

# Introduction to the Volume: Situating Health-Care: An Historical Perspective

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Where healthcare is provided and accessed are the two questions discussed in this volume – from a historical perspective. Today healthy persons in wealthier countries are more and more occupied with practices supposed to keep themselves in good health: in a society with many people working in sedentary occupations regular physical exercise is one topic; the choice of a healthy not too abundant nutrition another; and avoiding smoking or excessive drinking a third issue. The general diffusion of preventive health care is – considered from a historian’s point of view – a rather late achievement. No doubt, antique dietetics and its rediscovery since the Renaissance provided some of this knowledge in an earlier form, but the current interest in regular preventive health practices is partly linked to new bodies of knowledge, partly to increasing wealth and to a certain extent to the result of hygienists’ impact on the everyday life of people from all social strata since the end of the 19<sup>th</sup> century.

Self-medication now plays an important and often underestimated role – some medical sociologists attribute an important share of the market for pharmaceuticals ranging from one fifth to one half of the sales in different post-industrial societies to this practice – without counting the variety of esoteric and other “pseudo-medications”. Self-medication was even more important when professional medical care was not at the disposal of the majority of the population – as is presently the case in many countries of the so-called “developing countries”. Nevertheless, under the recent austerity measures in several welfare states, people reconsider whether to attend the physician and obtain a prescription or to decide on their own about another – directly accessible – medication. In Germany, at least during the last few years, the market share of self-medication has grown significantly under these financial pressures.

Considering the other side of the coin, the provision of health care, the present debate reconsiders the hyper-professionalisation of health care and its side effects, mainly high and fast growing expenditure. For more than a generation, the growth rate of the medical market has been faster than almost any other sector in nearly all “industrialized” countries. Together with an ever aging population this is begin-

ning to overstretch the affordability for medical care in these societies.<sup>1</sup> This situation has encouraged public debate about the possible role of voluntary, non professional aid and about other – often supplementary – actors in the medical market beyond general insurance and/or national health care schemes. Financial considerations were, and still are, predominant in these debates; questions of the quality of care unfortunately play still too little a role.

This critical public debate was the incentive for us as historians to organize a conference on “Health and Health Care between Self-help, Intermediary Organizations and Formal Poor Relief (1500–2005)”, which took place in Braga, Portugal, 2–4 July, 2004. It was co-organized by Prof. Marta Lobo de Araújo of the Universidade do Minho in Braga and Prof. Martin Dinges from the University of Mannheim and the Institute for the History of Medicine of the Robert Bosch Foundation, Stuttgart, Germany, under the auspices of the PhoenixTN (European Thematic Network on Health and Social Welfare Policy), and its coordinator Prof. Laurinda Abreu, Evora, Portugal, who also participated in the scientific committee. The more precise aim of the conference was to reconsider the dominant historiographical interpretation of the development towards the welfare state by exploring a new and fresh approach based upon local experiences in various European countries – as this is the particular opportunity provided by such a European Thematic Network.

The traditional narrative of the inter-relatedness of self-help, intermediary organizations and formal institutions was formulated, until recently, in the following way: when, in the time of late medieval cities, self-help failed to cope with health and care problems, mutual help was a partial substitute which led to the creation of intermediary institutions. These institutions were overburdened by rapid population growth, mainly since the sixteenth century, which in turn led to an ever growing commitment of the early modern city and – later – the territorial „state“ in this field, aiming to take over the guidance of the entire health care sector. National health-care insurance systems of the European type were the epitome and the definite result of this long-lasting historical process. In consequence, informal institutions are supposed to have played an ever more marginal role.<sup>2</sup>

It is only since the debate about the crisis of the welfare-state and more precisely of its healthcare budgets that new considerations of the relative role of self-help, informal and formal institutions have found their way to a wider audience. These ideas changed the agenda of historical research. Since the 1980s, the linearity of historical development and its irreversibility are under discussion. The relative role

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1 Dörner, 2004, 25–33, 45–52.

2 Some of these questions were addressed in an earlier conference of PhoenixTN (European Thematic Network on Health and Social Welfare Policy), and are published in Abreu, 2004, cf. the section introduced by Dinges, 2004a; Dinges 2004b.

of self-help, informal and formal institutions and their interrelatedness is now considered in a more open-minded way: Informal solutions may indeed be better solutions for certain health-problems than solutions by formal institutions. European history provides plenty of examples for different ways of inter-relating the three above-mentioned sectors.

In consequence, one important aim of this conference was to reflect upon the interrelatedness of the three levels of health-care throughout the ages. In the call for papers we stated: “Many perspectives are possible. Here are some examples, such as the patient’s point of view: patients’ attitudes or practices from a particular sector may have an impact on other levels of health-care. From an institutional point of view it may be interesting to look at the users – as for example ill children – who may get into an institution, then return to the family and finally go back to the institution. Patients’ recommendation of specific types of healers may influence the medical market as behaviour and recommendations of the providers of health-care may have effects on individual decisions.

For an analysis of health concerns and practices it is the individual who must be the starting point. Health is intimately linked to healthy and unhealthy lifestyles. These lifestyles were always based on a certain body of knowledge, which circulated between the oral tradition of any given community and the literature of hygiene. Since the invention of the printing press and especially since the general diffusion of the periodical press, an enormous growth of information on healthy lifestyles has developed.

Therefore, healthcare as an individual or collective practice changed during the centuries in relation to the available body of knowledge. The forms and results of these everyday practices are still largely unknown: an entire field of research covering healthy nutrition, smoking habits, the intake of drugs and the various forms of sports are part of it. Concerning more medicine-related practices, self-medication is an important issue: recent studies show the large impact of this practice on the pharmaceutical market.

Self help in health matters is practised within the family – be it a nuclear or an enlarged family, in households, neighbourhoods, and other networks, as for example networks of friends. Working relations and even relationships based on accommodation may play a role. All these person-based relationships play an important role in patients’ choice of medications, healers, lifestyles, and health-care institutions. It is important to acknowledge this essential role of self-help in health and healthcare.

Healthcare is secondly in the hands of more or less informal intermediary organizations such as religious associations or other brotherhoods, during later centuries in other self-help organisations such as labour-unions, charitable associations, friendly societies or other types of non-profit organisations. Their specific motivation often shapes the kind of health care priorities. It makes, for instance, a

difference, whether denominational competition is at work or not. It also matters whether upper class people – as for example entrepreneurs – have the intention to help third persons or whether workers want to help themselves and their families by founding friendly societies. These different informal institutions “invent” therefore different health care needs. They prefer solutions that suit their political and social goals.

The bulk of research focuses on formal institutions as an important provider of healthcare. Hospitals, insurance companies, and healthcare schemes of national states are the typical examples of these institutions. Even inside these formal institutions, the interrelatedness between self-help and help by third persons can be traced. One example could be a patient’s attitude to nursing.”

To have cited the call for papers for the conference in Braga so extensively, serves here to illustrate the large scope of issues, which was suggested to the participants. Only a part of these proposals has been taken up and reshaped by the authors according to the actual state of their research.

The contributors of this volume are mostly established scholars; some are just finishing or have just finished their Ph.D. We preferred to present here a small choice of the papers of this conference.<sup>3</sup> Functioning as a European Thematic Network, the geographical and thematic scope of the volume is large. The authors address the above developed issues for four European countries: Germany, Malta, Spain, Switzerland. Fortunately some of these papers concern so-called smaller countries, which are ordinarily not sufficiently taken into account in the international debate about the roots of the Welfare State. No doubt, it is one of the positive results of the recent cooperation in the human sciences under the auspices of the European Union that the specific experiences of these countries are ready to be more and more integrated into a more differentiated vision of the continent’s history. This choice intends to add to this development.

To put patients’ choices to the foreground, it is appropriate to start with a paper about an individual experience, Susanne Hoffmann’s „Illness and Self-Help in Late Eighteenth-Century Rural Switzerland: the Strategies of Ulrich Bräker (1735–1798)“. Bräker presents an exceptionally well documented life history representative of the large population of small peasants in Europe, we know so little about. As he left more than a 1500 pages of (a recently printed) diary he allows rare insights into the medical behavior and preferences of such a peasant family, active in small-scale trade inside the Swiss canton of St. Gall: most of the medical aid was organized internally in the household and within the wider network of family and friends. Together they provided the material, economic and immaterial resources to cope with ill health. The help of medical professionals was sought in less than three percent of illness episodes. Hoffmann reconsiders the reasons for these

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3 A larger choice of papers is in press: Dinges 2006.

choices proposed earlier by McCray Beier and underlines the partial overlapping of formal and informal aid.

Even if the role of self-help was not as predominant in the city as it was on the country side, Philip Rieder nevertheless shows in his article on „The Poor and the Patient: Protestant Geneva in the Early Modern Period“, the extent to which this municipal medical market and its rural surroundings were dominated by the patients' demand. His example is particularly significant, because Calvinist Geneva must be considered as a paradigm of a „well-policed“ city. Lay suspicion of all sorts of healers guided not only individuals, but also the public authorities, who tolerated and even funded the services of non-regular healers – notwithstanding legislation regulating the opposite. Introducing the category of class, Rieder shows that the rich had more affluent ways to choose, but it seems that the poor possibly received in the end the same kind and quality of medical care as the better-off citizens.

John Chircop addresses in his paper “Old age coping strategies of the Ionian and Maltese poor, 1800–1865” the question of how people could get the resources for health care and survival when getting old, ill, partially disabled and consequently (partially) unemployed. In his inspiring case study he follows their tactics to bring together aid from all three aforementioned societal levels considered in this publication: the household and the neighbourhood, the intermediate organisations and the state. He underlines to which extent these elderly poor have to be considered as active players, who tried to safeguard a certain independence by avoiding exclusive reliance on only one or two of these providers of aid.

Pilar León Sanz turns her attention to „Professional Responsibility and the Welfare System in Spain at the Turn of the 19th Century“. As in other European states around 1900 the Spanish physicians had to make up their minds about the emerging system of public health in which a general or national health insurance scheme was often a matter of debate. The tempting option to enlarge the access to healthcare to the entire population was here as everywhere linked to the less attractive side of the coin, which was more influence for assurance companies. Sanz analyses the arguments of the Spanish physicians, who reacted with a certain time lag as compared to the European debate, but beyond corporatist reflexes they showed in general a positive attitude to the new opportunities and challenges.

The impact of public debate and political interests on institutions dealing with health is particularly evident in the case of hospitals, which form the topic of the third section „Hospitals as a Result of Medical Choices“. Fritz Dross strongly makes his case of this perspective in his „The Invention of a Medical Institution? The Discussion of Hospitals Around 1800“. Insisting on the one generation-long debate about the advantages and disadvantages of a municipal hospital in the Rhenish town of Düsseldorf as an alternative to the traditional home-care, he makes clear the extent to which a hospital represents a negotiated form of order.

Such an institution which seems to us from the perspective of the 21st century – and having the consequent development of the clinic as the pivotal institution of medical modernity in mind – as completely self-understanding, was the result of choices not necessarily as evident for the contemporary perspective of the early 19th century.

All these papers invite further research, which could and should first try to take the results obtained by research about earlier periods as a starting point for research about later moments in history and vice versa. This could sharpen the sense for continuities and discontinuities in the field of healthcare and might add to a better understanding of some of the solutions and problems in the so-called developing countries. Secondly, one could and should focus on the very specific circumstances and conditions of these almost national, regional or local experiences and developments. Enlarging such an approach might lead to a better understanding of European communalities, time lags and mutual inspirations. If this choice of contributions from very different strands has contributed to open the attention of the scholars to such comparative research – as the conference itself did for the participants – it has already attained a part of his objectives.

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## References

- Abreu, Laurinda (ed.), *European Health and Social Welfare Policies*, Santiago de Compostela, 2004.
- Dinges, Martin (ed.), *Patients in the History of Homoeopathy*, Sheffield, 2002
- Dinges, Martin, “Health between Self-Help, Formal and Informal Institutions”, in Abreu, 2004, pp. 21–22 (= Dinges 2004a).
- Dinges, Martin, “A History of Poverty and of Poor Relief – Contributions from Research on the Early Modern Period and the late Middle Ages and Examples from More Recent History”, in Abreu, 2004, pp. 23–50 (= Dinges 2004b).
- Dinges, Martin (ed.), *Health and Health Care between Self-Help, Intermediary Organizations and Formal Poor Relief (1500–2005), Proceedings of the conference of the PhoenixTN (European Thematic Network on Health and Social Welfare Policy), in Braga, Portugal, 2004*, Evora, 2007.
- Dörner, Klaus, *Das Gesundheitsdilemma. Woran unsere Medizin krankt. Zwölf Thesen zu ihrer Heilung*, Berlin, 2004.