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Nagayo Sensai's international comparison and the historiography of public health

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Sensai Nagayo (1838-1902) was a medical practitioner trained in Dutch medicine and became the first Director of the Sanitary Bureau of the Home Ministry (1875-91). He rendered distinguished services as the first chief medical officer to the Meiji government (that replaced the Tokugawa Shogunate in 1867). The Meiji government's plan for public health administration was, to a large extent, designed by Nagayo himself, based on his experience of 3-year visitation to the Western countries (US, England, Holland, and Germany) in the early 1870s. This paper is not much about what he did as a medical officer, but more about how his view influenced historians, and how we should deal with it.

In 1888 (M21), Nagayo delivered a paper, titled 'Public health and local self-government', at a meeting of the Japan Sanitary Society. Outlining the development of public health movement in England, he pointed out that initiatives for reform often arose at the local level, and that the role of central government was merely to co-ordinate uneven developments between localities. Thus, England was regarded as 'the home of local self-government'. France, 'on the contrary', had a well-centralized administrative system. However, public health reform in France seemed to him to be inactive, due to lack of 'the spirit of self-government'. He acknowledged the diversity in German public health due to the federal polity. While some parts of Germany had traditions of local autonomy, some parts had developed the autocratic 'medical police'. The coercive nature of medical police tended to undermine people's subjective involvement in public health reform. Thus, he argued that public health reform had mostly been inactive in Germany as in France, until the 1860s. From the 1870s on, according to Nagaya, having learnt the importance of local self-government, as well as sanitation technologies, from England, public health movement became more active in wider sections in Germany.

This international comparison, if simplistic, provided the basis for Nagayo's discussion over

what sort of administrative machinery should be developed in Japan. He was apparently in favour of the English system. This sort of admiration for English public health reform was succeeded by Shimpei Goto (1857-1929), Nagayo's successor as the Head of the Sanitary Bureau. In 1891, Goto visited London (from Munich, where he studied), to attend the seventh International Congress of Hygiene and Demography. It seems that Goto was impressed by the mixture of local self-government and central state intervention in England. Goto expressed his admiration for the way in which the English Local Government Board (England's central health authority at the time) was proceeding with health policy innovation by leaving some space for local self-government. He remarked that, although its 'decentralist' approach was seemingly weak in comparison with 'centralist' approach in European countries, England's public health administration was effective, because it assumed the penetration of public health ideas into the general public, which could not be attained by one-sided enforcement from central government. He recognized the advantage of interactive connection between individual and state efforts through the medium of local government and voluntary organizations.

In fact, the Japanese central public health officials had once attempted to introduce the English style of local self-government. In 1879, under Nagayo's initiative, elective sanitary committees were set up at each small unit of local administration. This was to let local bodies, which were, if limited, subject to democratic procedures, deal with local health matters. However, things did not go afterwards as Nagayo had intended. In 1885, the elective sanitary committee system was abolished, for the reason that it proved difficult to secure suitable candidates for the committees. This action was part of the local government reform which was undertaken in the mid-1880s and early 90s, under the initiatives of the highest rank politicians, outside the reach of the sanitary officials. It was through this reform, that a highly bureaucratic, hierarchical local government system emerged in Japan. In 1893, at a later stage of the reform, the administration of public health regulations was put under the jurisdiction of the police forces at the local level. This was intended for an efficient execution of 'medical police' work. Thereafter, police officers came to play a central role at outbreaks of infectious diseases, in enforcing such measures as regulations of nuisances, compulsory notification, disinfection, isolation of the infected, and so forth.

The abolition of the elective local sanitary committee system and the transfer of important parts of local public health work to the police forces disappointed Nagayo. He argued later in his autobiography that the promotion of public health based on local self-government had been

‘frustrated’ by the predominance of sanitary police works carried out by police officers. Likewise, Goto expressed his regret in 1898 that there were few local authorities whose performance in the prevention of infectious disease was satisfactory. He saw its cause in the lack of cooperation between local police officials and the local public. The oppressive character which was inherent in the police tended to fail at obtaining local people’s cooperation. He warned that state initiatives which assumed one-sided direction from above, could result in ‘the general public’s neglect of public amenity’. Goto felt what Japan lacked were movements from the local grass-roots upwards involving not only officials and but also local lay citizens.

Thus, the Meiji public health reformers remarked their struggle for public health based on ‘local self-government’, as opposed to that enforced by ‘medical police’. And historians have readily accepted their claims. Although Nagayo (and Goto) tried to introduced the English style of liberal public health administration based on local self-government, their enlightened, far-sighted attempts were frustrated by the reactionary, authoritarian Meiji political leaders who intended to control and oppress people by means of ‘medical police’. This sort of understanding of the history of Japan’s public health administration, that a liberal sanitary administration was obliged to retreat in the presence of the autocratic Japanese state, remains commonplace until today. The discrimination, persecution and oppression by the sanitary police targeting on the ‘insanitary’ people, the infected, or those who were supposed to be susceptible to diseases, especially paupers, have been well documented by historians. Implicitly, the ‘German’ idea of medical police which was introduced by the authoritarian Japanese state and the mainstream of Japanese medical world who saw Germany as their ideal model, is a target of accusation there.

What I would like to reconsider today is this dichotomous understanding of ‘(the English-style) local self-government’ and ‘(the German-style) medical (or sanitary) police’. I would question whether they are really counter-concepts. Historians often automatically associate ‘medical police’ with the authoritarian nature of the Japanese state. While not intending to deny the authoritarian aspects that the Japanese state had and the problems derived from the oppressive and coercive character of the police, I would question the automatic association of the ‘medical police’ with authoritarianism.

First, we should distinguish policing activities for the purpose of public health, from the police as an administrative department executing duties in relation to public health. They seem to be confused in Nagayo’s usage of the term ‘medical police (*Iji-keisatsu, Eisei-keisatsu*)’. He remarked its authoritarian, oppressive character. But it is not clear from his writings whether he

thought that the ‘medical police’ per se was oppressive, or that it became oppressive or coercive only when it was carried out by the police forces. In view of the actual administrative changes taking place in the 1880s, what Nagayo deplored most seems to have been the latter: that the police was in charge of public health matters. Nagayo, as a chief medical officer of the central government, wanted to have his own staff specialized in preventive medicine, working at the local level in cooperation with local people. When Nagayo criticized a ‘medical police’, the term seems to designate the medical and public health work done by the police forces without specialist knowledge of medicine and public health. Thus the dimension of inter-departmental rivalry between police and sanitary departments, and that of inter-professional rivalry between police and medical practitioners are also to be noted, when we read Nagayo’s writings.

It has, however, been more common elsewhere to understand the term medical police not just as the police department executing public health duties, but as a wider concept including a variety of activities (e.g. surveillance, investigation, information gathering, regulation, intervention and enforcement) carried out by anyone (not just police officers) for the protection of health and safety and the execution of medical and sanitary laws and rules. The ‘medical police’ was thus not necessarily and exclusively a possession of the police. Of course, the meaning of medical police varies according to time and places. In the US today, for example, it sometimes means forensic medical activities of the police and judicial authorities; even narrower a meaning. But, when the term medical police came to the fore originally in the 17th and 18th century Europe, it covered a far wider range of issues and activities relating to medicine, health and safety.

There would be no objection to name Johann Peter Frank (1745-1821), the German physician who worked in Austria, as the most famous, if not the earliest, advocate of medical police. His six-volume book *System of Complete Medical Police* covered a full-range of public health issues: water supply and sanitation, regulation of unhygienic behaviours, infant welfare, food safety, sexual hygiene, the need for statistical records, and so on. His concept of ‘medical police’ was a system in which the state should play a major role in the protection of health and safety of the population.

George Rosen, the distinguished historian of public health, famously associated the concept of medical police with the paternalistic philosophy of ‘cameralism’, a German expression of mercantilism. For mercantilist absolute states, argued Rosen, a healthy population was important in pursuing industrial and military expansions. Thus they exercised medical police by

means of strong centralized bureaucracy under the divine right of monarchs. Rosen's argument is in line with the typification of public health administration in 19th century Europe derived from what theories of disease were adopted, presented by another influential historian in the same school, Erwin Ackerknecht (Table 1). According to this classification, European continental countries including those in Germany with a tradition of authoritarian regime were likely to adopt coercive quarantine measures based on the contagion theory, whereas England which had shifted to a liberal regime earlier was cautious about state intervention in the private sphere. Thus the miasma theory won the place and more emphasis was placed on environmental reform in England.

It is noticeable that Nagayo's international comparison matches with this contrast of the autocratic continental countries and the 'liberal' England. The concept of medical police was regarded by him as a symbolic feature of the former. And historians, too, have readily identified the police-oriented Meiji public health administration with the continental type. As Rosen's *A History of Public Health* has been translated into Japanese, his view has certainly consolidated the typification of Japan's public health system as the autocratic continental model.

This classic dichotomous understanding of public heath administration associated with politico-economic regimes has been subject to criticisms recently. Among other critics, Peter Baldwin has argued that differences in public health policy owed more to topological and epidemiological factors than to political or economic regimes. Not its political regime, but the distance from the 'disease zone' (South-Asia, Middle-east, in the case of cholera) exerted greater influence on the country's public health policy making: England, the furthest from Suez, was not so urged to adopt coercive quarantine as France and Germany were.

As for the concept of medical police in particular, Roy MacLeod and Patrick Carroll have pointed out the clear continuity from the 18th century German concept of medical police to the idea of 'state medicine' in 19th century England. It is true that much opposition arose from a localist point of view in England when Edwin Chadwick proposed the establishment of a central public health authority (the General Board of Health) in the mid-19th century. Eventually Chadwick was forced to retire and the GBH was abolished. But, under the guidance of John Simon, who became the chief medical officer to the Privy Council and the Local Government Board (1871-), England's state medicine developed gradually but markedly in the second half of the 19th century. In cooperation with local medical officers of health specialized in preventive medicine, local councils were in charge of dealing with local public health problems by

coordinating various interests and opinions locally. In this respect, as Nagayo and Goto admired, a sound balance between central and local government may be regarded as a characteristic of England. But, as far as I have gathered from Paul Weindling's article, German public health administration was more decentralized throughout the 19th century than has previously been assumed. And, importantly, a range of measures undertaken by English sanitary authorities largely overlapped with those in Frank's proposals of medical police in the 18th century and those pushed by Rudolf Virchow in the 19th century Germany.

Thus, the classic dichotomous typification presented by Rosen and Ackerknecht has been subject to revisions. In addition to differences which can not be reduced to political regimes, similarities and inter-relations between countries have also been pointed out. In relation to those similarities in English and German public health policy, we should think of the interactions, or should I say more radically 'transactions' as Professor Ichinokawa has proposed, of knowledge beyond the boundaries of nation states. Especially after the second half of the 19th century, international congresses were held regularly to form a consensus for international public health. (As mentioned earlier, Goto gathered a lot of information at the 7th International Congress of Hygiene and Demography in 1891.)

Let us come back to our initial question: local self-government and medical police were counter-concepts? Not necessarily. They can exist at the same time. I myself have worked on what local sanitary authorities did in late 19th century England in detail. Apart from large-scale investment in sanitary infrastructure such as water-supply and sewerage systems, local medical officers of health and their staff were engaged daily in sanitary inspections. They were indeed policing activities to ensure the health and safety of the people in the community. The medical officer was a qualified medical man, but his staff members, called inspectors of nuisances, were sometimes recruited from former police officers. Based on the principle of local self-government, their activities were limited in the scope that was decided by the local council whose members were elected by local residents. But the consent of the local council as a representative body of local residents did not necessarily mean that the voice of everyone in the community was reflected: especially, there were many poor people who were excluded from the franchise. The 'insanitary' residential areas of the poor people were often seen as 'nests' of infectious diseases and became targets of thorough sanitary police work. Coercive measures on them were sometimes justified under the name of local self-government, and discrimination and persecution due to sanitary police work took place even in the 'self-governed' English cities and

communities. Medical police was thus not peculiar to authoritarian states.

Following Nagayo's charge on 'medical police' on the basis of his international comparison, historians of Japan's public health administration have often emphasized the coercive, oppressive, interventionist aspects of police-oriented public health administration as a peculiar feature of the authoritarian Meiji government, in contrast with a 'liberal', 'evironmentalist' model of public health administration However, such a dichotomous understanding can no longer be sustained. This dichotomy is closely connected to a '*shimpo-shikan*', or a Whiggish view of history: the progressive England and the backward Japan.

We should draw attention to similarities and the structure of problems derived from 'medical police' activities which many countries, regardless of their political regimes, had in common. This is of course not to deny the necessity of analyzing differences and characteristics, but merely to point out that it is insufficient to reduce them solely to political regimes. The characteristics of the development of public health administration in Japan should not be reduced to its authoritarianism alone but should be examined more dynamically in the light of a variety of factors. There seem to be much room for further research in this respect.

I myself have been interested particularly in geo-epidemiological factors recently. Let me mention briefly characteristic ways of policy-making regarding infectious disease control in Japan and England. In Japan, a law prescribing notification and isolation of six major infectious diseases were established in 1880. Notification of cases to the sanitary authorities was made compulsory all over the country. On the other hand, it was in 1889 that the same sort of law prescribing compulsory notification passed Parliament in England: the Infectious Disease (Notification) Act. Like many of other public health statutes at that time, it was a permissive Act. Therefore, notification of infectious disease was made compulsory only in the localities where the local council agreed to adopt the measure. It was in 1899 that the Notification Act was made compulsory all over the country, in view that the experience of the local authorities which had adopted the Act proved to be successful. We can see here a good instance of the gradual pattern of policy innovation on the basis of local self-government in England. On the other hand, thanks to its stronger inclination to centralism, Japan established a nation-wide system of compulsory notification 19 years earlier than England. The first thing I would like to remark is that the same sort of interventionist, compulsory, 'medical police' measure was introduced both in Japan and England. Then, the next remark should be on the contrast: England seems to have been much more cautious about introducing the compulsory measure than Japan. In explaining this contrast,

I would like to take geo-epidemiological factors into account, apart from Japan's authoritarianism and England's liberalism. While there had been no cholera epidemic in England since 1867, Japan was in the midst of it (Table 2). The 'cholera years' of Japan persisted longer than those of England, as Japan was on the periphery of the 'disease zone' of south-east and east Asia, where cholera was semi-endemic in the 19th- and early 20th century. It seems understandable that the Japanese government hurried the introduction of compulsory notification under the threat of fierce cholera epidemics.

This is just an example indicating that we should pay attention to a variety of factors in explaining differences in public health policy between countries and regions, instead of reducing them only to political regimes. I am aware that there should be much more: they maybe not just epidemiological, but also political, financial, social, or cultural. I'm not denying authoritarian aspects of Japan's public health administration, but saying that they cannot be explained by Japan's authoritarianism, as it is just a tautology. And of course, Japan's authoritarianism alone would not explain the difference in public health administration between Japan, Taiwan, and Korea, under the Japanese rule.

I think that the dichotomous typification of public health administration by political regimes would obscure the power of medical or sanitary discourses, which could operate anywhere and anytime, but differently, under various circumstances, due to a variety of factors. A departure from such a typification might become a step forward to an exploration of medicine in 'transaction' that extended itself without boundaries of nation states.

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Table 1: The classic typifcation of public health administration

Environmentalist model	Quarantinist model
England	European continental countries
Miasma theory	Contagion theory (→germ theory)
Environmental reform	Medical police
Construction of sanitary infrastructure	Quarantine measures
liberal	autocratic, authoritarian
laissez-faire	interventionist
private＞public	private＜public
voluntary	Compulsory, coercive
decentralized	centralized

Table 2: Number of cholera cases in Japan

Year	Cases	Year	cases	Year	cases	Year	Cases
1877	13816	1897	894	1917	894	1937	57
1878	902	1898	655	1918		1938	18
1879	162637	1899	829	1919	407	1939	
1880	1580	1900	377	1920	4969	1940	
1881	9389	1901	101	1921	29	1941	
1882	51631	1902	12891	1922	743	1942	
1883	669	1903	172	1923	4	1943	
1884	904	1904	1	1924		1944	
1885	13824	1905		1925	624	1945	
1886	155923	1906		1926	25	1946	1245
1887	1228	1907	3632	1927	2	1947	
1888	811	1908	652	1928	1	1948	
1889	751	1909	328	1929	205	1949	
1890	46019	1910	2849	1930		1950	
1891	11142	1911	9	1931		1951	
1892	874	1912	1614	1932	4	1952	
1893	633	1913	87	1933		1953	
1894	546	1914	5	1934		1954	
1895	55144	1915		1935		1955	
1896	1481	1916	10371	1936		1956	

Source: Ministry of Health and Welfare. Japan. *Isei-100nen-shi* (1976)