SUMMARY

AID AND PREVENTION

From the beginning of the nineteenth century anatomy, physiology, pathology and pharmacology, the basic medical disciplines, have seen a rapid development. Knowledge of structure and functions of the human body grew and medical science has made it possible to make a connection between pathological symptoms on the one hand and changes in structure and functions of the body on the other. There is now a better understanding of the most important functions of the body: respiration, blood circulation, digestion, nervous system, endocrine secretion and sexual reproduction. Methods have been developed to measure these functions, so that disorders can be treated.

These developments have led to an improvement in medical treatment; they demand professional nursing as a follow up; and they open perspectives on the prevention of illness through individual and public hygienic measures. In short, the health service is no longer the sole domain of doctors, but also of nurses and engineers. The organisation of health care becomes more complicated. Education of doctors changes and nurses are being educated more and more. Public health services are seen as a task for local councils.

The Contagious Diseases Law of 1872 sets down regulations for local authorities. These turn out to be not very effective, however. That is why in the province of North-Holland in 1875 a health inspector called Penn takes the initiative for a private organisation for health care and for combating contagious diseases. The society is called the White Cross. The initiative is not very successful, because after 1872 there are no big epidemics. Around the year 1890 the White Cross is looking for a way to broaden its aims.

In 1900 a pastor and a doctor take over, rev. F.C. Fleischer and doctor W. Poolman. They develop an initiative to set up new societies outside North-Holland, with the aim of improving health care in the home and furthering public health interests. According to the wishes of the North-Holland societies they choose not a white but a green cross as their emblem. The result is that in 1901 and 1902 provincial cross societies are formed in South-Holland, Friesland and Groningen; down to 1910 these provinces see the formation of 226 local cross societies. As from 1906 other provinces follow suit with local and provincial societies and in 1912 Fleischer and Poolman establish the Algemene Nederlandse Vereniging Het Groene Kruis (General Dutch Society The Green Cross). After some time the White Cross also joins this society.
SUMMARY

The first local cross society in Friesland is formed in Franeker in 1901. In 1902 the provincial cross society follows. Nine years later around 50% of all Frisian families have joined one of the 96 local societies. At the end of the 1970s some 85% of Frisian households has a Green Cross membership.

In the early years the activities of provincial and local cross societies are financed for over 90% through contributions from members and payments by those who make use of the services. Provincial and local cross societies are still completely independent and free to choose their activities and the way in which they organise them.

Through the years an increasing proportion of the work done by the societies is financed by central government. In 1979 contributions by members form no more than 20% of the Frisian cross societies' income. As from 1980 the societies are financed fully through the Algemene Wet Bijzondere Ziektekosten (AWBZ – General Law for Special Healthcare Costs) and through insurance companies; each resident of the country now has access to the services of the cross societies.

The aim of the cross societies' work is combating adversity which hits individual members and which in principle demands individual remedies. In this dissertation the activities of the societies are called health care arrangements.

In the early years Frisian cross societies executed six health care arrangements, eighty years later this has grown to eighteen arrangements. For these arrangements there are collective, national and binding government regulations, based on the AWBZ and Dutch National Health legislation. In his Zorg en de Staat (Care and the State) De Swaan describes the process in which private services develop into services based on government regulation, and he calls these processes collectivisation processes.

On the basis of a description of the development of cross society activities in Friesland this dissertation answers three questions:

1. To what extent can we see this development of cross society activities in Friesland as an example of De Swaan's collectivisation process.
2. Who are the actors in the development of health care arrangements.
3. To what extent is this development in Friesland characteristic for cross society work in other Dutch provinces.

Between 1901 and 1980 health care was given in the form of 28 care arrangements, of which in the same period nine were dropped at one time or another. These arrangements can be grouped as follows: lending of health care materials, home care, social medical care, maternity care, prevention of tuberculosis and preventive health programmes for youth.

The health arrangement which consist in the lending of nursing materials is the only one for which there have never been government regulations.

In some districts home care was offered right from the cross society's start. In the 1920s this service becomes available to the members of all Frisian cross societies. There are ninety district nurses by then. This numbers grows to around one hundred nurses in 1940, 152 in 1945, while in 1979 this work is done by 159 district nurses and 33 day nurses. In that year these nurses offer care to 4,790 patients, perform 219,694 nursing acts and make 3,241 preventive visits.
SUMMARY

Social medical care includes rheumatism care, revalidation, food and diet education, care for the elderly, cancer control and aftercare for asthma. In the late 1940s and early 1950s the provincial cross society sets up special branches for this work, with specialised district nurses, doctors and dietists. In the 1960s this proves to be not very effective and efficient and the general district nurses are once more asked to do this work, after receiving extra schooling from the specialised district nurses. These remain available for consultation.

Initially only a limited number of local cross societies see maternity care as their duty. Sometimes they have their own maternity nurse or they organise maternity care courses. In 1916 local cross societies decide that the education of maternity nurses should be the responsibility of the provincial cross society and that the provincial society should start an office which could act as an intermediary between (private) maternity nurses and families. In 1926 central government regulates the education of maternity nurses, from 1943 it is financed by central government, and in the early sixties it is organised as a boarding school by the three northern cross societies together.

Initially maternity nurses are fully independent practitioners. This changes when the provincial cross society starts its intermediary office in Leeuwarden in 1924. Between 1927 and 1940 the number of maternity nurses increases from 40 to 76. In 1927 5% of births in Friesland is looked after by a registered nurse, in 1939 this is 11%. During the war the percentage falls, but in the 1960s it grows towards 30% and in 1979 it is 52%. This means that in that year of the 4127 home deliveries in Friesland 41102 receive maternity care through the cross society.

In the beginning of the 20th century tuberculosis is a common disease in The Netherlands. Practically the whole of the population has the infection at one time or another and of the five million inhabitants each year 100,000 suffer from an active tuberculosis, which means that they have the symptoms. Of the total number of deaths between the ages of fifteen and sixty one third is caused by tuberculosis. So right from the start cross societies have had to deal with the illness in their home care. From 1910 district nurses are educated to work as home visitors for tuberculosis prevention. Up to 1964 local cross societies and their nurses also help out in finding the necessary money for sanatorium care. In 1927 central government starts financing the health centres for tuberculosis prevention that have been set up. These centres try to bring active or open tuberculosis under control. When the three cross societies in the northern provinces start a general examination of the whole population, the information on the spread of tuberculosis in the province and on the people with a higher risk is soon almost complete. From 1944 effective medicine to combat tuberculosis becomes available. In the 1970s tuberculosis can no longer be called a common disease in The Netherlands. Elsewhere in the world it has remained, however, and resistant bacteria have developed.

Between 1930 and 1963 the provincial cross society had its own sanatorium for tuberculosis patients.
Besides tuberculosis, infant mortality is a serious health problem in the beginning of the 20th century. Of every 1,000 live births one hundred children die in their first year, one quarter of these in the first three months. The Society for Infant Care, established in 1908, soon pleads for the setting up of Infant Health Centres. In 1922 the State Commission for Tuberculosis Prevention does the same. Central government now stimulates these health centres by providing a subsidy for paediatricians. In 1927 the provincial cross society receives such a subsidy and in 1928 it starts setting up a number of Infant Health Centres. At the same time local cross societies and doctors are active in this field, so that a chain of health centres for infants now comes into being. Of 9,086 children born in 1939 35% is registered with a health centre. Each child visits the centre eight times on average. In 1962 the percentage is 80 and the average number of visits nine per year, and in 1979 this is 90% and again nine visits. In this care arrangement too from the end of the 1960s more and more district nurses are used. In 1979 42% of the visits is handled by them.

In 1946 health centres for pre-school age children are set up. In 1963 62% of these children are looked after, in 1979 90%. Initially the average number of visits is one per year, this slowly decreases to 0.7 per year.

In 1951 mass vaccinations against diphteria, whooping cough and tetanus are added to the programme, and this is extended towards polio in 1957, German measles in 1974 and measles in 1976. In 1979 98% of all children is vaccinated against diphteria, whooping cough, tetanus and polio and 93% against measles and German measles. Ear tests are introduced in 1965; in 1979 80% of all infants are checked. In 1967 screening newborn children for PKU (a metabolic disease) is started, which soon results in practically all newborn children being screened.

The health care service of cross societies in Friesland, therefore, has seen a strong growth between 1901 and 1980. It grew because new groups of patients were added, and because within these groups more people were reached. All of this led to a complicated organisational structure with many different procedures. Growth was made possible by a relative growth of government subsidies, from 8% to 73%, for cross society work, exclusive of maternity care. Maternity care is paid for through the AWBZ. State subsidies and AWBZ payments went hand in hand with strict regulation. The care arrangements which were added to the service have not been financed in a uniform way; and changes in government regulations have also led to modifications in structure and procedures.

The actors in the different care arrangements are local cross societies, the provincial cross society, central government and health organisations outside the cross societies.

We have divided the development of cross society work in Friesland into six periods. In the first period, 1901-1911, social action led to the setting up of local cross societies in most of the province. Between 1911 and 1927 these cross societies develop the care arrangements home care and tuberculosis prevention. The general meeting of the provincial cross society decides that schooling and mediation of maternity care will also be part of the task of the provincial cross society. In the third period,
1927-1940, the provincial cross society sets up centres for tuberculosis prevention, while the provincial and local cross societies together set up health centres for infants. These two care arrangements are financed largely by central government as part of the public health service. Its financial commitment gives the government the opportunity to regulate cross society work.

During the German occupation, between 1940 and 1946, the cross societies succeed in remaining independent from German regulations.

In the period 1946-1964 maternity care and youth health care see a strong quantitative and qualitative growth, and the provincial cross society develops a number of social medical care arrangements, mostly subsidised by central government. At the end of this period and in the beginning of the next this social medical care is incorporated gradually into the home care service. As a result of the growth of health care in the period 1964-1980 the organisation of cross society work needed to be streamlined. Cross society work was fitted into the general structure of health care. This process was completed when cross society work took its place in the AWBZ system of regulation and financing.

Local cross societies in Friesland started as local care collectives, resulting from social action and directed towards improvement of home health care and furthering of health generally. After almost 80 years Frisian cross society work has developed into an organisation for home care and preventive care within a framework of collective, national and binding rules and financed fully by or on behalf of central government. For each period this dissertation has studied to which extent collectivisation has developed with regard to the aspect of initiative, of realisation and of finance.

In his Zorg en de Staat (Care and the State) De Swaan has studied the collectivisation process in the battle against poverty, ignorance and illness, i.e. in the fields of poor relief, education and health care, in five countries and over five centuries. On this macro scale he distinguishes four aspects of the process:

* There are four factors which cause the collectivisation process: growing government influence, regulation of entrance, increase in scale and professionalisation.
* The consequences of the process is officialdom and bureaucratisation in the organisation.
* The start and the dynamics of the process are caused by conflicts within the elites.
* After 1946 the collectivisation process enters two different phases. In the first phase growth is mainly quantitative, in the second phase the process gets its own dynamic.

Compared with the collectivisation process studied by De Swaan, the process with-
SUMMARY

in the Frisian cross societies is a process on a micro scale. Yet our study shows that despite the difference in scale three of De Swaan's four aspects play their role in the collectivisation process of the Frisian Green Cross. The third aspect, conflicts within the elites, cannot be recognised. This is no doubt because in De Swaan's analysis this aspect plays a role mainly before 1900, that is before cross societies were set up in Friesland.

On the basis of this dissertation two new causes for the collectivisation process can be added to the ones De Swaan gives. These are interweaving and centralisation of the decision making process. Interweaving is found in the shared responsibility of provincial and local cross societies for the realisation of care arrangements.

And because the realisation of care arrangements develops into a routine, whilst at the same time the number of arrangements grows, centralisation of the decision making process takes place. The result is that decision making on policy and management shifts from local and provincial members' meetings to boards, commissions, administrators, provincial committees and finally to the general manager and staff of the provincial cross society.

Our conclusion is that the collectivisation process of the Frisian Green Cross can indeed be characterised as a collectivisation process according to De Swaan.

The last question that has to be answered is: to what extent is the development in Friesland characteristic for cross society work in other Dutch provinces. When we compare the health care service, the organisational structure of cross society work in other provinces, the uniforming effect of national meetings between provincial cross societies and regulation as a result of central government subsidies and government control of public health, the conclusion must be that the collectivisation process in other provinces is generally the same as that of the Frisian Green Cross.