THE HISTORY OF PUBLIC HEALTH IN EUROPE

Public health, private concern
The organizational development of public health in the Netherlands at the beginning of the twentieth century

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This article outlines an important period in the development of public health in the Netherlands. It starts with the development of a more active government policy, in the middle of the century and ends with the political decision to develop a public health system, based on private initiatives and funded by the central government and local authorities. In 1933 this decision was made implicitly. In that year a Health Services Bill was rejected, in which the suggestion was made that municipal health services should be established. To understand this development, the role of both the central government and local authorities is sketched, as well as that of private organizations. In parallel with the increased involvement of governments, private initiatives developed. Cross societies are considered crucial in this development. It was not until the second decade of this century that it became clear which way the Dutch health care system would develop. Private organizations were insecure about their role and government institutions were thought to be inadequate and expensive. The debate on the Health Services Bill illustrates this. The period in which this bill was discussed can be seen as a decisive one for the field of public health in the Netherlands.

Key words: health services, cross societies, public health, history

The Netherlands became industrialized in the nineteenth century. This process took place earlier in other countries, for example Great Britain and it happened at the same time, but more quickly, in Germany. The Netherlands traditionally was a 'trade and services' country. For a long time it did not have any raw materials for heavy industry, such as, for example, Germany and Great Britain had. Although industrialization in the Netherlands might not have been analogous to that in other countries, it was accompanied by similar developments, such as urbanization and modernization, coupled with an increase in poverty and social problems. The development of state intervention in public health during industrialization in the Netherlands was limited as compared to that of other countries.

Traditionally, the country had strong autonomous local and provincial governments combined with a liberal, relatively weak, 'laissez-faire' policy of the central government. This mid-nineteenth century liberal political ambience in the Netherlands changed to left-liberal at the turn of the century.

Jaspers ascribes this shift in politics from liberal to left-liberal to the existence of social problems. Not the miserable situation of the poor, but, in particular, the political instability and the growth of productivity forced the political elite to cooperate in attempts to decrease social misery. From the second decade of the twentieth century Dutch politics was heavily influenced by confessional groups. Religion gradually became an important factor in sociopolitical blocking. Increasingly, organizations were established based on religious emancipative conviction. The social democrats did not participate in Dutch Government until 1939. At the end of the nineteenth century, both the central government and the local authorities were to some extent involved in public health. However, private organizations simultaneously increased their role in this area.

In this article we will describe one of the organizational developments that has determined the make-up of the Dutch public health system. We will restrict ourselves to the organizational development of public health in the first decades of this century.

We will describe the development of cross societies, through time one of the main participants in public health work, parallel to governmental interference in matters of public health. Usually it is claimed that these private organizations were founded because of a lack of structural government action. History, however, reveals that, although this claim might have been true, through time both private and governmental initiatives were
launched. Several government institutions were developed to take action in the field of public health parallel to the development of private cross societies. The role of governmental institutions was continuously debated. So too was the role of private initiatives.

An attempt undertaken by the central government to place private and public organizations under the umbrella of public health services failed. This 'failure' is often seen as the starting point of a unique health care system which resembles a patchwork. Both private and public organizations are intertwined in this system. This 'interwovenness' can be found in all parts of the Dutch health care system. Only since the 1970s has there been a trend towards public organizations: public health services are now appearing nation-wide, while cross societies seem to be on their way out.

**GOVERNMENT INTERVENTION**

In the middle of the nineteenth century a group of physicians, referred to as the hygienists, started to develop a form of public health. In cooperation with the liberal Prime Minister Thorbecke and triggered by a continuing lack of initiatives from local authorities to improve the state of health of the population, they established a State Inspectorate in 1865. It was based on the Law on the State Health Inspectorate (Wet Regelende het Staatstoezicht). The main tasks that were imposed by the law upon the inspectors included conducting investigations on the health of the population, recommending measures to improve the health of the population and supervising the implementation of these measures.

To evaluate the state of health of the population, the inspectors used new methods such as the collection of health statistics. For these statistics, death rates were collected and the spreading of communicable diseases was reported. In this way the inspectors could inform the authorities about the state of health of the population. Following current assumptions about the etiology of disease, the inspectors focused on local sanitary conditions, which were assumed to influence health. Furthermore, they examined drinking water supplies, investigated environmental pollution and the relation between health and housing and the sanitary conditions in public buildings, such as schools, hospitals, prisons and barracks.

The inspectors recommended sanitary measures for the improvement of the population's health, based on both the results of these investigations and the statistics. The responsibility for implementing health measures, however, remained with the local authorities.7 In line with the prevailing liberal political view, central government was reluctant to interfere in the autonomy of the local administrations. The liberal Prime Minister expected local authorities to implement health measures once the inspectors had convinced them of the necessity of these measures. Because of this local responsibility, the inspectorate had neither the means nor the (effective) power to force local administrations to implement health measures.8

The Contagious Diseases Act (Besmettelijke Ziekten Wet) of 1872 was an exception to this local autonomy. The repeated outbreak of epidemics, such as cholera in 1866/1867, typhoid in 1869/1871 and smallpox in 1870/1872, often followed by ad hoc action of local governments, forced the central government to act. Local authorities were summoned to undertake action in the fight against infectious diseases.9 They had to inform the citizens in the case of an epidemic, to isolate the victims and to take care of disinfection. This law was only partially implemented. The number of isolation departments in hospitals steadily increased after 1872. However, local administrations often neglected to inform the citizens and to take the legally required disinfection measures.

Furthermore, the population was often not willing to cooperate. They frequently refused physicians access to their homes or refused to be admitted to a hospital if they suffered from a contagious disease.10 Municipalities, often governed by the upper classes who were normally not affected by the outbursts of infectious diseases, wanted to restrict interventions as much as possible. Responsibility meant financial consequences. Therefore local governments wanted to restrict health care as much as possible to care for the poor. From 1880 onwards, however, this attitude gradually changed. Some local authorities began implementing more sanitary measures because the living conditions in the cities deteriorated increasingly due to the population growth accompanying the industrialization. Local water supplies and sewage systems were built, rubbish removed and cheap housing provided. By the end of the nineteenth century, water supply systems had been built in 51 municipalities. They provided 40% of the Dutch population with clean drinking water. Simultaneously, local authorities in larger cities set up sanitation departments for rubbish removal and city cleaning.11

Cities, such as Amsterdam, where new initiatives were launched, were not under the jurisdiction of the inspectorate while simultaneously the inspectorate had failed to instruct other local authorities to implement public health measures. A mere request by the inspectorate was not sufficient to convince the local authorities. This lack of authority, combined with political and social changes at the turn of the twentieth century, stimulated radical physicians and left-liberal politicians to reorganize the inspectorate. Both groups wanted an increase in state intervention.

In 1901 the left-liberal government constituted the Health Law. A Central Health Council was established, whose purpose it was to advise the central government and direct the inspectors. Furthermore, the law ordered local authorities to set up health boards. The purpose of these local boards was to investigate the health of the population in the municipalities, to advise local authorities on the necessary health measures and to control local sanitation. From the very beginning, the Central Health Council was confronted with internal conflicts and lack of cooperation between the inspectors. Members of Parliament therefore ridiculed the performance of the inspectorate.12 Despite the problems and the lack of political support, the inspectors continued their public health inquiries in the first decades of this century.
After the First World War the role of the inspectorate changed. The amount of advice given on sanitary measures decreased. A reason for this change in roles may have been the establishment of new institutions. In 1910, the Dutch Government created a laboratory for public health research. In 1913, the Government Bureau for Water Supplies was founded and in 1920 a Government Bureau for Sewage Treatment was established. These institutions also investigated environmental issues and gave advice on sanitary questions. Consequently, they took over part of the traditional role of the inspectorate.

When the ‘traditional’ public health issues such as proper hygiene, water supplies and housing disappeared from the public health agenda, the provision of medical care, infant mortality and tuberculosis became important public health issues. This change brought about the reorganization of the State inspectorate in 1919 which involved a clear change in tasks. From that time onward, the activities of the inspectorate were focused on the fight against contagious diseases, child welfare and tuberculosis. At the same time, local authorities had to provide medical care to the poor. To carry out this task, an increasing number of local authorities contracted physicians, pharmacists and midwives. Responsibilities shifted from private and religious charity organizations to local authorities. In 1912, a new Poor Law forced all local governments to take responsibility for the provision of medical care to the poor.

Before the First World War, 3 larger cities, Amsterdam, The Hague and Utrecht, also established local health services. With some local variations, these services provided medical care to the poor. They were also concerned with the medical examination of local employees, medical inspection of schoolchildren, supervision of environmental hygiene and coordination of the fight against infectious diseases. Many smaller cities followed and established some kind of local health service, though often not as comprehensively as in Amsterdam, The Hague and Utrecht.

In 1920, of all 27 cities with more than 25,000 inhabitants, only 2 did not have a health service. The number of health services increased to 37 in 1934. However, these were mainly to be found in the larger cities. Rural regions did not follow this trend. Here, in close-knit thinly populated communities, cross societies were much further developed than in the large, individualised, densely populated cities.

Thus, during the second part of the nineteenth century and the first decades of the twentieth century, the Dutch Government gradually became more involved in public health. In general, central government restricted its responsibility for public health to research and supervision. Local authorities were responsible for the implementation of measures to improve public health, a task they gradually grew into from the end of the nineteenth century onward. Nonetheless, some thought that government action in matters of public health – both local and central – was insufficient. Hence, in addition to the described governmental action on public health, private initiatives were launched. These initiatives expanded from 1900 onwards and came to play a major role in Dutch public health.

PRIVATE INITIATIVES: CROSS SOCIETIES

One of the private initiatives came from a governmental medical inspector for the province of North-Holland, J. Penn. His initiative was a reaction to the ad hoc way of forming local committees, whenever there was an outbreak of cholera. When the cholera outbreak was over, these committees vanished as quickly as they had been set up. Penn wanted a more permanent organization that was not focused only on cholera, but on the whole range of epidemic diseases. This idea was in line with the Contagious Diseases Act of 1872. The medical board of the province of North-Holland agreed with Penn’s idea and in 1875 the provincial White Cross was founded.

The goal of the White Cross was to cooperate as members of the community in the fight against contagious diseases, to give support during epidemics and to promote public health. Later, the phrase ‘nursing the sick’ was added. Equipment was bought and made available for combating epidemics, district nurses and disinfectors were trained, house calls were made to give advice and support and help was given to the poor and infected.

It is important to note that although the initiative came from a government employee, Penn, the White Cross was a private organization, supported and largely run by local inhabitants. To receive individual support, one had to be a paying member of the organization. In this way, local citizens became involved in the implementation of the Contagious Diseases Act.

With this system, health care in the Netherlands developed into a privatized health care system, later described by Querido as an ‘astonishing shift in the history of health care in the Netherlands’: not just care for individuals, but care for the entire community was carried out by private organizations, because government interference was not sufficient. Thus, the White Cross became important in the preservation of social hygiene and public health. Nevertheless, the organization did not develop as expected. In 1886, interest was decreasing and in 1892 there were only 15 departments.

This changed by the end of the nineteenth century. The general public became more interested in health care issues. At that time new health problems, such as tuberculosis and infant mortality, were recognized as preventable and therefore entered the field of public health. Private organizations were established not only to fight contagious diseases, but also to deal with child welfare and to combat tuberculosis. In 1904 the ‘Netherlands Committee for the Fight against Tuberculosis’ was founded, later renamed as the ‘Netherlands Association for the Fight Against Tuberculosis’.

Other people adapted Penn’s idea outside North-Holland. Fleisher and Poolman started the Green Cross in the province of South-Holland. One year later, in 1905, a provincial association was founded. Many provinces followed this initiative. Finally in 1911, a national association was founded. Still, it was not until 1917 that all
provincial associations were connected to this national organization. This emphasizes the independent role of the provincial associations within the national association. Until 1910 the Green and White Cross were not linked to one specific religion. The aim of the Green Cross was to 'serve everybody through everybody'. They were 'neutral'. Querido uses the term 'general' to emphasize that no religion was excluded in the organization. The organization was meant for both religious and non-religious members. This changed when the province of Limburg established its own Green Cross. Here, the association was Catholic. In spite of this it joined the national Federation of Green Crosses. Later it also joined the national Federation of White-Yellow Crosses.

From the early 1920s onwards, religion became a significant element in the cross societies, in parallel with a broader development in Dutch society in which religion became the basis of many organizations. Many religions wanted to have their own organization. Important in this development was the emancipatory struggle of the Catholics during the first decades of this century. This resulted in the creation of a Catholic cross organization: the White-Yellow Cross. It was founded in the province of Brabant in 1916, because the Limburg example of a Catholic Green Cross was not acceptable to the Brabant community. In Brabant people wanted their own organization to 'first and foremost' serve the religious moral interests of the families and to promote the divinity of the soul by nurturing the body. In 1923 the National White-Yellow Cross was established. The Limburg Green Cross joined this national federation, but also remained part of the national Green Cross. Finally, in 1946 the Protestants established their own Orange-Green Cross. Cross societies became the prototype of private initiative in the Dutch public health field.

The turn of the century also marked the beginning of a system of governmental funding, both local and central. In 1904 the first central government grant was given to the Dutch Tuberculosis Association. Until the First World War this remained the largest grant awarded by central government.

From 1919 onwards, the State Inspectorate supervised the allocation of these subsidies. Local governments and provinces, however, also provided grants. Nevertheless, this funding remained only a relatively small part of the income of private organizations. The funds varied enormously between municipalities and were never sufficient. In 1910 approximately 10% of the local cross societies were supported by local governments, with only small subsidies, between 5 and 10 guilders. Sometimes these local governments also paid the contribution for the poor. The remaining finances were extracted from membership contributions, fund raising and gifts. Initially, much of the work undertaken by the organizations was done by nuns; costs were therefore low. This changed when cross societies expanded. In 1910, 3% of the Dutch population were members of one of the cross societies. In 1940 it was 36%, and in 1957 this number had increased to 57%. It must be said here that individuals often became members only after they needed the services of the cross society.

Government support became essential. From 1925 onwards, cross societies were directly funded by the central government. Although these grants were also marginal, they became an important tool for the government to direct and control the private organizations. Grants were given on certain conditions only. The financial checks and balances needed government approval. According to the central government, this type of control would ensure a certain degree of quality and provide basic preventive health care to the public.

In 1925 the Dutch Green Cross, for example, received DF 800,000 (Dutch Guilders) through contributions and gifts. For tuberculosis prevention they received DF 150,000 from the central government. Furthermore, they received a municipal grant of DF 266,389, a provincial grant of only DF 13,338 and DF 48,771 from other sources. The already marginal support from local and central governments decreased in the interwar period because of the global economic depression, despite an increase in the population and an increase in the work undertaken by the cross societies. Nevertheless, in the interwar period, private initiatives prevailed. There was no government incentive to coordinate these initiatives. Funding only increased after the Second World War and has led to a system in which the practical work is carried out by private organizations and in which the government only supports and controls them.

Although, through time, private organizations clearly increased their role in public health, no formal decisions were ever made. Up to the 1920s and 1930s the choice in favour of private initiative was not made. In fact, political discussion focused on the formalization of central and local government implementation of public health. In this context a proposal was made for a Health Services Act. The discussion of this act had major implications for the development of public health in the Netherlands.

THE HEALTH SERVICES BILL

Immediately after the First World War, Dutch society went through a short period of openness to social change. This is generally seen as a response to the decline in health of the population during the war, to the fear of the middle classes of revolutionary changes and to an increase in economic activity. This period did not last long.

In this short period, however, the Minister of Labour, Commerce and Industry introduced a District Health Services Bill. This law aimed to improve public health. Furthermore, it was an attempt to characterize public health as a government task, contrary to the claim on this domain by private organizations, which were not mentioned in the first draft of the bill. According to this law, each municipality had to have a Health Service. The minister, Aalbers, was inspired by the cities of Amsterdam, The Hague and Utrecht, who by then had their own health services.

The health services were to investigate the state of health of the population and carry out measures to promote...
public health.\textsuperscript{11} Later, in 1928, this vague description of tasks was further specified. Health Services had to take care of child welfare, deal with infectious diseases, tuberculosis, venereal diseases and alcoholism and collect health statistics.\textsuperscript{20} Both the central government and local authorities were to pay half the expenses.\textsuperscript{21} Intense discussion on this law took place from 1920 up to 1933. The financing of the health services and the relation between private and public organizations in matters of public health were important issues in this debate. Members of parliament were critical of the costs. For many, it was unacceptable that central government should pay half these costs.\textsuperscript{11} A cost calculation requested in 1926 by social democrat De Vries-Brujin was made in 1928. The social democrats disputed the idea of health services being too expensive.\textsuperscript{22} However, the cost calculation was later used as an argument against this law.

Confessional groups, by that time both an important factor within private organizations and in central government, disagreed with the bill and argued that their own private initiatives showed positive results and were therefore a good alternative to expensive government interference. Cross societies did indeed play an important role in the field of social hygiene, district nursing, tuberculosis and child care. Therefore, private organizations claimed to be the cheapest solution for the central government. Not only did private organizations believe they were best fitted to do the job, they also thought, because they had been more involved in the field of public health, that they had the right to provide the public health service. However, the dominant role claimed by the private cross societies was not always undisputed. For some time, the cross societies were insecure about their capability to play a key role in public health. In 1919 for example, they debated the question whether they should hand over district nursing to the local authorities. It was not because they thought they did not have the expertise to play an important role in public health. Finances restricted their role; a role which became more important because central government increasingly involved the societies in its own tasks.

Another solution was suggested: cooperation between private and public sectors. According to this suggestion, cooperation did not have to be a problem, because of the different roles which private and public intervention had in the health care system.\textsuperscript{8} Physicians working in the already existing health services, for example, pleaded in favour of tasks for private organizations, in particular tasks that had to do with the private life of individuals. While the debate went on, these physicians stressed the willingness of the health services and private organizations to work together.\textsuperscript{23-25} Accepting the fact that many tasks were carried out by private organizations, did not imply, according to Heijermans, the director of the Amsterdam Health Service, that centralization of public health was impossible.\textsuperscript{26} He believed that centralization of public health could be achieved through a system of health services. Simultaneously, decentralization was possible by delegating certain tasks to private organizations.\textsuperscript{22} In his view, private organizations needed to be part of the structure of the health services because of an apparent lack of cooperation and coordination between the private organizations.\textsuperscript{27} He also felt that public health needed a stable organizational structure and this was exactly what the existing private organizations lacked.

Meanwhile, the number of local health services increased. They were willing to cooperate with private organizations. Nevertheless, the Dutch Government rejected the idea of cooperation between private and public organizations under the umbrella of health services. In 1933 the Health Services Bill was withdrawn. In the same year, the existing local health boards were also dismantled. The official reason given for the failure of the introduction of the Act was the financial problems both local authorities and the central government were faced with.

As mentioned earlier, private initiative at that time was greatly influenced by various confessional groups. Every religious group wanted its own organization. The withdrawal of the Health Services Act might therefore be seen both as resulting from the mechanism of sociopolitical compartmentalization, along the lines of religion\textsuperscript{18} and cause for further sociopolitical segmentation, because the implementation of public health had become and remained the task of private organizations.\textsuperscript{17} The first step in this direction was taken at the end of the nineteenth century. The second came with the withdrawal of the act, an event which can be seen as the acknowledgement of the role of private initiative. This second step was of major importance. Public health became the focus of cross societies, which became powerful entities. This only changed after the 1970s.

CONCLUSION

Looking back on a significant period in Dutch public health history, some conclusions can be drawn. First, the development at the end of the nineteenth century and the first half of this century shows that the growth of private organizations in the Dutch public health field cannot be attributed blindly to the failure of state intervention in public health. History shows that from the mid-nineteenth century onwards the Dutch Government gradually became involved in public health matters. It founded a State Inspectorate. The purpose of this inspectorate was to conduct investigations into the state of health of the population and advise on measures that were required to improve health. In addition, at the end of the nineteenth century, local governments started to implement sanitary measures to improve public health. Through time, a growing number of local authorities expanded their public health tasks through the foundation of local health services.

Secondly, from the beginning, the development of state interventions was often believed to be problematic. The organization and structure of the State Inspectorate faced major barriers. It was thought to be difficult to persuade local authorities of the necessity for implementing public health measures. Furthermore, local initiatives were often
retracted to the larger cities and varied enormously between the many districts.

This conception of government 'failure' was often used by private organizations, such as the cross societies, to rationalize their own inception. Indeed, the first cross organization was established to fight contagious diseases in a more structural way than the local authorities were known to do at the time. However, their tasks changed, soon to include duties such as district nursing, child health care and tuberculosis prevention. From 1900 onwards private organizations expanded. Along with this expansion, religion became an important issue within the cross societies.

Both local authorities and private organizations thus expanded their involvement in public health from the beginning of this century onwards, often in similar areas. Nevertheless, the Dutch Government made an attempt to claim public health as a primarily (central and local) government task by proposing a Health Services Bill. The debate on this bill made it clear that both proponents of public health services as well as some advocates of private organizations were in favour of cooperation. In 1933, however, the Dutch Government decided to withdraw the Health Services Bill. A definitive choice was made instead for private organizations.

Two reasons might be given for this decision. First, the global recession clearly restricted government expenditure. Indeed, this was the official reason given for the withdrawal of the bill. However, secondly and probably just as importantly,confessional groups had by that time gained an important position, not only within private organizations, but also in Dutch politics. These groups saw an opportunity to establish their own organizations, based on religion. This emancipatory claim proved to be important in the decision in favour of private initiatives in public health. Moreover, they paved the way for a further segmentation of Dutch society. The acceptance of a private public health system became a catalyst in this process.

REFERENCES


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