

Medical wage slave or worthy professional?

The Dutch medical profession and the health funds 1900-1941*

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Summary

The development of mutual and commercial health insurance, and state health insurance programs in particular, typically provoked much criticism from the professionals involved with them. Moreover, the efforts of the Dutch medical association, the NMG, to influence state proposals met with little success. As a consequence, the NMG developed a health fund policy of its own, the demands of which newly established funds had to meet. The policy was designed to minimize lay control, improve fees and introduce an income limit to protect private practice. In the country's cities, collective contracts were instrumental to the enforcement of the NMG's conditions. However, the goal of creating a nationwide network of NMG funds was slow to materialize, maturing only: 1) because health fund regulation was expected after compulsory sick pay was introduced; and 2) due to the involvement of the trade union movement in the establishment of health funds. When the Decree on compulsory health insurance was promulgated in 1941, the NMG became the biggest health care insurer in the Netherlands, but this legislation ignored everything it had strived for, instead introducing a centralized, bureaucratic system, which left carrier organizations with virtually no capacity to plan their own policies.

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1. *Introduction*

From an international perspective, the history of Dutch compulsory sickness provision is quite exceptional. In general, global sickness benefit laws insured both sick pay and medical treatment, since proper medical attention was the obvious way to restrict absence from work through ill health. In the Netherlands, however, legislation on sick pay took precedence, although the legislative process took an exceptionally long time to be completed. The first such bill was sent to parliament in 1904, but it took until 1930 before the Sickness Benefit Act came into force. Compulsory health insurance¹

* I want to thank Dr. M. Kraaijestein and Dr. K.P. Comanje for their critical comments on earlier drafts.

¹ The Dutch 'ziekenfonds' is usually translated to mean a sickness fund. In the twentieth century the term was mainly applied to institutions providing health care. I have, therefore, decided to use the phrase health fund. The Dutch term 'ziekenkas' for providing sick pay is translated as sickness fund.

took even more time to materialize, and was only introduced in 1941 when the country was under German occupation. By that time, almost half of the Dutch population was already voluntarily insured for health care. It is also astonishing to note that many health funds were owned and run by doctors.

By about 1900, doctors in several countries were concerned about the development of sickness funds and the intended state intervention in the area of health insurance. Fearing for their status as independent professionals, they stressed the importance of professional organization in order to achieve the establishment of generally accepted rules regarding health funds, with political pressure to be applied if necessary. A brief overview of the 'battle of the clubs' in different countries is, therefore, provided herein to pinpoint the specific Dutch nature thereof.² The section which follows contains an historical explanation of these characteristics, and also provides a rough sketch of the health insurance market around the turn of the century. Section 4 then analyzes how the Dutch Medical Association (Nederlandse Maatschappij tot bevordering der Geneeskunst, the NMG) both attempted to influence the state social insurance program and also developed a policy of its own to safeguard its professional interests. In doing so, the NMG laid down a set of rules to apply to future health funds, deciding in 1913 to establish the *Maatschappijfondsen*, which were funds it owned and controlled. These funds can be regarded as the cornerstone of the NMG's policy. The NMG also argued that its policy was in the best interests of the people insured, as it would result in better health care and improve national health.³ How the NMG attempted to impose its ideas upon other interested parties - the state, mutual funds and commercial health funds (the so-called *directiefondsen*) - is fairly well known. However, the actual development of the second pillar of the NMG policy, the *Maatschappijfondsen*, is a much less explored field.⁴ The first such

² J. Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London/New York, 2001) 79. I will use the same term for the struggle between doctors and insurance funds in other countries.

³ *De ziekenfondsactie van de NMG* (Haarlem, 1918) 4, claimed that promoting people's health care had always been its idealistic aim. K.P. Companje, "Ziekenzorg en ziekengeld gescheiden verzekeringen, 1908-1940", in Idem (ed.), *Tussen volksverzekering en vrije markt: verzekering van zorg op het snijvlak van sociale verzekering en gezondheidszorg 1880-2006* (Amsterdam, 2008) 225-339, 325.

⁴ T. Kappelhof in a book review in *Bijdragen en Mededelingen betreffende de Geschiedenis der Nederlanden (BMGN)* 121 (2006) 550-552, 551-2.

fund was set up in 1914 and, by 1941, when compulsory health insurance was introduced, the NMG version had been established almost everywhere.⁵

Available sources contain contradictory information on the state of affairs relating to health funds. Moreover, our knowledge of the quantitative development thereof before 1936 is poor. What is known is that in the mid 1920s the National Medical Inspectorate conducted an inquiry into this issue, but the processing of data in respect thereof proved to be time-consuming; the results were only published in 1931. Indeed, it is only since 1936 that the Central Bureau of Statistics (CBS) has published annual figures on health funds. Nevertheless, some data from the NMG's archives and other sources, along with the statistical inquiries referred to above, enable us to reconstruct the overall picture of the development of these funds until the implementation of the National Health Decree in 1941, which is the subject of Section 6. The consequences of the Decree - measured in terms of numbers of those insured - was the final test for doctors' claims that they could bring about a major improvement in health care without state enforcement. However, the fact that most voluntary health funds provided only standard medical care, but not hospital treatment, suggests that significant improvements were impossible without outside assistance.⁶

2. The international perspective

German social insurance laws, which were introduced in the 1880s, were part of the anti-socialist policies of Bismarck, who hoped to bind the working classes to the state and involved the latter in the implementation of sickness laws, which provided sick pay and medical provision to those in need. The relevant board was comprised of two thirds workers and one third employers, and the self-administered workers' fund – the *Hilfskasse* - was also incorporated into this system. As a consequence, since their organizations were banned, the socialists used the sickness funds to mobilize German workers, with the Socialist Party intensifying its efforts to control these funds when the ban was lifted in 1890. For their part, the country's doctors had initially shown little interest in the Bismarck scheme and had not been involved in the project at all. Indeed, the scheme did not seem to bring about any major changes, since the Act

⁵ Except in the big cities, where successful doctors' funds established in the nineteenth century had refused to give up their independence.

⁶ *Maandschrift CBS* 35 (1940) 893-896. In 1940, 188 health funds insuring hospital care covered only 30% of national membership.

covered only nine percent of the population in 1883. Nevertheless, the medical press soon began to publish critical comments on the effects of the law, with the sickness funds being held responsible for the unhappiness of many doctors with their status, income and prospects of making a decent living. In reality, however, much unrest was caused by the exceptional increase in the size of the medical profession, with the number of practising doctors doubling between 1883 and 1905. At the same time, the number of people insured under Bismarck's law also doubled, but still covered less than 20 percent of the population.⁷ Meanwhile, in the same period, medical costs per member increased from 2.1 to 4.7 Marks. The available data does not, therefore, confirm the doctors' complaints that the insurance funds' boards reduced their fees to an absolute minimum in order to improve sick pay. Researchers also challenge the view that sickness funds threatened private practice. Indeed, the opposite seems to be true, with compulsory insurance opening up new markets.⁸ However, to defend themselves against the growing dependency on these sickness funds, German doctors borrowed the instruments of their opponents by establishing a trade union (Hartmannbund 1900) and even calling strikes.

In the UK, meanwhile, the friendly societies were important providers of both sick pay and health care, and often employed a doctor or ran their own infirmaries. However, since the 1880s, the relationship between these funds and the medics had become difficult, with the latter complaining about their fees and the arbitrariness of some of the former when it came to hiring and firing doctors. The result was a battle between the two groups. Moreover, the doctors' suggestion of the imposition of a wage limit on their members was unacceptable to the friendly societies, not only because it implied that loyal members would be excluded, but also because it would introduce class divisions in membership. However, because the medics themselves had to recognize the need for contractual practices, the British Medical Association

⁷ H. Herold-Schmidt, "Ärztliche Interessenvertretung im Kaiserreich 1871-1914", in R. Jütte (ed.) *Geschichte der deutschen Ärzteschaft: organisierte Berufs- und Gesundheitspolitik im 19. and 20. Jahrhundert* (Köln, 1997) 43-95, 83, 88; K. Veraghtert, B. Widdershoven, *Twee eeuwen solidariteit: de Nederlandse, Belgische en Duitse ziekenfondsen tijdens de negentiende en twintigste eeuw* (Amsterdam, 2002) 74.

⁸ Herold-Schmidt, "Ärztliche Interessenvertretung", 86-89.

(BMA) recommended that this should be organized by doctors.⁹ Accordingly, when the UK government announced a plan to introduce the Sickness Benefit Act of 1911, the BMA set out a number of demands about the legislation's content. The majority of which were accepted by the state.¹⁰ However, since doctors were in the minority on insurance fund committees, the BMA continued its opposition to government proposals. Despite this, the Prime Minister at the time, David Lloyd George, persisted. Finally, when he increased the fees promised to them, more doctors became part of the state system and the BMA had to capitulate.¹¹ The separation of medical benefits and sick pay was, however, an important result. Indeed, medical opinion actually had more influence than the NMA had expected given the relatively small number of medical representatives on the boards. Indeed, the 1911 Act actually promoted employment and strengthened doctors' powers, while simultaneously weakening the position of the friendly societies.

In the US, medical provision by mutual societies was late to develop.¹² In the 1870s, so-called lodge practices were mainly restricted to ethnic and immigrant fraternal organizations. However, by the 1890s, more of the bodies providing sick pay also began to introduce medical care. In general, medical remuneration was based on a capitation fee. In the early twentieth century, lodge practice became a hot topic in medical journals, and doctors started to discuss strategies to halt the trend. As elsewhere, they rejected lay control and criticized capitation fees, which were far below their private equivalents, declaring the lodge practice to be demoralizing for the profession.

As competition kept capitation fees under pressure, medical societies asked the different states for tighter certification requirements, resulting in a shrinking supply. The professional bodies also developed policies to discourage colleagues from entering into lodge contracts and threatened to expel disloyal physicians and arranged boycotts. These medical societies even succeeded in persuading hospitals to boycott lodge doctors, which meant that the latter's private patients were denied access to

⁹ D.G. Green, *Working-class Patients and the Medical Establishment. Self-help in Britain from the mid-nineteenth century to 1948* (Aldershot, 1985) 55.

¹⁰ R. Lubove, *The Struggle for Social Security 1900-1935* (Cambridge (Massachusetts), 1968²) 70.

¹¹ Green, *Working-class patients*, 112-114.

¹² D.T. Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967* (Chaphill & London, 2000) ch. 6, 109-129.

these facilities. Meanwhile, the judiciary sanctioned the profession's role as the guardian of professional behaviour.¹³ Most fraternal societies could not, however, afford to increase medical fees to the level doctors demanded, and thus had to reconsider their health policies. As a result, many abandoned the lodge practice and increased sick pay. By the early 1920s, attempts to diversify health provision had been aborted and the medical profession was triumphant. Many ethnic fraternities and the communist International Worker's Order did, however, escape this fate because they were able to rely on ethnic or ideological loyalty.

The fraternal societies' role in health insurance was also challenged by a proposal put forward by intellectual reformists to introduce compulsory sickness benefits, to include both sick pay and health care.¹⁴ The fraternal movement rejected state intervention on principle, as it would damage the dearly held notion of people helping themselves. Furthermore, state insurance was thought to be paternalistic and too bureaucratic. The proposed levels of provision also meant that it was highly unlikely that the fraternal organizations would be able to meet the minimum requirements and act as carriers for state insurance. Moreover, state intervention even threatened the very existence of the movement. The trade unions were divided,¹⁵ with some leaders fearing that state insurance would discourage trade union membership. There was also concern that the proposals would bring the state into workers' households, which was seen as an infringement of individual liberty. Others thought that the trade unions should act for the working classes in general and not just organized workers; compulsory health insurance should benefit all.

Initially, some doctors regarded state intervention as a way to get rid of the hated lodge practice, but ultimately the profession turned against it as well.¹⁶ Even if neither the commercial insurers nor employers had a vested interest in sickness provisions, they claimed that the very idea of state insurance was un-American by

¹³ *Ibidem*, 127.

¹⁴ *Ibidem*, ch. 8, 143-160.

¹⁵ B. Hoffman, *The Wages of Sickness: the Politics of Health Insurance in Progressive America* (Chaphill & London, 2001) ch. 6, 115-136.

¹⁶ According to R.L. Numbers, the doctors organized in the American Medical Association (AMA) "have since 1920 consistently and effectively opposed compulsory health insurance." *Idem* (ed.), *Compulsory Health Insurance: the Continuing American Debate* (Westport & London, 1982) 4. The AMA meeting had voted against state insurance in 1920.

making reference to “the autocratic, imperialistic German system”, which they feared was about to be introduced into US society by stealth. Even after the end of World War I, the German threat was replaced by a still more dangerous Bolshevist version. By 1920, however, all of the proposals based on the model law first published in 1915 had failed. Some authors put the blame for this entirely on the AMA (American Medical Association), but Beatrice Hoffman thinks that the initiators thereof were equally to blame because they had neglected to sell the idea to the intended beneficiaries, thus failing to win their support.¹⁷ Moreover, these instigators of state insurance were surprised by the coalition of their opponents in 1919 and the methods they used to discredit the proposals. State health insurance continues to be a highly controversial topic in the US.

2. Historical characteristics

For a proper understanding of the typically Dutch separation of sick pay and health care and the strong position of doctors in the health insurance market in the Netherlands, we first need to understand how the relationship between doctors¹⁸ and health funds developed over time. By the start of the twentieth century, the Dutch landscape of voluntary health insurance and sickness funds was extremely diverse and fragmented, with considerable regional inequalities. W. Gertelmann analyzed the process of this separation and found that it was almost complete by 1900;¹⁹ new sickness funds usually only provided sick pay from the 1880s onwards. According to the NMG survey of health funds from 1908, only 20 percent provided both health care and sick pay, with these generally being those established before the 1880s and factory funds.²⁰ The survey also highlights the comparatively strong position of doctors in the health insurance market. Indeed, since the 1840s in particular, several

¹⁷ Hoffman, *Wages*, 170.

¹⁸ There were many different qualifications for the practising of medicine before 1865, the main difference being between university trained doctors (*doctores medicinae*) and surgeons. Unless the difference is important, I will use the modern term ‘doctor’.

¹⁹ W. Gertelmann, *Analyse der niederländischen gesetzlichen Krankengeldversicherung unter besonderer Berücksichtigung der Trennung von Bar- und Sachleistungen, der Entwicklung zu Selbstverwaltungsträgern und der Funktionsweise des Systems* (Berlin, 1972) 79-100. His analysis was based on inquiries on sickness provisions made between 1885 and 1912. For a summary of the results, *Idem*, 101.

²⁰ *Rapport omtrent den toestand der ziekenfondsen in Nederland* (Amsterdam, 1901/1908) Vol. 2, 23.

health funds had been established by doctors (and apothecaries), while they were also represented on the boards of other providers. Moreover, many doctors, especially those in the countryside, had private arrangements for their less well off patients. These were known as *doktersfondsen*, and for a weekly subscription fee the patient received medical treatment from the scheme's doctor as well as drugs.²¹ Accordingly, even if Dutch doctors had the same complaints about health insurance as their colleagues elsewhere, their position was actually much stronger. However, for an explanation of this phenomenon, we have to delve further back into the nineteenth century.

Before the 1840s, the insurance of medical provision was, with a few exceptions, only available in the cities in Holland.²² In Rotterdam, the societies that were often set up by doctors did not provide sick pay, while elsewhere mutual societies insured sick pay, medical provision and burial costs. Moreover, some societies were actually profit orientated and their clients could choose which risks they wanted to insure. It is, however, unknown when rural surgeons introduced their subscription system, but by the 1840s such an approach was quite well established in the western provinces and Utrecht. However, the establishment of a *doktersfonds*, which only insured medical costs, was perhaps mainly a matter of self-interest, since it protected the surgeons against default and prevented medical poor law applications.

Around the same time, university trained doctors in the big cities in Holland began to worry about their prospects because their numbers were growing. Competition between doctors and surgeons likewise increased and was no longer limited to urban areas. As medicine had become more scientific, doctors argued that every such professional required science based training, a consequence of which should be a shrinking supply. However, despite this, it took more than 25 years before medical training became exclusively academic (1865) and university trained doctors achieved a monopoly for practising medicine.

²¹ They are comparable with English doctors or family clubs. Green, *Working-class Patients*, 11.

²² L. van der Valk, "De ziekenfondskwestie rond 1840: een Amsterdams of een nationaal probleem?", *Gewina* 26 (2003) 22-39, 28. According to the national inquiry in the 1840s, the majority of those insured lived in the cities of Amsterdam, Rotterdam and The Hague. The provinces of North and South Holland overlap the traditional territory of the province of Holland. I will use the term Holland when both provinces are referred to as opposed to the other provinces.

In the meantime, the profession had to solve its own problems. Doctors complained about remuneration, the need to compete for contracts, lay control and the admission of people to funds who could afford private fees. They were particularly critical of the *directiefondsen*, because these aimed to make a profit at the expense of medical personnel and patients alike. Contractual practice was regarded as threatening the dignity of the profession and encouraging unethical behaviour.²³ Doctors in Amsterdam thus took the lead and asked for state intervention. When the state did not respond positively, however, these doctors simply founded their own health fund, the AZA (General Health Fund of Amsterdam). The AZA was not the first doctors' fund to be established but, as the most successful, it became an example for other cities to follow. Indeed, in reaction to the growth of the *Directiefondsen*, more doctors in Holland than ever before entered the health insurance market. Their goal of standardizing training and the desire to set out rules on professional behaviour encouraged the establishment of professional organizations, at first locally and, since 1849, also nationally with the formation of the NMG.

From the 1850s onwards, the economic tide turned and rapid urbanization began to take place in the 1870s, although the standard of living remained poor. Gradually, however, more people could either afford health insurance or were required to join a health fund because they no longer qualified for poor law medical assistance. In these circumstances, low capitation fees were caused by poverty, not by growing competition, as had been the case in the UK. Indeed, the opposite was the case, and the number of doctors began to steadily decline after the introduction of medical laws in 1865, with the successful formation of health funds depending more than ever before on the willingness of doctors to co-operate. The mutual aid provided by the emerging trade organizations was usually restricted to sick pay and burial costs. However, since the 1880s, workers' funds were also established in some cities to alleviate the disadvantages of the health funds in place in these locations. These workers believed that contract patients received poorer care, and the new funds, therefore, introduced a fee for service payment. This unfortunately proved to be too costly, because both professionals and members took advantage. In general, however, the medical profession refused to serve workers' funds because, just as in Germany, they resented the consequential control exerted by the lower classes. As a result, it

²³ *Ibidem*, 28, Table I.

was only in the big cities where there was never a shortage of doctors that these health funds were able to succeed. Indeed, it proved to be difficult to discourage young doctors in these locations from joining workers' funds because they preferred living in the city and needed a practice to get them started on their career. Elsewhere, however, a combination of applying professional pressure and ostracising newcomers was often effective.

Social provision by industrial companies, which included medical care, was slow to develop. However, when these new businesses did set up funds for sick pay, and sometimes medical provision, workers were often compelled to join. Yet the medical cover provided by these company funds was a poor option, since entitlement thereto was usually linked to sick pay, which was only given for 13 weeks.²⁴ Moreover, by then, the general health funds also covered a member's family as well.

By the end of the nineteenth century, health provision was more widespread, but the traditional regional pattern was still strong. In approximately 1900, members of health funds amounted to 27 percent of the population in the western provinces compared to only 0.5 percent in the southern provinces.²⁵ Moreover, in western cities, club practice often outnumbered private practice. With rising standards of living, doctors began to ask for higher capitation fees and, depending on local circumstances, relations between them and the health funds became more strained. In some districts, doctors united to prevent the founding of new health funds and the medical press once again commented that such provision was a threat to doctors' dignity and independence. Contemporary documents one-sidedly stress so-called misuses of these funds and the negative effects thereof for doctors in particular. In reality, however, many doctors either ran their own or were represented on the boards of mutual and charitable funds. Indeed, in both speech and print, the profession rejected the *directiefondsen*, even though these often provided individual doctors with a good living. The doctors who had always feared the potential power of the health funds in an overcrowded medical market believed that it was degrading to serve a

²⁴ Directie van den Arbeid, *Onderzoek naar de in Nederland bestaande fondsen tot ondersteuning van arbeiders bij ziekte* (publ. nr 8, 's-Gravenhage, 1912), 21.25 percent of company funds provided medical provision, covering 40 percent of the workers insured thereby.

²⁵ H. van der Velden, "The Dutch Health Services before Compulsory Health Insurance, 1900-1941", *Social history of medicine* (1996) 49-68, 59.

workers' health fund. Accordingly, as in Germany, they decided to adopt the methods of their antagonists to defend class interests.²⁶

3. Social insurance legislation and health care

In 1901, the first compulsory social insurance law was passed by the Dutch parliament in the form of the Workmen's Compensation Act, which offered both health provision and an allowance. Indeed, under the Act, care for injured workers improved considerably and more employees were able to receive medical treatment over a longer period of time. Although doctors had not been involved in the legislative process, they were nevertheless quite happy with the fees on offer, since they were able to treat more patients for higher sums than either a worker or his health fund could afford. When the Act was discussed in parliament, however, there was some regret that priority had not been given to sickness benefits.

In his government statement, the new Prime Minister, Abraham Kuyper (1901-1905), announced an ambitious social insurance program covering invalidity and old age and sick pay and medical care. To get an idea of why it took so long before any of this coverage was introduced, it is important to be aware of the fact that the country was ruled by the right and the left alternately. Indeed, even after the relevant bills were passed in 1913, another change of government meant that the discussions began all over again.²⁷

A leading principle in Dutch social insurance legislation before 1940 was the notion that the insurance had to pay its own way and be governed by the same actuarial principles as its private counterpart. However, because the state made social insurance compulsory, it was consequently required to contribute towards the administrative costs thereof, with the only exception being old age pensions. This was because the state had failed to deal with the issue of provision for old age, meaning that it had to correct this omission and pay the deficit for any worker who was too old to contribute to a minimum pension. State supported health insurance was often

²⁶ Herold-Schmidt, "Ärztliche Interessenvertretung", 90. L. Heijermans, "Het ontwerp ziektewet Treub", *De Socialistische Gids* 1 (1916), 864-881, 873-4.

²⁷ In comparative studies on the introduction of social security, 1913 is mistakenly regarded as the start of compulsory sick pay and invalidity pensions.

discussed, but was rejected time and again for budgetary reasons.²⁸ The right opposed state contributions in principle, because only (part of) the working classes were to be included in the compulsory system. According to the left (social liberals and socialists), however, social insurance was in the public interest and state contributions were therefore justified. Furthermore, the denominational parties regarded state subsidies as state assistance for the poor, which was against Dutch poor law principles and was thought to have a negative impact on the notion of self-help. These denominational parties, thus, developed the idea of 'postponed' wages, whereby workers had to earn enough to live on, including during periods of illness and old age; with this approach, the role of the state was simply to ensure that workers got what they were entitled to. After the introduction of universal suffrage in 1917 (with women being included in 1922), the denominational parties came to dominate Dutch political life.

The NMG board was, however, concerned about Kuyper's program, because it bound sick pay and medical care together. Accordingly, the response was immediate and the board met with the prime minister in January 1902.²⁹ Despite this meeting, the NMG's concerns escalated in 1903 when a newspaper reported on the proposed sickness scheme,³⁰ creating the (false) impression that doctors would not be consulted at all. This was incorrect, but the NMG's later confidential submissions about the proposals had little effect. When Kuyper presented his bill in 1904, neither the combination of health provision with sick pay, nor the proposed administration thereof had been altered as the NMG had recommended.³¹ Indeed, the proposals for health care were more ambitious than those in operation elsewhere, because wives and

²⁸ Companje, D. Rigter, "Ontwerp der wet regelende de ziekteverzorging", in Companje, *Volksverzekering*, 399-476, 460.

²⁹ National Archives, The Hague (hereafter, NA), *Arbeidersverzekeringen*, entry 2.15.08, inv. no. 600. The NMG letter of 30 May 1908 to the minister refers to this interview. The inventory returned by the NMG must have been collected in 1901 or 1902, not 1908.

³⁰ [C.W.A.] Van Uden, "Het ziekenfonds van niet tot iets in bestuur en wetgeving" ch. XXI, *Ziekenfondsvragen* 11 (1960) 56. The feature was published in the *Nieuwe Rotterdamsche Courant*, 17 October 1903. It was only on the 28th that the draft was sent to the NMG.

³¹ Companje, R.A.A. Vonk, "Ziektekostenverzekeringen en wettelijk geregelde arbeidsverhoudingen tot 1941", in Companje, *Volksverzekering*, 173-476. This study analyses the legislative process in great detail and also pays attention to internal differences amongst doctors, a subject I have deliberately put to one side.

children and resident next of kin (e.g. the elderly) were to be covered as well. However, these bills were never discussed in parliament because the coalition lost its majority in the elections of 1905.

The new bill in 1907 did not contain any novel elements and did not reassure the doctors, who believed that their status as independent professionals was under threat and feared that they would become as dependent on the sickness funds as their German colleagues were said to be. Dutch doctors were especially worried about the proposals to provide both sick pay and health care. They had always favoured separate funds for these provisions and now state intervention threatened to ignore these concerns. In the doctors' view, the proposed bills were turning the clock back and they feared that improvements in sick pay would have a negative effect on their fees. The professionals were also kept in the dark because the bills said nothing about future fees, meaning that it was impossible to win their support with an offer of initially attractive amounts, as had happened under the Workmen's Compensation Act. Indeed, in the UK, the level of fees on offer had proved to be instrumental in winning the co-operation of the medical profession there.

In turn, the NMG had also made mistakes in its efforts to influence the decision-making process. In 1906 its critical comments had been submitted far too late to have any impact,³² and the body, therefore, decided to petition parliament.³³ In doing so they argued that instead of improving national health, the proposals would actually make matters worse. Only regular workers would be entitled to benefit, and this was provided they were in good health. After 180 days entitlements expired even if medical attention was still required. Moreover, if regular workers were treated differently, it would become more difficult to insure both the self-employed with limited means and day labourers. Furthermore, the NMG stressed, the proposals would not end current abuses, but would also create new problems as the German experience had demonstrated. Moreover, by promoting private enterprise, the bill would encourage fragmentation and the establishment of company, denominational and trade union funds. The doctors, therefore, pleaded the case of regional funds and

³² On 12th February 1906 the minister had a meeting with the NMG board and decided on 1 April as the deadline for comments. Despite this, it was only in June that the NMG submitted its observations on the bill.

³³ *Adres over het ontwerp van Wet. Ingediend bij de Tweede Kamer der Staten Generaal door het hoofdbestuur van de NMG* (Amsterdam, 1907).

panel practices, provided that they were also represented on the relevant boards. It is clear that the state's motivation for denying doctors and apothecaries any management influence increased the latter's distrust of the former. The professionals were supposed to be "like civil servants and therefore subordinate to the fund."³⁴ They, in turn, argued that "the State could trust the medical profession for future improvements in the health fund system".³⁵ The bill of 1907 was, however, like its predecessor, withdrawn after a change in government, but relations between doctors and the state had undoubtedly been damaged.³⁶

A.S. Talma, who was a minister from 1908-1913, then made the decision to disentangle sick pay and health insurance (in 1910). Threats to boycott compulsory health insurance were not Talma's main concern; even if the number of doctors was increasing, the countryside still had shortages. In his view, however, the state could only guarantee medical treatment if there was a medical civil service.³⁷ Such statements were not particularly helpful when it came to restoring good relations with doctors. Yet, the decision did bring about a temporary reprieve, which enabled the NMG to try to align conditions in the health insurance market with professional interests. Nevertheless, Talma's sickness benefit bill did still set out rules for the future approval of health funds which did not fit in with the doctors' ideas.

Since lobbying had had little impact, the NMG began to develop its own health fund policy because internal pressure to pay more attention to the interests of family doctors remained high.³⁸ The NMG's investigation into the circumstances of health funds produced important results. Its report, published in 1908, laid down some principles for the relationship between doctors and health funds and proposed model rules. In 1912, the general assembly of the NMG decided on its policy towards new health funds, the content of which demanded separate administration for sick pay and

³⁴ *Adres*, 62.

³⁵ *Medisch Weekblad* 20 (1913/14) 33 "dat de Staat ook de verdere ontwikkeling van het Ziekenfondswezen met gerustheid kan overlaten aan de geneesheeren zelf."

³⁶ Relations remained strained until the early 1920s. In 1926 the NMG honoured P.J.M. Aalberse, because he had shown respect and improved relations between the NMG and the bureaucracy. *Geneeskundige Gids* 4 (1926) 694-695.

³⁷ N.E.H. van Esveld, "De zilveren ziekteverzekering", *Sociaal Maandblad Arbeid* (1955) 140-149, 142.

³⁸ The NMG had already decided in 1902 to favour local collective contracts in order to eliminate competition between doctors.

health provision, a free choice of doctor, equal representation of doctors on funds' boards and the introduction of a wage limit for fund membership. New funds had to meet these requirements or face the penalty of a boycott.³⁹ Furthermore, NMG-members ignoring the guidelines risked expulsion and a heavy fine, if necessary to be enforced by way of legal action. Finally, in 1913, the last piece of the jigsaw was put in place with the decision to establish the *Maatschappijfondsen*.⁴⁰ The doctors were able to take such a firm stand as they (and the apothecaries) had a legal monopoly on health services and because most of them had joined the NMG.

Doctors felt obliged to enter the battle on this issue because their interests were being ignored. They had always served the health funds at fairly low capitation fees, but only for philanthropic reasons, and believed that it would be unfair if this became institutionalized in social insurance legislation. In order to safeguard its position in the long-term, the profession considered it to be imperative to get a majority on the insurance boards. Accordingly, in the ensuing discourse the negative effects of dependency on the boards and the importance of philanthropic behaviour were underlined. In reality, these actions were not altruistic and many non-medics thought the attitude of the doctors was arrogant. They seemed to think that health funds existed for their benefit and this caused much annoyance and intensified the controversy. The NMG focussed its 'battle' on mutual and workers' funds, because the state was proposing that only not-for-profit organizations would be admitted under the intended system.⁴¹ The *directiefondsen*, which were earlier seen as a major threat, were therefore no longer the main enemy.

³⁹ H.F. van der Velden, *Financiële toegankelijkheid tot gezondheidszorg in Nederland, 1850-1940* (Rotterdam, 1993) 59-72; 200-205; Idem, "Dutch health services", 57-62; Companje, *Over artsen en verzekeraars: een historische studie naar de factoren, die de relatie ziekenfondsen-artsen vanaf 1827 op landelijk en regionaal niveau hebben beïnvloed* (n.p., 1997) 117-140.

⁴⁰ A *Maatschappijfonds* could only be established by the majority of a branch. Without a majority the fund could, however, be authorized as a 'special' fund.

In a comment on the bill H. Burger had already argued in 1905 that doctors had to establish health funds in order to prevent "the foundation of unwanted insurance bodies". H. Burger, "Het ontwerp-ziekteverzekeringwet", *NTvG (Nederlandsch Tijdschrift voor Geneeskunde)* 41 (1905) vol. I, 570. However, Burger also recommended co-operation with trade unions, employers and apothecaries to prevent misunderstandings about doctors' motives.

⁴¹ Companje, 'Ziekenzorg en ziekengeld', 271.

In reaction to the NMG's policy, some mutual societies came together in the *Federation* (1913) to defend their interests and promote the notion of self-help.⁴² Since the majority of doctors had joined the NMG, it was almost impossible to ignore its demands. Moreover, mutual funds were often quite small, and it thus proved to be difficult to collect the necessary means to establish new mutual funds and resist boycotts. Relations worsened when some of the larger mutual funds tried to become self-supporting by engaging salaried doctors and setting up pharmacies, moves which the professional organizations (NMG and NMP) fiercely opposed.

Initially, the trade unions had kept out of the debate, because they considered compulsory sick pay to be more important.⁴³ Indeed, in 1915, they rejected attempts by the Federation to join forces against the NMG. Likewise, many mutual funds also declined to work in close co-operation with the trade unions because they feared politicization.⁴⁴ However, for a number of reasons, the attitude of the labour movement began to change in the early 1920s. During World War I, the trade unions had implemented unemployment insurance in close co-operation with employers and the state. Their involvement as carrier organizations of social insurance also seemed to have paid off in terms of a rise in membership numbers. Furthermore, the Dutch consultation structure began to take shape around this time, with the Minister of Labour, P.J.M. Aalberse, setting up the Supreme Council of Labour in 1919, which was an advisory body consisting of 13 representatives from each of the employers' organizations, trade unions and specialists, along with six government officials. One of the Council's sub-committees dealt with the issue of social insurance policy. These new circumstances were particularly important when it came to ideas on the executive structure of the Sickness Benefit Act. The socialist union (NVV, Dutch league of trade unions) developed its own proposals, however, and no longer favoured the implementation of sickness benefits by the state. E. Kupers argued that the organizing power of both employers and workers had increased considerably, meaning that they

⁴² In full, the *National federation for the protection of health funds*. In 1937, it was reconstituted and continued its existence as the *Central Federation for Mutual Health Funds* (CBOZ).

⁴³ Moreover, before World War I, the 'new' socialist trade union confined itself primarily to the issue of labour conditions; social insurances were left to the political socialist organization, the Social Democratic Labour Party (SDAP).

⁴⁴ *Het Ziekenfonds* (1926) 4.

could, therefore, be put in charge.⁴⁵ When it came to the executive structure of sickness benefits, the NVV had moved closer to the ideas of the denominational unions, but, unlike the Catholic union, did not favour trade union health funds.

In 1916, the Dutch episcopacy decided that the trade unions were the obvious bodies to provide health insurance.⁴⁶ Indeed, in the 1920s, the foundation of health funds became an important topic for Catholic workers.⁴⁷ As Catholic doctrine did not accept family planning and demanded medical behaviour in line with its moral code, the Catholic funds could not agree to the notion of the free choice of doctors demanded by the NMG.⁴⁸ The NMG, in turn, rejected the idea of denominational division on principle, and opposed the notion of health provision by labour organizations. Accordingly, for many years, the NMG was not prepared to enter into contracts with Catholic funds or their umbrella association, which was established in 1932. Even after the relationship between the NMG and the Catholic organizations had improved, it continued to be impossible to normalize matters. This was because the branches in the south of the country refused to co-operate,⁴⁹ which even Festen, the author of a history of the NMG, recognized was inspired by their deeply felt aversion to trade union health funds.⁵⁰

The NVV, on the other hand, argued in favour of compulsory health insurance implemented by regional bodies, since it would be more cost effective and result in better health care.⁵¹ In its view, the establishment of trade union health funds was counterproductive. Events of the time did, however, necessitate change. Time and again, the medical profession displayed its profound distrust of the labour movement. In fact, the NMG's goal of dominating the health insurance market brought about

⁴⁵ E. Kupers, 'De wet op de ziekenverzorging', *Sociale Voorzorg* (1920) 729-782. The *Socialistische Gids* (1920) thought the move was surprising.

⁴⁶ *25 Jaren bond van Rooms-katholieke ziekenfondsen* (n.p., n.d.[1957]) 230; 242.

⁴⁷ In 1925, the Catholic labour organizations were united in a national trade union, the RKWV.

⁴⁸ *25 Jaren bond*, 243-244.

⁴⁹ *Idem*, 247-255; J. Paulus, *Vijftig jaar Centraal Ziekenfonds in het bisdom Roermond* (Sittard, 1976) 22; C.W.A. van Uden, *Gezondheidszorg in eigen hand: vijftwintig jaar geschiedenis van het Centraal Ziekenfonds in het Bisdom Den Bosch, 1930-1955* ('s-Hertogenbosch, 1955) 138-142. It took until 1940 before the agreement from 1937 resulted in the first contract.

⁵⁰ H. Festen, *125 Jaar geneeskunst en maatschappij. Geschiedenis van de Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst* (Utrecht, 1974) 369.

⁵¹ Kupers, 'Ziekenverzorging', 743-4.

what it had feared the most, a coalition between its opponents; in 1929, the socialist NVV, the Christian Union (CNV) and the *Federation* joined forces.⁵²

Even if the NMG's guidelines were only intended to apply to new health funds, they were nonetheless forced upon other funds as well. Doctors tried to convince boards/owners "that it is only in their own interest to accept our will".⁵³ Agitation by doctors was even able to force funds to close down, but they were not always successful in doing so. Indeed, in 1915, the attempt to liquidate the *Eendracht en Vlijt* in Brielle and transfer its members to a *Maatschappijfonds* failed because some doctors refused to agree. Yet boycotts by doctors evoked much opposition and they were accused of failing in their duty to care for patients. Many regarded boycotting as another move in the attempt to monopolize health insurance. Since feelings were running so high, the NMG published a pamphlet to explain its position.⁵⁴ It did not, however, abandon the notion of a boycott as a weapon which could force a fund to close down, with this happening in 1929 to the traditional sickness and burial society in Hellevoetsluis when its doctor refused to fulfil his contract and no replacement could be found because the NMG supported its medic.⁵⁵

The collective contract policy proved to have far-reaching consequences, and became an important instrument with which to impose the NMG's conditions on the health funds which were not included in the 1912 decision. In reality, though, a collective contract brought an end to the conflict between doctors and health funds in many cities.⁵⁶ The introduction of wage limits excluded the middle classes and, as a result, health insurance for this group was developed, often being set up by

⁵² Companje, *Convergerende belangen: belangenbehartiging van de zorgverzekeraars in historisch perspectief, 1900-2001* (Zeist, 2001) 62-65. The co-operation ended in 1934 when the unions and the NMG agreed on equal representation. *Het Ziekenfonds* (1934) no 7/8. The NMG couldn't force the branches to accept the agreement and the truce soon came to an end.

⁵³ P.A. de Wilde, "Het ziekenfondswezen te Amsterdam in de jaren 1900 tot 1932", *NTvG* 76 (1932) vol. II, 733-750, 734.

⁵⁴ *De ziekenfondsactie van de NMG* (Haarlem, 1918). Published in response to the allegations made by the socialist member of parliament, J.H. Schaper, in *Dokters-tyrannie: aan de Nederlandsche arbeiders* (Amsterdam, 1914).

⁵⁵ *Het Ziekenfonds* 5 (1929) 2-3.

⁵⁶ De Wilde, "Rechtspositie der artsen bij de ziekenfondsen gedurende de laatste 25 jaar", in *Gedenkschrift bij het honderd-jarig bestaan van den Geneeskundige Kring Amsterdam* (Amsterdam, 1948) 162-65, 164.

commercial insurers. Such businesses did not provide insurance in kind, but instead remitted an agreed sum of money for a doctor's visits and drugs. After some debate, in 1918, the NMG decided that these funds should be free to develop because they did not affect the relationship between doctor and patient.⁵⁷ For commercial insurers this market was far more appealing than the health fund market regulated by collective contracts. Moreover, this target group was also more likely to be open to buying other insurance as well.

By 1930, the NMG's goals had largely been achieved, even if doctors' complaints about 'misuse' suggest otherwise. The Sickness Benefit Act of 1929 referred to future health fund legislation, but was silent about its content.⁵⁸ However, even if the *Federation* had rejected the idea of the free choice of doctors on principle and some mutual funds had employed their own doctors, the panel practice had become widely accepted. Capitation fees had also improved and were subjected to periodic negotiations. Collective contracts likewise set a kind of national standard for health care provision, which meant that there were some improvements. However, in general, rising contributions were, for the most part, absorbed by rising remuneration rates.⁵⁹ The introduction and rigorous implementation of a wage limit caused much unrest. The mutual funds thought that it was unfair to expel loyal members only because their income had improved, and 65 of these bodies still did not have a wage limit in 1936. By the end of the 1920s, however, most funds did apply some kind of wage cap, even if differences of opinion on the level thereof could run high.⁶⁰ The composition of the boards also continued to be an important source of conflict. The doctors' views on equal representation were also rather peculiar, because apothecaries were regarded as being in a category of their own, which meant that members got only a third of the available seats on a board. The mutual funds recognized only two

⁵⁷ The debate continued, but these companies were never boycotted. H.L. Kunneman, *De ziektekostenverzekering* (Zeist, 1951) 94-116.

⁵⁸ The Act of 1929 was so different that it can hardly be regarded as an amendment to the original 1913 bill. Van Esveld regards the Act as Talma-law. According to Slotemaker de Bruïne, who finally enacted the law, the amendments to the original bill had resulted in a new law. Van Esveld, "De zilveren ziekteverzekering", 141; J.A. Berger, "Welke organen zullen bij unificatie met de uitvoering worden belast?", *De Vakbeweging* 10 (1930) 205-216, 208.

⁵⁹ Van der Velden, "Dutch Health Services", 61-62.

⁶⁰ CBS, *Overzicht*, 20-24 gives an overview of wage limits. In 1936, 23 percent of the mutual funds did not apply a wage limit.

partners, namely suppliers of services and consumers, and believed that the former tried to hijack the funds. The mutual funds were, however, increasingly ready to accept a doctor's representative on their boards, but only in districts without a *Maatschappijfonds*.⁶¹ In the early 1930s the NMG-board once again vetoed the notion of equal representation by consumers and set in train another "battle of the clubs".⁶² By then the NMG was extremely strong, and in 1931 only 97 of the 2,137 health fund doctors were not registered as NMG members.⁶³ The doctors were convinced that they were right and demanded no less than total surrender. Indeed, because the Talma laws were postponed and the dispute about the executive structure was reopened, the state had enabled the NMG to develop its health fund policy in full.⁶⁴

4. *The development of the Maatschappijfondsen*

The decisions made about the *Maatschappijfondsen* were an essential complement to the boycotting of the funds that refused to accept the NMG's conditions. Only when they could refer patients to another (preferably a doctor's) fund was a boycott not depicted as a strike. Although the general meeting of 1913 had supported the idea of *Maatschappijfondsen*, the results were initially rather disappointing. At first the plan seemed to have taken off. According to contemporary sources, 32 branches submitted proposed rules for the founding of a *Maatschappijfonds* in 1914 and 1915, but the actual foundation of the funds often either failed, or the rules did not meet the NMG's requirements.⁶⁵ Accordingly, by 1924, only 23 *Maatschappijfondsen* and 10 'special' health funds had been established.⁶⁶

⁶¹ Festen, *125 Jaar*, 374; *Het Ziekenfonds* (1932) no. 1/2, 3.

⁶² *Idem*, 6-7.

⁶³ F.S. Noordhoff, "Het NVV en het ziekenfondswezen", *De Vakbeweging* 13 (1933) 134.

⁶⁴ Talma couldn't reconcile the opponents of state implementation, namely big business, in the first place. His own party favoured societal organization over state intervention, but was also convinced that compulsory insurance required sufficient control to minimise the risks for the state. He therefore created a system in which the interested parties – state, employers and labour – had an important role.

⁶⁵ According to the CBS, *Overzicht van den omvang van het ziekenfondswezen in Nederland op 1 januari 1936* (s-Gravenhage, 1937) 19 were founded in 1914 and 1915. The enquiry of the Public Health Inspectorate from 1926 also registered too many (48). This enquiry was published in *Verslagen en mededelingen betreffende de volksgezondheid* (s-Gravenhage, 1931) 1565-1572. NA, NMG Archief 1849-1942, entry 2.19.053.01, inv. no. 181, 5 June 1935 W.J.M. Drooglever Fortuyn to Chr. Eggink.

Van Lieburg identifies the turning point for the *Maatschappijfondsen* as the mid 1920s, due to the development of health funds by trade unions.⁶⁷ However, this observation only holds true for Catholic regions, where the doctors' response to union activities was the *Maatschappijfondsen*. Elsewhere, the enactment of the Sickness Benefit Act and the 1929 agreement between the unions and the *Federation* were conclusive, with the number of *Maatschappijfondsen* nearly doubling between 1929 and 1941. The *Maatschappijfondsen* were regional, and, compared to the mutual funds, fairly large organizations (Appendix, Table III). So, why did the initial enthusiasm fade so quickly, and why was this policy more successful in the 1930s, when the economy was hit by recession and unemployment?

The delay in introducing the Talma laws reduced the sense of urgency, but this was not the only reason. Internal differences (between family doctors and specialists, city and country doctors and between the NMG board and its committee for health funds) led to endless debates.⁶⁸ Furthermore, the NMG's collective contract policy resolved the most pressing problems in the cities, where during World War I inflationary pressures had forced the funds to readjust capitation fees.⁶⁹ Moreover, as many of their demands were met, doctors were no longer interested in the *Maatschappijfondsen*. Indeed, in many regions there were no health funds at all. Numerous doctors also refused to co-operate because they preferred private practice.⁷⁰ Indeed, in the countryside, the actual founding of an approved fund often failed because doctors did not want to give up their private *doktersfondsen*. Overall, the doctors did seem to have been rather reluctant to unite under the NMG, instead preferring their independence. Indeed, in the big cities, successful health funds set up

Eggink counted several NMG-funds which were not yet approved by the NMG. Moreover, a sub-branch was sometimes registered or counted as an independent fund.

⁶⁶ *Gedenkboek der Nederlandsche Maatschappij tot bevordering der Geneeskunst, 1849-1924* (Amsterdam, 1924) 180, in 1924 21. H.H. van Eyk, H. Pinkhof (eds), *Artsenboekje 1921* (NMG, 1921) 169-170 registered 27 *Maatschappijfondsen* and nine special funds.

⁶⁷ M.J. van Lieburg, *Negentig jaar OZ zorgverzekeringen: een rondgang door de medische geschiedenis van de regio West-Brabant, Zeeuws-Vlaanderen en de Zuid-Hollandse eilanden* (Rotterdam, 2005) 45.

⁶⁸ Festen, *125 Jaar*, 240 ff, 370 ff.

⁶⁹ Van der Velden, "Dutch health services", 60-61.

⁷⁰ M.A. Jansma, "Ontstaan en positie van den huisarts gedurende het bestaan der Maatschappij", in *Gedenkboek ter gelegenheid van het honderd-jarig bestaan* (Amsterdam, n.d. [1949]) 212-225, 218.

by doctors in the nineteenth century had nothing to gain by changing their status to *Maatschappijfonds*. In this respect it is illustrative that in 1925 the *Algemeen Ziekenfonds Rotterdam* even reconsidered its position and regained its independence.⁷¹ Conditions were different in smaller cities, however, where recently founded doctors' funds were more inclined to turn into a *Maatschappijfonds*. Elsewhere, the (imminent) foundation of a new health fund was decisive.

In the countryside, and in the southern and north-eastern provinces in particular, the NMG's goal of setting national standards for contributions, fees and a wage limit did not suit rural conditions.⁷² In reality, the urban based wage limit threatened private practice since, with the exception of the local elite, almost the entire population would become eligible. The NMG thus had to quickly recognise that local conditions demanded different criteria, but even this did not solve the problem. *Doktersfondsen* offered only a few services and used to be cheaper. Indeed, agricultural workers could not afford to make higher contributions,⁷³ while in many poor districts the doctor preferred to continue with his private *doktersfonds* and earn some extra money instead of increasing the number of his poor law patients.

For approval as a *Maatschappijfonds*, a fund had to meet the criteria set out by the NMG. The NMG did not, however, offer much in return, apart from (moral) support. Initially, many funds were simply a collection of *doktersfondsen*, and the medic still had to collect the contributions thereto. Although patients had to pay more to a *Maatschappijfond*, they were also insured for specialist care and, later on, dental work. However, apart from the transfer to the central organization of only small amounts for this specialist care, nothing changed. Indeed, in Alkmaar, which had the first *Maatschappijfonds*, it was only the city which earmarked some money as a reserve.⁷⁴ Local conditions did, however, prove to be more divergent than the NMG had assumed, not only between regions, but also between cities and nearby villages. Consequently, even the early *Maatschappijfondsen* found it difficult to comply with the rules of the NMG's model health fund.

⁷¹ NTVG 70 (1926) 350. The change-over had taken place in 1914.

⁷² A national wage limit was introduced in 1912, but it was soon abandoned. NA, Volksgezondheid 1918-1950, entry 2.15.37, inv. no. 1338, minutes. Even inside the *Maatschappijfondsen*, different income criteria were used according to local economic conditions.

⁷³ P. Muntendam, *60 Jaar in de gezondheidszorg* (Assen/Maastricht, 1984) 27-28.

⁷⁴ R.G.C. Schröder, "12½ jaar afdelingsziekenfonds praktijk", NTVG (1926) 1335-1341.

There are, however, some indications that the NMG, or rather its sub-committee on health funds, did try to improve its services.⁷⁵ In the 1920s, it even considered entering into close co-operation with industrial life insurers, who were interested in collecting contributions because doing so provided plenty of opportunities to sell life insurance products.⁷⁶ Nevertheless, the general meeting of 1926 vetoed this plan, the content of which was in sharp contrast to traditional attitudes towards commercial insurers. Ultimately, the NMG, therefore, established its own administrative organization known as the *Cavined*. Moreover, for the first time, it also arranged meetings for both the governors and managers of its funds, with the aim being to create a platform for debate and develop a corporate identity.⁷⁷ The funds were, however, suspicious of the NMG's real motives and feared a violation of their autonomy. In 1928, the NMG-board turned down proposals by its sub-committee on health funds to unite the funds in one body. By the early 1930s, however, the local funds had gradually come to recognise the need for closer co-operation against the umbrella organizations of the Catholic and mutual funds, but the NMG-board again opposed any such concentration scheme.⁷⁸

In general, the founding of *Maatschappijfondsen* was motivated by competition, and prior to 1920 they were primarily established in Holland, where ample opportunities to take out health insurance already existed. In this region, the *directiefondsen* were expanding into the countryside, meaning that rural doctors were ready to participate therein. Many of the early *Maatschappijfondsen* originated from either a conflict between doctors and local health fund(s) or the introduction of a new health fund, particularly a workers' version. Indeed, the provinces with comparatively few health funds (other than Groningen) were left behind, and by 1929 the *NMG-funds* only insured 490,000 people, which was not an impressive figure.

5. *The battlefield in the thirties*

⁷⁵ The situation was more complicated because the NMG board and its committee had differing opinions. Companje, "Ziekenzorg en ziekengeld", 319-323.

⁷⁶ *Geneeskundige Gids* 4 (1926) 692-693; *Het Ziekenfonds* (1925) nos 5 and 7, (1926) no. 6; (1929) no. 11.

⁷⁷ "Vergadering van de vertegenwoordigers van Maatschappijfondsen", *NTvG* (1926) 359; *Geneeskundige Gids* 4 (1926) 695-697.

⁷⁸ Companje, *Convergerende belangen*, 72-76.

The clause in the Sickness Benefit Act which made sick pay conditional upon health fund membership was postponed until rules on approved health funds were introduced. In anticipation of this legislation, the unions promoted - in co-operation with the Federation - mutual health funds. In fact, every interested party intensified their recruitment efforts and the umbrella organizations attempted to establish new branches. Once again, the NMG favoured the strict application of its conditions, of which the composition of the board was the most controversial. Doctors also harboured a deeply felt distrust of trade unions, which were suspected of having political motives. The NMG even presented this argument in top-level talks with the Department of Health. In the former's view, political motives led to more mutual funds and more power for the other party to over-rule doctors. The NMG even referred to the example of Germany in the past.⁷⁹ It is clear that ideological differences became more pronounced once the Federation and the trade unions joined forces. Furthermore, the growing number of doctors kept the pressure on,⁸⁰ with the NMG encouraging its members, and rural doctors in particular, to establish as many *Maatschappijfondsen* as possible.⁸¹ As a consequence, between 1929 and 1934, 27 new *Maatschappijfondsen* were established and membership doubled.⁸² As the policy to boycott health funds had earlier been met with great disapproval, a new tactic was now applied. Unless a new fund accepted the NMG's conditions, doctors refused to treat patients for a capitation fee, but instead claimed full rates and sometimes charged for unnecessary treatments.⁸³ As a result, new mutual and workers' funds got into serious financial difficulty, causing the *Federation* to seek mediation by way of the state authorities.⁸⁴

In the meantime, the immediate future looked bleak. With rising unemployment, an increasing number of people could no longer afford membership of

⁷⁹ NA, Geneeskundige Hoofdinspectie 1902-1952, entry 2.15.38 inv. no. 253, the minutes are undated.

⁸⁰ *Het Ziekenfonds* (1934) no. 6, 2. In 1920, there was one doctor for 4,900 inhabitants; in 1933, there was one for 2,900.

⁸¹ Annual meeting 1929. Quoted in *Het Ziekenfonds* (1929) no. 10.

⁸² NA, NMG archief, inv. no. 175, meeting of *Maatschappijfondsen*, 30 March 1935. In 1929, 490,000 people; in 1933, 922,000; in October 1934, 1,055,523; and in 1936, according to the CBS statistics, 1,096,000.

⁸³ *Het Ziekenfonds* often published examples, e.g. in (1932) no 5, 2; (1933) no 12, 4-8.

⁸⁴ The *Federation* published the letters in its periodical *Het Ziekenfonds*, see e.g. *Idem* (1935) no. 5.

a fund and had to apply for poor law medical assistance instead. These losses were, however, at least partially compensated for by new members, who became eligible as their income fell.⁸⁵ Any attempt by local authorities to introduce a discount for people on the dole was, nevertheless, initially refused by the Minister of Social Affairs. However, in July 1934, he finally agreed to a special rate, with local authorities, medical staff and health funds having to bear the costs.⁸⁶ Despite this, many local authorities instead preferred to provide medical relief, which cost them less. According to an enquiry by the CBS, only 100,000 of the more than 600,000 who were unemployed were covered by this emergency rule.⁸⁷ However, Van der Velden's assumption that "overall membership of the funds stagnated" and that growth only resumed with falling unemployment after 1936 is disputable.⁸⁸

Membership of the *Maatschappijfondsen* doubled between 1929 and 1934. Moreover, even if this was partly caused by takeovers, these data indicate that there was growth followed by only two years of stagnation.⁸⁹ Indeed, in 1936, growth began again and membership showed a 40 percent increase between 1936 and 1941.

In 1934, having held an enquiry into health fund membership in nine cities and separately registering the numbers insured with the *directiefondsen*, the chief medical officer (CMO) produced a missive on these funds and future legislation.⁹⁰ When compared to the CBS's statistics of 1936, the CMO had registered three extra *directiefondsen*. As the CBS did not register funds which reimbursed medical costs to those insured, these three companies must have been middle-class funds. One such fund was the EHL Bank, which was mentioned as being one of the largest (along with the 'Rotterdams Ziekenfonds'). In 1933, the *directiefondsen* insured 428,741 people, while in 1936 this had risen to 565,560, an increase of 32 percent. On the one hand, it

⁸⁵ B. Widdershoven, *Het dilemma van solidariteit: de Nederlandse onderlinge ziekenfondsen, 1890-1941* (Amsterdam 205) 244; Van der Velden, "Dutch Health Services", 66. The chief medical officer expected a continued growth in membership because the income of the self-employed was dropping. Geneeskundige Hoofdinspectie, inv. no. 254, 22 August 1934.

⁸⁶ *Het Ziekenfonds* (1934), no. 3. Sometimes, local government pressed the unemployed to join a health fund and in the case of refusal reduced benefits accordingly, e.g. Beverwijk.

⁸⁷ *Maanschrift CBS* 31 (1936) 1283.

⁸⁸ Van der Velden, "Dutch Health Services", 66.

⁸⁹ See note 79. According to the CBS statistics of 1936, 13, the numbers above the age of 16 increased during 1935 as well. This was due to demographic conditions.

⁹⁰ NA, Geneeskundige Hoofdinspectie, inv. no. 254, 22 August 1934.

could be said that the increase was greater because three companies had not been included in the 1936 statistics, but on the other it is unknown whether the numbers in 1933 were converted to insured individuals.⁹¹ However, in spite of these uncertainties, the data indicate growth rather than stagnation. Indeed, between 1936 and 1941, these funds increased by another 20 percent.

Since our knowledge of company funds is poor, it is impossible to reconstruct how they fared during the early years of the depression. Apart from the miners and the railway funds, which covered 72 percent of those insured in this category in 1936, only 63 company funds - insuring only slightly more than 100,000 people – provided health care. It is possible that the collectivisation of sick pay and the need to economise as the depression deepened forced enterprises to close down their company funds, which meant that their workers had to move over to the general health funds, which had always provided family coverage.⁹² As a consequence, company funds probably became less important.

The two other categories – mutual and others – seem to have been stagnant between 1926 and 1936, which can be explained by the fact that only the health funds from these categories changed into a *Maatschappijfonds*.⁹³ As far as data on the membership of individual funds in these categories are available, it seems that their growth rates were rather low. The data do, however, suggest that there was some growth in the late 1920s, followed by stagnation or decline in the early 1930s. Indeed, Widdershoven's study of the development of mutual funds suggests that they stalled between 1930 and 1940.⁹⁴ In contrast, the national figures produced by the CBS registered a 22 percent increase in national membership of mutual funds between 1936 and 1941, suggesting that local differences must have been considerable.

It is difficult to assess the different, often contradictory, developments. Why growing unemployment was not followed by a drop in health fund membership is usually explained by the fact that more people qualified for it because of a fall in their

⁹¹ See Appendix 36 for details.

⁹² Directie van den Arbeid, *Onderzoek*, 21, counted 130 company funds providing health care. In 1936, there were 65 company funds, only 33 of which had started before 1912, which means that about a 100 had disappeared.

⁹³ For example, in 1931 in Amersfoort (1931 12,457 members), 1933 VHZ in Utrecht (1934, 55,000 members).

⁹⁴ Widdershoven, *Het dilemma*, 93.

income. Wage reduction might also have made more people aware of the need to join a health fund. The emergency rule undoubtedly had some influence as well, and at the local level it could even make a significant difference. In Amsterdam, the number of health fund members covered by the emergency rule rose from eight percent in 1934 to 15 percent in 1936,⁹⁵ while in the city of Utrecht membership only decreased in 1934, but began to rise again in 1935. It was only 'Ziekenzorg' which experienced a decline, and this was because it was hit by a boycott.⁹⁶ Moreover, on some occasions, health funds and medical providers agreed special rules for the unemployed without a municipal subsidy and in doing so succeeded in keeping them in the health insurance system. In addition, the emergency rule was later introduced in more districts, and on 1 January 1938 it covered more than 300,000 individuals, equating to nine percent of those insured.⁹⁷ The most important motivation for joining a fund was the introduction of the Sickness Benefit Act, which was used by health funds to convince people of the need to become a member, while the same pressure also emanated from the medical control of sick pay. Moreover, the Act led to fierce competition, increased recruitment efforts and, above all, readiness on the part of doctors to unite behind the *Maatschappijfondsen*. Finally, in 1931, the NMG introduced an excellent tool with which to press doctors to establish its funds; to end the recurring disputes on the foundation of new funds, the NMG initiated an agreement with the other parties to abandon any attempt to start a new fund in communities with a well functioning health fund.⁹⁸ In a sense, this made a *Maatschappijfonds* a necessary condition to keeping the mutual funds out. At the same time, this condition frustrated the growth of the mutual movement. While in 1936 more than 3.4 million people were insured, this number had risen to nearly 4.3 million on 1 January 1941. The increase in membership of the *Maatschappijfondsen* nearly equalled the growth of the other funds put together, amounting to more than 1.5 million members in 1941 (Appendix, Table I).

6. *The National Health Decree (Ziekenfondsenbesluit) of 1941*

⁹⁵ *Ibidem*, 240. Amsterdam had already introduced a special rate without the minister's consent.

⁹⁶ Companje, *Artsen*, 286; 298.

⁹⁷ *Maandschrift CBS* 33 (1938) 885.

⁹⁸ NA, Geneeskundige Hoofdinspectie, inv. 253. Companje, *Artsen*, 184.

When the Germans occupied the Netherlands, some expected that the adoption of German leadership principles would lead to a resolution of some of the persistent problems that had proved to be impossible to resolve as long as politicians wanted consensus. The NMG negotiator, Chr. Eggink, tried to exploit the situation and put pressure on the representatives of the *Federation* and the Catholic funds to accept a blueprint to unite every health fund under a national NMG-organization. This was the so-called concentration scheme, and its supporters argued that it was better to take such a step now, voluntarily, rather than later on when forced to do so by the Germans. Eggink presented the scheme at a meeting arranged by the Department of Health and thought that the other parties had assented to his proposals. In fact, there was an objection to the notion of unconditional consent, although there was agreement that some concentration was desirable. The minutes do indeed suggest that there was agreement between the parties, but this document was actually conceived by Eggink and was never authorised.⁹⁹

The Director General (DG) of Public Health and the chairman of the meeting, C. van den Berg, had not been informed of the NMG's proposal beforehand. However, the idea of revolutionizing health insurance by regional concentration had already been made public in the *Geneeskundige Gids* (Medical Guide).¹⁰⁰ As acting DG, Van den Berg was explicitly invited to act according to the NMG's wishes, but he made it perfectly clear that the Department of Health had no intention whatsoever of violating Dutch traditions.¹⁰¹ Indeed, Van den Berg intended to complete the project in line with previous instructions and did not expect the new regime to be interested in the subject. As it turned out, he was wrong, because the Germans, who wanted to win over Dutch workers and feared Dutch price competition, insisted on the introduction of compulsory health insurance. The Dutch national socialists were equally interested in the subject, because they expected to become more popular if they could claim the credit for improvements in social security. German officials, thus, developed a scheme of their own, but, because of internal differences, Dutch

⁹⁹ NA, Volksgezondheid 1918-1950, inv. no. 1338, meeting of 15 August 1940.

¹⁰⁰ "Concentratie van ziekenfondsen. Nu en naar eigen inzicht beter dan weldra gedwongen", *Geneeskundige Gids* 18 (1940) 636-639.

¹⁰¹ NA, Volksgezondheid 1918-1950, inv. no. 1338. Speech by the Director General on 31 July 1940. 13 August 1940, meeting with the NMG. More details in H.C. v. d. Hoeven, *Ziekenfondsen en de Duitse bezetting: de werkelijkheid over het Ziekenfondsenbesluit* (Den Haag, 1989) 18-25.

officials were able to influence the final Decree to some extent.¹⁰² The post-war government did not reverse the improvements made to social security provision and claimed that they were in line with Dutch developments. This was, of course, an ad hoc argument because, in reality, it was impossible to cancel all of the social policy interventions made by the Germans, particularly because the Dutch authorities in London, influenced by the English example, had already promised structural changes to social security. Van der Hoeven has established that the German influence on the Decree was greater than was generally acknowledged.¹⁰³ In particular, the centralized, bureaucratic executive structure was the opposite of the autonomy that the doctors - and the other funds - had always pursued. Furthermore, both compulsion and taxing the premium on employers and workers alike was also a demand of the Germans.

The National Health Decree of 1 July 1941 was to come into force on 1 November, meaning that there was little time to prepare for the massive change in membership that was expected. Funds with fewer than 3,000 members had to go into liquidation, which typically *affected doktersfondsen* and mutual funds. To prevent unwanted developments, in particular an uncontrolled race to establish branches, the state ruled that approval depended on the circumstances on 15 October 1941.¹⁰⁴ This decision was to the advantage of the doctors with their nationwide network, with the state allowing them to reap the benefits of the 'battle of the clubs', which had impeded the growth of the mutual health movement. Mutual and co-operative funds had, almost by definition, a limited radius of coverage, namely one city or village, and were therefore quite small. To overcome these limitations, the *Federation* had already established a national fund, the Anoz, in 1938, in order to prevent the forced liquidation of small mutual funds as a result of state rules.¹⁰⁵ This meant that they could continue as branches of Anoz. Until the National Health Decree, however, the Anoz was nothing more than an empty shell. Only the funds of the Catholic union

¹⁰² According to the commissioner for health funds, the Decree was based on the original draft by the DG and followed the guidelines of the Department of Health. *Verslag van de commissaris, belast met het toezicht op de ziekenfondsen, over het tijdvak 1 nov. 1941-31 dec. 1942* (1946) 16.

¹⁰³ Van der Hoeven, *Duitse bezetting*, 27-39.

¹⁰⁴ *25 Jaren bond*, 260.

¹⁰⁵ E.W. van der Hoeven, *Anoz van A tot Z. Vijftig jaar landelijk ziekenfonds en zijn eigenaardigheden*, 14-16. The NMG was furious because it regarded the Anoz as a sign that the mutual funds intended to extend into the countryside.

were regional, but they had been limited by medical opposition to them. The NMG-funds, on the other hand, were regional organizations and covered the countryside as well. Under the new conditions, hospital care was included and funds providing hospital insurance thus feared for their existence and considered applying for the status of an approved health fund. Since these hospital funds had a regional basis and covered the countryside as well, doctors were afraid that they would provide fierce competition and enable the mutual health movement to penetrate rural areas, which used to be the medics' exclusive playing field. Moreover, the state's bureaucracy pressed the *Federation* to reject the notion of combining with these organizations.¹⁰⁶ However, before another fight broke out, there were some important developments, meaning that traditional controversies were replaced by national loyalty, as set out below.

When in occupation, the Germans wanted to incorporate every Dutch organization into the national socialist system, and in July 1940 the Dutch national socialist movement (NSB) began to take over the trade unions. Then, in December 1941, the NSB organization for doctors - the *Artsenkamer* - was founded and the NMG was dissolved. By that time, however, many NMG members had already resigned and a medical resistance movement had come into existence. Nevertheless, the *Artsenkamer* claimed the *Maatschappijfondsen* as its own. A foundation was established in an attempt to protect the funds from national socialist influences, but this was quickly dissolved on German orders.¹⁰⁷ When rumours spread that the NSB was about to take over, people started to desert the *Maatschappijfondsen*. Worried by this development, in the spring of 1942 the NSB asked the acting DG, R.A. Verwey, to intervene, and he decided to end the freedom to join another insurer.¹⁰⁸ The efforts of the bureaucracy to maintain the status quo worked in favour of the *Maatschappijfondsen*, as their disproportional growth demonstrates (Appendix, table I).¹⁰⁹ Indeed, for many years, free competition between health funds was impossible

¹⁰⁶ Van der Hoeven, *Duitse bezetting*, 50-1.

¹⁰⁷ Festen, *125 Jaar*, 397-398.

¹⁰⁸ This message was circulated on 14 April 1942.

¹⁰⁹ *Het Ziekenfonds* (1942), no. 1. In 1942, 3.4 million people were compulsorily insured as opposed to 2 million on voluntary contracts, which was twice as high as had been expected. In general this covered low income civil servants and the self-employed with limited means. The effect of the introduction of a

and the ban, which was only lifted in 1947, was a breach of the rights of Dutch citizens.

Conclusion

Professional organization and the development of health insurance by commercial insurers and mutual societies ultimately ended in a struggle for autonomy by the medical profession. In general, a rapid increase in the size of the profession, coupled with the development of health funds, particularly workers' funds, and/or state insurance schemes, produced an explosive mix. In this respect, the Dutch case was in line with the general pattern across the globe.

However, the historical development of the country had resulted in it having some specific characteristics. Indeed, in some regions, doctors were already closely involved in health funds as their proprietors by 1900. A growing shortage of professional medics following the introduction of the medical laws of 1865 and a single professional organization enabled doctors to develop co-ordinated local health fund policies. At the turn of the century, therefore, a separation between funds providing either sick pay or health care was nearly complete. Doctors claimed that they regarded their services as an act of charity, but their complaints about arbitrariness and undercutting suggest otherwise. However, with rising wages, less charity was needed and doctors accordingly sought better fees. At the same time, more doctors were graduating and competition for club practices increased. Tensions were building in some regions, while elsewhere there was still very little opportunity to insure oneself for medical help. Pressure increased when the government announced the introduction of compulsory social insurance, but when this did occur Dutch doctors were in a far stronger position in the health insurance market than their British colleagues. Since contract practices had been a fact of life for over a century in some urban regions, doctors could not reject the very notion of collectivization as their counterparts had in the US. However, the Dutch medics did reveal the same stubbornness as their American colleagues in defending a once determined position, and both succeeded in keeping their ranks closed.

national income limit is unknown, but must have been higher with the NMG funds, which usually applied a lower limit.

Dutch doctors were very anxious about the intentions of the state and feared a subordinated position and low capitation fees, or, in their own words, a downgrading to 'wage slavery'; compulsory insurance might bring about improved national health standards, but not at their expense. However, the state had little sympathy for the doctors' anxieties since improving class relations by introducing social insurance was its main concern. State officials thus ignored doctors' demands and, time and again, offended medical self-esteem by ignoring the medics' 'rights' as independent professionals.

By deciding that health provision would not be an integral part of social insurance laws, the state actually recognised the position of the NMG that health insurance had to be part of a national health policy instead of a social policy, as originally intended. This change delayed legislation and allowed the NMG to develop its own health fund model. As the *directiefondsen* were not expected to qualify as carrier organizations, the profession set its sights on mutual (and workers') health funds. The decision to found the *Maatschappijfondsen* was innovative, and it proved to be an important weapon in the struggle for dominance. However, as long as the war and its aftermath delayed the introduction of sick pay, doctors had little interest in founding a *Maatschappijfonds*, and their 'idealistic aim' of improving health care and public health seemed to have been forgotten. The NMG's policy was criticized time and again in parliament and the press, but the state let it pass. Indeed, until the 1930s, state officials took the legal line that conflicts between funds and doctors were the province of civil law. What is more, the state was still planning health care legislation and seemed to ignore the fact that the NMG, as a private body, was trying to turn its monopoly on medical treatment into regulatory powers in the health market which was, essentially, in the public domain.

Even when united in a national Federation, the mutual funds' movement was far too weak to be effective and possessed neither the financial means nor the mass base necessary to launch a counterattack. Most doctors were NMG- members and the mutual funds could not afford to lose their services. Moreover, the funds' 'natural ally', the labour movement, was still in its infancy and had other priorities. The NMG, meanwhile, overreacted to the establishment of the Federation and many Federation members were hit by boycotts.

Conflicts with mutual and workers' funds in particular were inherent in the basic assumptions of the NMG's health fund policy. Coupled with the profession's

class consciousness, they were also unsolvable. Since the doctors demanded means tested membership, the board of a mutual fund which met this condition was disqualified as an acceptable employer. Gradually, the trade unions grew stronger and widened their objectives, not only demanding improvements in social provision, but participation in their implementation as well. In time, health funds also came to be regarded as a standard trade union concern, and when the unions had achieved their goal of the introduction of compulsory sick pay, they next focussed their attention on health insurance and joined forces with the Federation. This was precisely what the doctors had wanted to prevent. Moreover, the Sickness Benefit Act made the state regulation of health funds inevitable. Once again the NMG pressed its members to unite behind the *Maatschappijfondsen* and prevent the establishment of workers' funds. It was only under these circumstances that doctors fulfilled their promise to improve national health care by promoting insurance.

The uncompromising attitude towards mutual and workers' funds, and the firm resistance to the equal representation of consumers, was also dictated by internal motives since many doctors had not yet become firm believers in the *Maatschappijfondsen*. In this respect, 1929 marked a turning point. Differences on matters of principle continued to be an important factor in delaying health fund legislation. In the end, the failure of the state to cut the ties holding changes back was the worst solution for every health fund. The German demand to put an end to differentials in labour costs resulted in compulsory health insurance for those entitled to sick pay. It also provided the means to cover hospital care as well, because the employer had to contribute. Yet, even though the health funds now had greater financial resources and became carrier organizations, they still had to taste defeat. Unlike the intentions of the Dutch state, which had only wanted to introduce approval procedures, the National Health Decree established a centralized, bureaucratic system which left the health funds with little freedom in terms of policy. Moreover, the Decree put an end to the position of power of the doctors and also determined entry conditions. This violated Dutch traditions in many respects and did not fit well with traditional NMG demands.

APPENDIX

Sources

- *Verslag van den Hoofdinspecteur van de Volksgezondheid over het jaar 1931*, 1565-1572.
- CBS, *Overzicht van den omvang van het ziekenfondswezen in Nederland op 1 januari 1936* ('s-Gravenhage, 1937).
- “Overzicht van het aantal bij ziekenfondsen aangesloten personen”, *Maandschrift CBS* (1937) I, 861-862.
- *Ibidem* (1941) I, 70.
- *Ibidem* (1942) 635-636.
- *Verslag van den commissaris belast met het toezicht op de ziekenfondsen, over het tijdvak 1 nov. 1941-31 dec. 1942*. Offprint from *Verslagen en mededeelingen betreffende de volksgezondheid* (oct. 1946).

Comment

In 1926, the Medical Inspectorate (MI) held an inquiry. Then, from 1936 onwards, the CBS began to collect annual data on health funds. According to the CBS, its categorisation differed from that of the MI, and it applied the category ‘others’ to funds founded by doctors and apothecaries. Indeed, in 1926, the *Nutsfondsen* (the funds of the ‘Society for the Common Good (Maatschappij tot Nut van ‘t Algemeen) were included in the category ‘others’, while in 1936 they were registered as mutual. Moreover, mutual factory funds were included in ‘mutual funds’ in 1926, while in 1936 they were included in ‘factory funds’. Accordingly, the different categories in 1926, which are not comparable with the 1936 statistics, are put between brackets. However, taken together, the categories ‘mutual’ and ‘others’ indicate how they developed. With the exception of the province of South Holland, the original data from the 1926 inquiry did not survive and we cannot, therefore, adjust the numbers. Furthermore, it is also clear that many *directiefondsen* did not co-operate in 1926. The NMG, on the other hand, reported too many *Maatschappijfondsen*.

In 1927, the MI conducted a special inquiry into *doktersfondsen* in the provinces of South Holland and Zeeland and counted 171 thereof in the former and 27

in the latter (NA, Geneeskundige Hoofdinspectie 1902-1952, entry 2.15.38, inv. no. 254). Therefore, *doktersfondsen* were underestimated as well, not only in 1926, but probably also in 1936. In this latter year, however, South Holland still registered the highest number thereof. Moreover, in the NMG report of 1908, this province was again supreme with 108 of a total of 230 funds. North Holland had 47, which had reduced to 10 in 1936 as a result of the foundation of the *Maatschappijfondsen*.

The CBS report of 1936 had already noted the existence of another 49 *doktersfondsen*, insuring 36,170 individuals (CBS, *Overzicht*, 12, note 1). In 1937, the CBS registered 636 funds (with 12 refusing to give any information; save for one, all were *doktersfondsen*) compared with 547 in 1936. Because more data had been acquired in 1936, the number of people insured was adjusted (+76,072). The majority (56,365) were members of a *doktersfonds*. Deviation in the other categories was negligible. Table 1 contains the revised data for 1936 and Table III is based on these new data. Because the original data on doctors' practices were so poor, and because they are small scale organizations in their own right, they are not included in the table of average membership.

As some funds refused to cooperate, the CBS made estimates of the membership thereof as far as was possible. Several other funds meanwhile only registered the head of the household or a husband and wife, but not the children under the age of 14 or 16 who, at that age, had to pay an individual premium. Therefore, the MI and the CBS had to convert family data into insured individuals, but it is unknown how many individuals a family was supposed to represent. The only surviving list for 1926 for South Holland (NA, entry 2.15.33, Gezondheidsraad, inv. 609) does not provide any clues about how the estimates were made, because different numbers of singles result in different multipliers for membership. The inquiry into doctors' practices from 1927 counted a family as four individuals. The 1926 enquiry probably did the same.

Tables

Table I

Number of insured (x1.000) according to type of insurer
1926, 1936, 1941 and 1942

Year	Maatschappij- fondsen	Dokters- fondsen	Mutual funds	Commercial insurance	Others	Company funds	Total
1926	347	229	(849)	223	(384)	(298) ¹	2,331 ¹
1936	1,096	146	931	595	290	365	3,414
1941 ²	1,531	148	1,138	718	373	364	4,273
1942 ³	2,528	-	1,407	851	536	126	5,735

¹ Including 147,044 insured with the health fund of the railway company, registered separately in 1926.

² 1941: 1st January before the introduction of compulsion.

³ 1942: 31st December, the numbers include those compulsorily and voluntarily insured. The health funds of the railway company, the miners and the police, established in 1942 (together 286,688 individuals) are included in the total. *Verslag van de commissaris belast met het toezicht op de ziekenfondsen over het jaar 1943* (n. p., 1948) 106.

Table II
Number of health funds according to type of insurer
1926, 1936, 1941 and 1942

Year	Maatschappij	Dokters	Mutual	Commercial	Others	Company	Total
1926	48	247	(148)	29	(39)	(64)	574
1936 ¹	81	133	205	50	17	65	551
1941	89	225	201	49	17	60	650
1942	73		63	51	11	36	234 ²

¹ In 1937, 214 doctors', 216 mutual, 22 other and 62 company funds were registered. Most of them already existed in 1936.

² The process of admitting health funds as carrier organizations under the Decree had not yet been completed.

Table III
Average number of insured people per insurer
1926, 1936, 1941 and 1942

Year	Maatschappij	Commercial	Mutual	Others	Company
1926	7,229	7,705	5,737	9,851	2,390
1936	13,532	11,899	4,539	17,053	5,615
1941	17,205	14,654	5,663	21,936	6,073
1942 ¹	34,627	16,693	22,332	48,755	3,504

¹ The health funds of the railway company, the miners and the police are not included.