil' at Coromandel, Greytown, Lawrence, Masterton. Included in 'Provisions' by New Plymouth and Ross, 'Drugs' by Queenstown. This total seems fairly accurate.
Significant reductions in the expenditure of virtually all hospitals under the combined influence of the inspector and retrenchment. A total similar to this is maintained for the rest of the era. There was a small per head reduction in consumption, however, because of the increases in the number of patients admitted to hospitals.

6. 1890. All returns registered. Invercargill and Ross included in 'rations', Queenstown in 'drugs and dispensary'. The figures for 1890 are fairly typical of the times and show that consumption remained large in the four main centres, but was compensated for by a drop in the expenditure of the smaller hospitals.

Source: AJHR 1882-91.
APPENDIX C.

Number of beds in New Zealand hospitals.

Probably the best measure of the size and importance of individual hospitals in New Zealand was their bed capacity. Four reports in the period 1877-92 included statistics on this aspect of hospital development. In 1881 no figures were available for Westport and Wanganui. No alternative source for Westport was obtainable, but its bed capacity was probably about 14, the figure given for 1883. An estimate for Wanganui was made from an individual report which mentioned the bed capacity of the hospital. Returns in the other three reports were complete.

<table>
<thead>
<tr>
<th></th>
<th>1881</th>
<th>1883</th>
<th>1885</th>
<th>1886</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picton</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Blenheim</td>
<td>14</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Nelson</td>
<td>68</td>
<td>68</td>
<td>62</td>
<td>68</td>
</tr>
<tr>
<td>Westport</td>
<td>No Inf</td>
<td>14</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Charleston</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Reefton</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Greymouth</td>
<td>37</td>
<td>37</td>
<td>40</td>
<td>51</td>
</tr>
<tr>
<td>Kumara</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Hokitika</td>
<td>58</td>
<td>57</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>Ross</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Christchurch</td>
<td>110</td>
<td>108</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Akaroa</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
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<td>Ashburton</td>
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<td>66</td>
<td>66</td>
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</tr>
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<td>Oamaru</td>
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<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Dunedin</td>
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<td>168</td>
<td>168</td>
<td>150</td>
</tr>
<tr>
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<td>20</td>
<td>22</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Cromwell</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Arrowtown</td>
<td>12</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Queenstown</td>
<td>22</td>
<td>20</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>1881</td>
<td>1883</td>
<td>1885</td>
<td>1886</td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Naseby</td>
<td>18</td>
<td>13</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Lawrence</td>
<td>41</td>
<td>33</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>Invercargill</td>
<td>30</td>
<td>28</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>Riverton</td>
<td>19</td>
<td>19</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>South Island total.</td>
<td>849</td>
<td>848</td>
<td>815</td>
<td>796</td>
</tr>
<tr>
<td>NEW ZEALAND total.</td>
<td>1222</td>
<td>1221</td>
<td>1222</td>
<td>1203</td>
</tr>
</tbody>
</table>

North Island.

<table>
<thead>
<tr>
<th></th>
<th>1881</th>
<th>1883</th>
<th>1885</th>
<th>1886</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>98</td>
<td>89</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>Thames</td>
<td>28</td>
<td>30</td>
<td>42</td>
<td>31</td>
</tr>
<tr>
<td>Coromandel</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Gisborne</td>
<td>12</td>
<td>16</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>New Plymouth</td>
<td>19</td>
<td>23</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Patea</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Napier</td>
<td>35</td>
<td>33</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Waipukurau</td>
<td>14</td>
<td>15</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Wellington</td>
<td>106</td>
<td>106</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Wanganui</td>
<td>718</td>
<td>26</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Masterton</td>
<td>9</td>
<td>9</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Greytown</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>North Island total.</td>
<td>373</td>
<td>373</td>
<td>407</td>
<td>407</td>
</tr>
<tr>
<td>NEW ZEALAND total.</td>
<td>1222</td>
<td>1221</td>
<td>1222</td>
<td>1203</td>
</tr>
</tbody>
</table>

A - excluding Westport.

There was little change in the total number of beds in the colony, but a number of variations occurred within the hospitals themselves. Most North Island hospitals increased their capacity, but the great majority of those in the South Island, because of their mushroom development in the affluent years of the provincial period, decreased or remained in the same size. Assuming that the number of beds at Westport in 1881 was not in excess of 17, this may be summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>Increases</th>
<th>Decreases</th>
<th>No Change</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Island</td>
<td>7</td>
<td>13</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>North Island</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>
Hospitals can be divided into three basic types: town, country-town and rural. Although the lines of demarcation are somewhat arbitrary, town hospitals, in the context of this thesis, normally refers to those with 35 or more beds. Country-town hospitals generally had between 20 and 34 beds and rural hospitals less than 20. On this basis, the status of hospitals in the two islands was as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>S.I.</th>
<th>N.I.</th>
<th>S.I.</th>
<th>N.I.</th>
<th>S.I.</th>
<th>N.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1881</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>1</td>
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</tr>
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<td>1883</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>1885</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>1886</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>5</td>
</tr>
</tbody>
</table>

The association of their constituencies with the various types of hospital appears to have affected members' attitudes to legislation on the subject. Within the context of this thesis, the term 'town' usually refers to those members whose electorate was served by a hospital with a capacity of 35 or more beds. Similarly 'country-town' members were generally associated with hospitals 20 to 34 beds in size and 'rural' or 'country' members with those with a bed capacity of less than 20.

Because changes in the status of some hospitals did not radically affect the views of their parliamentary representatives, this classification cannot be rigidly applied. A further guide to members' sympathies, however, can usually be gleaned from their electorates which are included in the footnotes.

Sources: 
AJHR 1882 H23 pp 3-6.
AJHR 1883 H3A p 25 (Wanganui).
AJHR 1886 H9 p 22.
AJHR 1887 H19 p 39.
APPENDIX D.

Income and expenditure of hospitals and charitable aid in New Zealand, 1876-92.

A survey made of government expenditure on hospitals and charitable aid was made in 1888. It produced the following summary of accounts:

Government expenditure 1876-86.

<table>
<thead>
<tr>
<th>Year</th>
<th>Benevolent Institutions</th>
<th>Hospitals &amp; Outdoor Relief</th>
<th>Orphanages &amp; Industrial Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1876-77</td>
<td>£12,790 8 7</td>
<td>£6,983 4 2</td>
<td>£1,841 16 6</td>
</tr>
<tr>
<td>1877-78</td>
<td>£35,104 5 11</td>
<td>£17,768 4 10</td>
<td>£4,542 19 3</td>
</tr>
<tr>
<td>1878-79</td>
<td>£38,086 5 4</td>
<td>£19,948 6 9</td>
<td>£3,840 17 5</td>
</tr>
<tr>
<td>1879-80</td>
<td>£30,298 7 1</td>
<td>£15,472 10 2</td>
<td>£3,970 1 2</td>
</tr>
<tr>
<td>1880-81</td>
<td>£36,719 7 10</td>
<td>£21,280 9 10</td>
<td>£5,771 9 10</td>
</tr>
<tr>
<td>1881-82</td>
<td>£37,017 19 4</td>
<td>£23,735 1 10</td>
<td>£6,404 16 5</td>
</tr>
<tr>
<td>1882-83</td>
<td>£45,395 15 0</td>
<td>£28,812 9 0</td>
<td>£6,423 18 11</td>
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<td>1883-84</td>
<td>£49,884 13 7</td>
<td>£26,817 9 8</td>
<td>£7,401 7 2</td>
</tr>
<tr>
<td>1884-85</td>
<td>£53,687 6 7</td>
<td>£34,393 3 8</td>
<td>£8,954 13 0</td>
</tr>
<tr>
<td>1885-86</td>
<td>£48,300 11 0</td>
<td>£32,183 15 3</td>
<td>£7,678 0 4</td>
</tr>
<tr>
<td>Totals</td>
<td>£390,387 0 3</td>
<td>£225,394 15 2</td>
<td>£56,829 14 4</td>
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</tbody>
</table>

Female Refuge. Totals.

<table>
<thead>
<tr>
<th>Year</th>
<th>£</th>
</tr>
</thead>
<tbody>
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<td>-</td>
</tr>
<tr>
<td>1877-78</td>
<td>230 0 0</td>
</tr>
<tr>
<td>1878-79</td>
<td>469 4 9</td>
</tr>
<tr>
<td>1879-80</td>
<td>348 17 0</td>
</tr>
<tr>
<td>1880-81</td>
<td>714 2 8</td>
</tr>
<tr>
<td>1881-82</td>
<td>380 5 8</td>
</tr>
<tr>
<td>1882-83</td>
<td>1,124 11 5</td>
</tr>
<tr>
<td>1883-84</td>
<td>430 1 2</td>
</tr>
<tr>
<td>1884-85</td>
<td>787 13 6</td>
</tr>
<tr>
<td>1885-86</td>
<td>1,021 15 5</td>
</tr>
<tr>
<td>Totals</td>
<td>5,506 11 7</td>
</tr>
</tbody>
</table>

A - six months
B - amended total, printed figure 225,395.2.2.
This is probably the most complete and reliable account of government expenditure in the period 1877-92. Although the analyses differ, the figures for charitable aid expenditure corresponded exactly for the period 1881-84, the only years in which annual returns were printed. The figures for hospitals, however conflict with government receipts as printed in the annual reports.

Some of this confusion arises because all accounts in the annual reports appear to have been for the calendar year, while those in the survey were based on the financial year.

Another source of confusion is that the accounts for some years are incomplete. The worst offender in this respect is the account for 1882, which does not include figures for Auckland, Greymouth or Patea. Their inclusion would bring this account into line with those of other years.

Even when these factors are taken into consideration, there is still some conflict between the 1883 survey and the annual reports. The latter generally show lower figures for government grants to hospitals. The grant for 1884 is particularly hard to explain. According to the 1883 survey there was a further rise in government expenditure; if the annual report is to be believed this item decreased significantly. All hospitals made returns for this year and the difference between the calendar and financial years is not sufficient to account for the discrepancy. A rise in government expenditure as suggested in the survey, would be in keeping with the current trend and the whole income account for the year 1884 seems inexplicably low.

The following shows detailed income returns and the total annual expenditure, compiled for annual hospital reports.

<table>
<thead>
<tr>
<th></th>
<th>1881</th>
<th>1882</th>
<th>1883</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subs &amp; Donations</td>
<td>£8,137</td>
<td>£7,180</td>
<td>£9,269</td>
</tr>
<tr>
<td>Patients</td>
<td>£3,566</td>
<td>£3,713</td>
<td>£4,454</td>
</tr>
<tr>
<td>Government</td>
<td>£31,536</td>
<td>£35,713</td>
<td>£49,833</td>
</tr>
<tr>
<td>Borough Council</td>
<td>£3,183</td>
<td>£827</td>
<td>£703</td>
</tr>
<tr>
<td>County Council</td>
<td>£5,497</td>
<td>£2,559</td>
<td>£1,888</td>
</tr>
<tr>
<td>Rents &amp; Misc.</td>
<td>£4,780</td>
<td>£1,440</td>
<td>£2,058</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>£56,703</strong></td>
<td><strong>£50,895</strong></td>
<td><strong>£68,207</strong></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>£58,064</strong></td>
<td><strong>£51,647</strong></td>
<td><strong>£63,840</strong></td>
</tr>
<tr>
<td></td>
<td>1884</td>
<td>1886</td>
<td>1887</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Subs &amp; Donations</td>
<td>£7,208</td>
<td>£7,396</td>
<td>£6,833</td>
</tr>
<tr>
<td>Patients</td>
<td>£3,964</td>
<td>£5,340</td>
<td>£6,635</td>
</tr>
<tr>
<td>Government</td>
<td>£44,994</td>
<td>£31,471</td>
<td>£23,713</td>
</tr>
<tr>
<td>Borough Council</td>
<td>£658</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council Council</td>
<td>£2,070</td>
<td>£13,106</td>
<td>£31,019</td>
</tr>
<tr>
<td>Rents &amp; misc.</td>
<td>£1,325</td>
<td>£5,304</td>
<td>£9,466</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>£60,222</td>
<td>£75,571</td>
<td>£77,668</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>£67,825</td>
<td>£70,427</td>
<td>£75,313</td>
</tr>
<tr>
<td><strong>1888-89</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subs &amp; Donations</td>
<td>£5,711</td>
<td>£5,371</td>
<td>£4,781</td>
</tr>
<tr>
<td>Patients</td>
<td>£7,490</td>
<td>£7,712</td>
<td>£9,042</td>
</tr>
<tr>
<td>Government</td>
<td>£34,563</td>
<td>£29,543</td>
<td>£27,895</td>
</tr>
<tr>
<td>Local bodies &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital boards</td>
<td>£26,344</td>
<td>£24,788</td>
<td>£21,119</td>
</tr>
<tr>
<td>Balance from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>previous year</td>
<td>£2,965</td>
<td>£7,214</td>
<td>£5,340</td>
</tr>
<tr>
<td>Bequests</td>
<td>£861</td>
<td>£1,047</td>
<td>£1,751</td>
</tr>
<tr>
<td>Rents</td>
<td>£2,966</td>
<td>£2,878</td>
<td>£3,347</td>
</tr>
<tr>
<td>Misc.</td>
<td>£692</td>
<td>£964</td>
<td>£745</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>£81,594</td>
<td>£79,522</td>
<td>£74,023</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>£73,550</td>
<td>£69,686</td>
<td>£70,326</td>
</tr>
<tr>
<td><strong>1891-92</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subs &amp; Donations</td>
<td>£4,736</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td>£9,318</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>£30,658</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local bodies &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital boards</td>
<td>£22,559</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>previous year</td>
<td>£3,295</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bequests</td>
<td>£2,493</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rents</td>
<td>£3,132</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc.</td>
<td>£995</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>£79,189</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>£74,039</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Excluding Auckland, Greymouth, Patea, Wellington and Westport.

B Excluding Auckland, Greymouth and Patea. Including treasury figures of £5,625 for Wellington and £827 for Westport.

This is an amended total, printed as £50,747.16.9. Arithmetical errors were made in the addition of Invercargill and New Plymouth accounts and the addition of these (incorrect) figures was £140 short of the true total.

C Excluding Auckland, Greymouth and Patea. Including treasury figures of £5,625 for Wellington and £827 for Westport.

D Excluding Patea. This is an amended total, printed as £68,206.7.9 because of a mistake in the addition of Thames Hospital accounts.

E Excluding Patea and Westport.

F Amended total, printed as £5340.0.2.

G Amended total, printed as £5304.7.3.

H Amended total because of above errors and other minor mistakes in Ashburton and Timaru accounts and in the addition of the total.

I Includes special building grants to Waipukuru and the new Palmerston North Hospital.

J Amended total, printed as £632.0.6.

Subscriptions and donations gradually declined over the period, but payments on account of patients rose steadily. Government expenditure, according to these accounts, rose until 1884. No accounts were presented for 1885. According to the 1888 survey, which seems more reliable, government expenditure rose until the Hospitals and Charitable Institutions Act was passed. Local body contributions decreased until 1886 when, with hospital boards, they assumed a considerable part of the burden. From 1886, in contrast to earlier accounts, income always exceeded expenditure. After the 1888 survey, accounts for the financial year, instead of for the calendar year, appeared in the annual reports. With one exception, accounts from that time were free of arithmetical errors.

Graphs have not been employed here because they are not particularly appropriate to the material and would introduce unnecessary complexity and confusion. A rough outline in trends of hospital income, however, can be gained from the following tables, which show a sample of accounts in percentage form.
Although returns for three years (1881-84) were printed at the request of various members of parliament, itemized charitable aid accounts did not appear until 1889. These indicated that charitable aid sources were similar to those of the hospitals.

Charitable aid income and expenditure.

<table>
<thead>
<tr>
<th></th>
<th>1888-89</th>
<th>1889-90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance from last year.</td>
<td>-</td>
<td>9,162 0 4</td>
</tr>
<tr>
<td>Government</td>
<td>42,426 7 1 1/2</td>
<td>41,109 2 11</td>
</tr>
<tr>
<td>Rates</td>
<td>41,798 5 2 1/2</td>
<td>38,550 0 1</td>
</tr>
<tr>
<td>Patients</td>
<td>2,177 2 7</td>
<td>2,554 19 5</td>
</tr>
<tr>
<td>Voluntary contributions</td>
<td>2,469 7 7</td>
<td>2,316 3 6</td>
</tr>
<tr>
<td>Bequests</td>
<td>730 1 7</td>
<td>10,819 15 0</td>
</tr>
<tr>
<td>Rents</td>
<td>976 13 0</td>
<td>1,407 4 9</td>
</tr>
<tr>
<td>Misc.</td>
<td>2,176 2 10</td>
<td>3,495 17 7</td>
</tr>
<tr>
<td>Total income</td>
<td>92,753 19 11</td>
<td>109,121 3 7</td>
</tr>
<tr>
<td>Indoor Relief</td>
<td>28,333 14 1</td>
<td>37,562 13 9 1/2</td>
</tr>
<tr>
<td>Outdoor Relief</td>
<td>40,395 4 4</td>
<td>37,955 5 11</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>68,728 18 5</td>
<td>75,517 19 8 1/2</td>
</tr>
<tr>
<td>Source</td>
<td>1890-91</td>
<td>1891-92</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Balance from last year.</td>
<td>6,552 18 3</td>
<td>7,320 11 8</td>
</tr>
<tr>
<td>Government</td>
<td>33,301 1 5</td>
<td>32,713 19 7</td>
</tr>
<tr>
<td>Rates</td>
<td>28,636 9 3</td>
<td>29,477 14 9</td>
</tr>
<tr>
<td>Repayments (patients)</td>
<td>1,841 9 9</td>
<td>2,178 5 5</td>
</tr>
<tr>
<td>Voluntary contributions</td>
<td>3,613 8 10</td>
<td>2,285 11 3</td>
</tr>
<tr>
<td>Bequests</td>
<td>1,121 14 3</td>
<td>4,410 18 3</td>
</tr>
<tr>
<td>Rents</td>
<td>1,073 3 1</td>
<td>529 0 10</td>
</tr>
<tr>
<td>Misc.</td>
<td>1,822 1 1</td>
<td>2,170 9 4</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>77,962 5 11</td>
<td>81,086 11 1</td>
</tr>
<tr>
<td>Indoor Relief</td>
<td>32,648 2 1</td>
<td>29,081 12 7</td>
</tr>
<tr>
<td>Outdoor Relief</td>
<td>41,896 19 5</td>
<td>41,896 19 7</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>74,545 1 6</td>
<td>70,901 12 2</td>
</tr>
</tbody>
</table>

Sources:
- AJHR 1888 H9 pp 3, 18-22.
- AJHR 1882 B22.
- AJHR 1883 H23.
- AJHR 1884 Sess II B12.
- Annual hospital reports, AJHR 1882-92.
Government Maintenance of Hospitals and Charitable Institutions, 1877-85.

Hospitals maintained wholly by the government.

<table>
<thead>
<tr>
<th>Auckland</th>
<th>Nelson</th>
<th>Christchurch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thames</td>
<td>Westport</td>
<td>Akaroa</td>
</tr>
<tr>
<td>Napier</td>
<td>Picton</td>
<td>Timaru</td>
</tr>
<tr>
<td>New Plymouth</td>
<td>Blenheim</td>
<td>Waimate</td>
</tr>
<tr>
<td>Wellington</td>
<td>Hokitika</td>
<td>Dunedin</td>
</tr>
</tbody>
</table>

Charitable institutions maintained wholly by the government.

| Thames Orphanage | Kohimarama Naval Training School |
| Lyttelton Orphanage | Burnham Industrial School |
|                    | Caversham Industrial School |

Hospitals subsidized £1 for £1 by the government.

<table>
<thead>
<tr>
<th>Gisborne</th>
<th>Greytown</th>
<th>Kumara</th>
<th>Dunstan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masterton</td>
<td>Ross</td>
<td>Naseby</td>
<td></td>
</tr>
<tr>
<td>Wanganui</td>
<td>Ashburton</td>
<td>Omaramu</td>
<td></td>
</tr>
<tr>
<td>Charleston</td>
<td>Arrowtown</td>
<td>Invercargill</td>
<td></td>
</tr>
<tr>
<td>Reefton</td>
<td>Queenstown</td>
<td>Riverton</td>
<td></td>
</tr>
</tbody>
</table>

Other hospitals subsidized by the government.

| Coromandel | £2 for £1 |
| Waipukuru | £2 for £1 |
| Lawrence | £3 for £1 |
| Patea | Cost met by local council and half of this sum reimbursed by the government. |

Charitable institutions subsidized by the government.

| Howe Street Industrial School | Auckland |
| St. Mary's Roman Catholic Orphanage and Industrial School for Girls | Ponsonby |
| St. Stephen's Church of England Orphan Home for Boys | Parnell |
| St. Joseph's Roman Catholic Providence Orphanage for Girls | Wellington |
| St. Mary's Roman Catholic Orphanages and Industrial Schools for Boys & Girls | Nelson |
| Motueka Orphanage for Boys & Girls | Motueka |
| Benevolent Institution (old people & orphans) | Dunedin |
The government also subsidized a few refuges and a number of benevolent societies.

The hospitals maintained by the government were generally those in the chief centres of population. Ashburton Hospital was transferred to complete government control in 1884 thereby making all the hospitals in the Canterbury district the responsibility of the government. The subsidy for Lawrence Hospital was so large as to make it virtually wholly dependent on the government for maintenance. The only large hospitals not wholly maintained by the government were those at Greymouth and Invercargill.

Charitable institutions generally received £1 for £1 on voluntary subscriptions. 'Head money', usually between 5s and 10s per week, was also paid for children sent to them by the government.

Sources: IA 64/10 Hospital and charitable aid returns, 24 June 1878.
AJHR 1884 Sess II H13 pp 1-3.
Whelan pp 119, 139-140.
APPENDIX F.

Analysis of Attitudes to the First Charitable Aid Bill, 1877.

The second reading of the charitable aid bill was passed by a majority of 31. Those in favour numbered 42, those against 11 and there were 9 pairs. The first column shows the members' attitude to Atkinson's government in the no-confidence motion of 9 October. Despite the handicap of a two months time lapse, the motion is probably the best available measure of political attitudes. The second column records the trend of members' speeches. Voting on the second reading of the bill appears in the third column.

<table>
<thead>
<tr>
<th>Auckland</th>
<th>Hawkes Bay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cox</td>
<td>Ormond</td>
</tr>
<tr>
<td>Dignan</td>
<td>Russell</td>
</tr>
<tr>
<td>Douglas</td>
<td>Sutton</td>
</tr>
<tr>
<td>Grey</td>
<td></td>
</tr>
<tr>
<td>Hamlin</td>
<td>Wellington</td>
</tr>
<tr>
<td>Lusk</td>
<td></td>
</tr>
<tr>
<td>Macfarlane</td>
<td></td>
</tr>
<tr>
<td>Morris</td>
<td></td>
</tr>
<tr>
<td>O'Rorke</td>
<td></td>
</tr>
<tr>
<td>Rees</td>
<td></td>
</tr>
<tr>
<td>Rowe</td>
<td></td>
</tr>
<tr>
<td>Sheehan</td>
<td></td>
</tr>
<tr>
<td>Swanson</td>
<td></td>
</tr>
<tr>
<td>Tole</td>
<td></td>
</tr>
<tr>
<td>Wallis</td>
<td></td>
</tr>
<tr>
<td>Whitaker</td>
<td></td>
</tr>
<tr>
<td>Williams</td>
<td></td>
</tr>
<tr>
<td>Wood R.G.</td>
<td></td>
</tr>
<tr>
<td>Taranaki</td>
<td></td>
</tr>
<tr>
<td>Atkinson</td>
<td></td>
</tr>
<tr>
<td>Carrington</td>
<td></td>
</tr>
<tr>
<td>Kelly</td>
<td></td>
</tr>
<tr>
<td>Nelson-Malborough</td>
<td>Otago</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Baigent</td>
<td>Bastings</td>
</tr>
<tr>
<td>Curtis</td>
<td>Brown J.C.</td>
</tr>
<tr>
<td>Gibbs</td>
<td>Burns</td>
</tr>
<tr>
<td>Harper</td>
<td>De Latour</td>
</tr>
<tr>
<td>Henry</td>
<td>Hislop</td>
</tr>
<tr>
<td>Hursthouse</td>
<td>Hodgekinson</td>
</tr>
<tr>
<td>Kennedy</td>
<td>Joyce</td>
</tr>
<tr>
<td>Kenny</td>
<td>Lernach</td>
</tr>
<tr>
<td>Richmond</td>
<td>Lumsden</td>
</tr>
<tr>
<td>Seymour</td>
<td>Macandrew</td>
</tr>
<tr>
<td>Sharp</td>
<td>Manders</td>
</tr>
<tr>
<td>Woolcock</td>
<td>McLean</td>
</tr>
<tr>
<td></td>
<td>Murray</td>
</tr>
<tr>
<td></td>
<td>Pyke</td>
</tr>
<tr>
<td></td>
<td>Reid</td>
</tr>
<tr>
<td></td>
<td>Reynolds</td>
</tr>
<tr>
<td></td>
<td>Seaton</td>
</tr>
<tr>
<td></td>
<td>Shrimski</td>
</tr>
<tr>
<td></td>
<td>Stout</td>
</tr>
<tr>
<td></td>
<td>Thomson</td>
</tr>
<tr>
<td></td>
<td>Wood W.</td>
</tr>
<tr>
<td></td>
<td>Maori</td>
</tr>
<tr>
<td>Bowen</td>
<td></td>
</tr>
<tr>
<td>Brown J.E.</td>
<td></td>
</tr>
<tr>
<td>Fisher</td>
<td></td>
</tr>
<tr>
<td>Fitzroy</td>
<td></td>
</tr>
<tr>
<td>Montgomery</td>
<td></td>
</tr>
<tr>
<td>Moorhouse</td>
<td></td>
</tr>
<tr>
<td>Murray-Aynsley</td>
<td></td>
</tr>
<tr>
<td>Richardson</td>
<td></td>
</tr>
<tr>
<td>Rolleston</td>
<td></td>
</tr>
<tr>
<td>Stafford</td>
<td></td>
</tr>
<tr>
<td>Stevens</td>
<td></td>
</tr>
<tr>
<td>Teschmaker</td>
<td></td>
</tr>
<tr>
<td>Wakefield</td>
<td></td>
</tr>
<tr>
<td>Wason</td>
<td></td>
</tr>
</tbody>
</table>

| For          | Against (p) pair |

F = For, A = Against (p) = pair
Swanson (Newton, A) promised to support the bill, but earnestly requested the government to revise it. Fox (Wanganui, Wn) spoke against the bill and was presumably satisfied when the government promised to adopt some of the measures he recommended. Although Shrimski (Waitaki, O) spoke against the bill, he abstained from voting. In all other cases, members voted in the way indicated by their speeches.

Voting on the bill and attitudes to Atkinson can be summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>Bill</th>
<th>Atkinson</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For</td>
<td>Against</td>
</tr>
<tr>
<td>Auckland</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Taranaki</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Wellington</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Nelson-Marlborough</td>
<td>8</td>
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<tr>
<td></td>
<td>51</td>
<td>20</td>
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</tbody>
</table>

Of the 16 who abstained from voting on the bill, 13 were politically unsympathetic to Atkinson. In Otago, feelings towards the bill clearly overrode those to Atkinson. This tendency was also present in Wellington and Westland. Elsewhere voting did not differ significantly from political allegiances.

APPENDIX G.

Division on Bowen's Motion for the Establishment of Land Endowments, 9 October 1878.

**Ayes 34**

<table>
<thead>
<tr>
<th>Auckland</th>
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<td>Williams</td>
<td>Reeves</td>
<td>Otago</td>
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<td>Saunders</td>
<td>Bastings</td>
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<tr>
<td>Atkinson</td>
<td>Sharp</td>
<td>Brown J.C.</td>
</tr>
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</tr>
<tr>
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</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Murray</td>
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<td></td>
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**Noes 21**

<table>
<thead>
<tr>
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<tbody>
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<td>George</td>
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<td>Hamlin</td>
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</tr>
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<td>Sheehan</td>
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<td>Whitaker</td>
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<td>Wood</td>
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<tr>
<td>Taranaki</td>
<td>Fisher</td>
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<td>Montgomery</td>
<td>Takamoana</td>
</tr>
<tr>
<td>Kelly</td>
<td>Turnbull</td>
<td></td>
</tr>
</tbody>
</table>

Political inclinations exerted only a limited influence on the division. One estimate placed 20 opposition members in favour of the resolution and classified the remainder as government supporters. Of the five ministers who voted, however, only Macandrew favoured the resolution.

North Island members were fairly evenly divided on the issue. Of the 35 South Island members who voted, 25
supported the motion. A further 4 Canterbury and Otago politicians – Saunders, Wakefield, Wason and Manders – declared for the motion in the next debate on endowments.

Sources: PD 29 p 677.  
PD 30 pp 731-733, 737-738.
APPENDIX H.

Attitudes to the Hospitals and Charitable Institutions Bill, 1885.

The third reading of the hospitals and charitable institutions bill was passed by a majority of 34. Those in favour of it numbered 55 and 21 were opposed. Each member's occupational affiliation follows his name in the following analysis. No accurate guide to members' political inclinations in 1885 is available. The best indication is voting in the motion of 1884, which finally placed the Stout-Vogel ministry in power. Although the political attitude of some members to Stout and Vogel changed between the time of the motion and the presentation of the bill, the division is at least an approximate guide to members' allegiances and is shown in the first column. The second column records voting on the hospitals and charitable institutions bill.

Auckland.

Buckland W.F. lawyer A F
Cadman businessman F F
Dargaville businessman F F
Fraser journalist F F
Grace lawyer - A
Grey retired Governor F A
Hamlin farmer A F
Hobbs businessman A A
Hurst W.J. businessman A A
Lake farmer A F
Locke estate owner A F
Mitchelson businessman A F
Most farmer A F
Moss education board secretary A A
O'Rorke (Speaker)
Pescock optician A F
Thompson T. merchant F F
Tole lawyer F F
Whyte J.B. farmer A F
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<thead>
<tr>
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<th>Notes</th>
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<td>F</td>
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<td>-</td>
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<td>A</td>
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<td>F</td>
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<td>F</td>
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<td>------------------</td>
<td>------------------</td>
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</tr>
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<tr>
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These statistics can be summarized as follows:

**Political (1884)**

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<td>46</td>
<td>36</td>
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**Provincial.**

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<td>-</td>
</tr>
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<td>7</td>
<td>6</td>
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<td>Maori</td>
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<tr>
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<td>55</td>
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</table>

**Occupational.**

<table>
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</thead>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>55</td>
<td>21</td>
<td>18</td>
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</tbody>
</table>

It was not possible, with the limited information and time available, to compile a reliable dossier of members' town-country affiliations. Members' occupations and electorates, however, give some indication of their loyalties and reference to the leading town and country advocates is made in the text of this study.

**Sources:**
- PD 48 p 112.
- Scholefield DNZB Vols I and II.
- K. Sinclair *The Significance of "the Scarecrow Ministry", 1887-1891*.
**APPENDIX I.**

Number of Patients in the Hospitals, 1881-92.

<table>
<thead>
<tr>
<th>Year</th>
<th>Out-patients</th>
<th>In-patients</th>
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<td>1881</td>
<td>8,985</td>
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</tr>
<tr>
<td>1882</td>
<td>9,452</td>
<td>6,110</td>
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<tr>
<td>1883</td>
<td>9,286</td>
<td>6,056</td>
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<tr>
<td>1884</td>
<td>6,268</td>
<td>6,471</td>
</tr>
<tr>
<td>1885</td>
<td>6,381</td>
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</tr>
<tr>
<td>1886</td>
<td></td>
<td></td>
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<tr>
<td>1887</td>
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<tr>
<td>1888</td>
<td></td>
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<tr>
<td>1889</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1890</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1891</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1892</td>
<td></td>
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</tbody>
</table>
The numbers of patients shown in the tables are compiled from annual hospital reports. In-patient returns were generally accurate. Up to one third of the hospitals, however, left their out-patient returns blank. As they were usually the smaller hospitals, it seems likely that this was because they provided very limited out-patient services or none at all.

Out-patient figures here are probably too conservative. However, the trend they reflect—a levelling out in numbers at a time when the total number of patients was increasing—is compatible with the efforts of MacGregor and the medical profession to limit out-patient services.

No figures were given for hospital patients in 1887 or for out-patients in 1884. Out-patient figures for 1881 and 1883 were distorted because some hospitals returned the number of admissions instead of patients. For this reason they have been excluded from these tables.

The increase in 1889 was largely due to a temporary rise in the number of out-patients admitted to Auckland Hospital. A rise in the number of out-patient admissions at Wellington in the same year was offset by the decline in the number of patients treated at Thames.

Source: AJHR 1882-1893.
BIBLIOGRAPHY.

A. PRIMARY.

I. Manuscript (Official).

Hospital and charitable aid returns from local bodies, 1880. Series IA 64/11. (National Archives, Wellington).

New Zealand Central Board of Health. Minutes, 1876-1900. (Health Department Library, Wellington).

Registered files, Colonial Secretary's Office, 1877-1892. Series IA 1. (National Archives, Wellington).

Returns from local boards of health to the Central Board of Health, passed through the Colonial Secretary's Office, 1877. Series IA 19/1. (National Archives, Wellington).

Statistical returns of charitable aid given by municipalities, counties, hospital boards, etc. Also Treasury circular re financial adjustments relative to subsidies paid for charitable purposes. 1878. Series IA 64/10. (National Archives, Wellington).

II. Printed.

(a) Official.

Appendices to the Journals of the House of Representatives, 1877-1909.

Appendices to the Journals of the Legislative Council, 1878-85.


Journals of the House of Representatives, 1877-86.

New Zealand Gazette, 1880-86.

New Zealand Parliamentary Debates, 1877-98.


New Zealand Statutes, 1866-1909.

(b) Non-official.


(c) Newspapers.

Auckland Evening Star. Auckland, 1878-86.
Evening Post. Wellington, 1877-86.
Evening Star. Dunedin, 1877-86.
Lyttelton Times. Christchurch, 1877-86.

SECONDARY.

Published.

(a) Official.

New Zealand Department of Health: Report for 1939. Published in Appendices to the Journals of the House of Representatives, 1939 H31.

(b) Books.

Robb, D. : Medicine and Health in New Zealand. Christchurch, 1940.


(c) Articles.


II. Unpublished Theses.

All of the following theses were presented for the M.A. degree and, unless otherwise stated, were presented in history.

Higgins, E.M.: 'The Hospital and Charitable Aid System of New Zealand.' (Economics). Canterbury, 1931. This thesis was primarily concerned with the contemporary system.


Rauch, F.C.: 'The History of the Auckland Hospital and Auckland Hospital and Charitable Aid Board, 1847-1914.' Auckland, 1933.