UNIKLINIK KÖLN

EAHMH Conference 2015

> Cash and Care: Economics and Values in the History of Medicine and Health

European Association for the History of Medicine and Health

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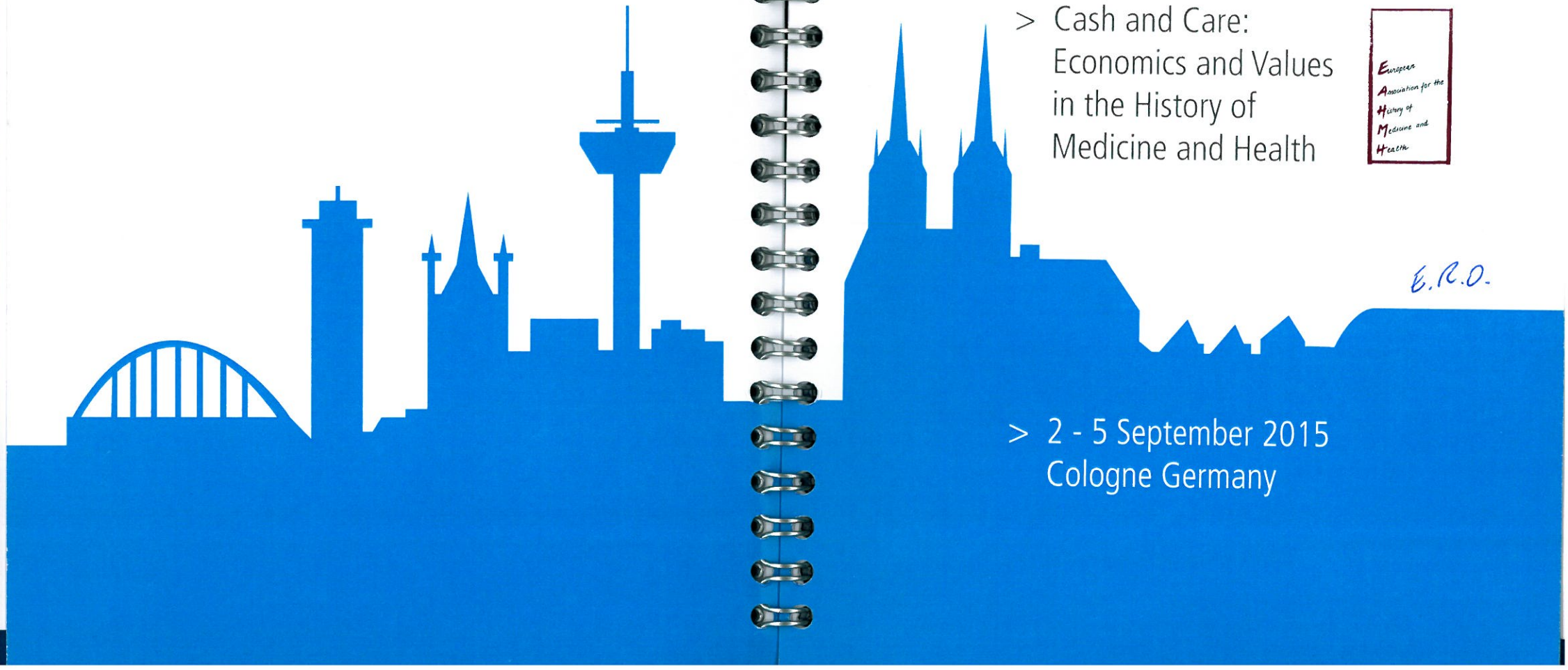

> 2 - 5 September 2015
Cologne Germany

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Cash and Care: Economics and Values in the History of Medicine and Health

European Association for the History of Medicine and Health

Stichting Historia Medicinae

Institut für Geschichte der Medizin Robert Bosch Stiftung

2 - 5 September 2015
Cologne Germany

Institute of the History of Medicine and Medical Ethics
Joseph-Stelzmann-Straße 20, 50931 Cologne

Wednesday, September 2

18:00 **Welcome Reception**
(Joseph-Stelzmann-Straße 20, Forum, Building No. 42)

Welcome (Heiner Fangerau)

Greetings (Representative from the University of Cologne)

Welcome presentation

Klaus Bergdolt: 'Money and glory? Successful doctors in old paintings'

Thursday, September 3

09:00 **Introduction and Keynote**

Paul Unschuld: "Medicine in the Era of an Industrial Health Economy. Global Dynamics and Local Change"

(Joseph-Stelzmann-Straße 20, Forum, Building No. 42)

10:30 **Panels 1 - 4**

> Panel 1 / Forum

The Political Economy of Health Care in the British NHS since 1948

Chairperson: Laurinda Abreu

Davies, Stephen
Promoting efficiency in the British National Health Service 1959-1966

Gorsky, Martin
'Resource allocation' for equity in the NHS: the roots of the RAWP. 1970-1986

Sheard, Sally
Getting better, faster: the origins and implications of financial incentives to reduce lengths of hospital stay in the British National Health Service

> Panel 2 / Oratorium

Interwar health services in municipal contexts

Chairperson: Astri Andresen

Doyle, Barry
The Impact of the First World War on Provincial Hospital Finance in France

Lucey, Sean
Interwar municipal health expenditure in Belfast: The impact of devolution, politics and religion

Seymour, Jane K
Local democracy and spending on health in interwar London

> Panel 3 / Frauenklinik

Coal, Steel, Work and Health

Chairperson: Anne Hardy

Mantin, Mike
'Neither a Sick Man nor a Whole Man':
Disability and Employment in the British Coal mines, 1880-1948

Kleinöder, Nina
Safety First? Debates on the costs of health and safety in the German Iron and Steel Industry in the 1920s and 1950s

Perdiguero-Gil, Enrique / Comelles, Josep
The economic and social failure of the compulsory health insurance of Franco's dictatorship (1942-1967): the perspective of professionals and workers

Thompson, Steve
Cash and Care in the South Wales Coalfield: An Alternative Culture?

> Panel 4 / MTI

Money and Infection

Chairperson: Frank Huisman

Haalboom, Floor
Tuberculous cows and Salmonella-infected pigs: the tensions between cash and care in dealings with livestock-associated public health problems in the Netherlands (1890-1978)

Millward, Gareth
'Payments', not 'Compensation': The Collective and Individual Costs of the British Pertussis Vaccine Scare, c. 1974-1980

12:15 **Lunch**

> Lunch session / Forum

Chairperson: Heiner Fangerau

Toon, Elizabeth / Ananiadou, Sophia / Duvall, Nick / Mcnaught, John / Thompson, Paul / Timmermann, Carsten / Worboys, Michael
Text Mining for Medical Historians: Big Data, Big Questions

14:15 **Panels 5 - 7**

> Panel 5 / Forum

Cost, Time, and Care Management of Health

Chairperson: Jonathan Reinarz

Hüntelmann, Axel C
Accounting, Auditing, and Cost Management of Hospitals, 1890s–1930s

Falk, Oliver
Diabetes and the Management of Life (1900–1950)

Michl, Susanne
Time Management: Hospital Industrial Engineering and Time Studies in the US (1911–1960)

> Panel 6 / Oratorium

Cost, Class, and Psychiatry in the United Kingdom

Chairperson: Jonathan Simon

Hands, Thora
Taming the 'Wild Horses': Private Treatments for Addiction in late Victorian and Edwardian Scotland

Farquharson, Jennifer
Health in the District Asylum: Soldiers, Civilians and the 'cost of care' in Great War Scotland'

Lux, Erin
Class, Crime, and Child Psychiatry in the UK Since 1945

> Panel 7 / MTI

Money and Infection

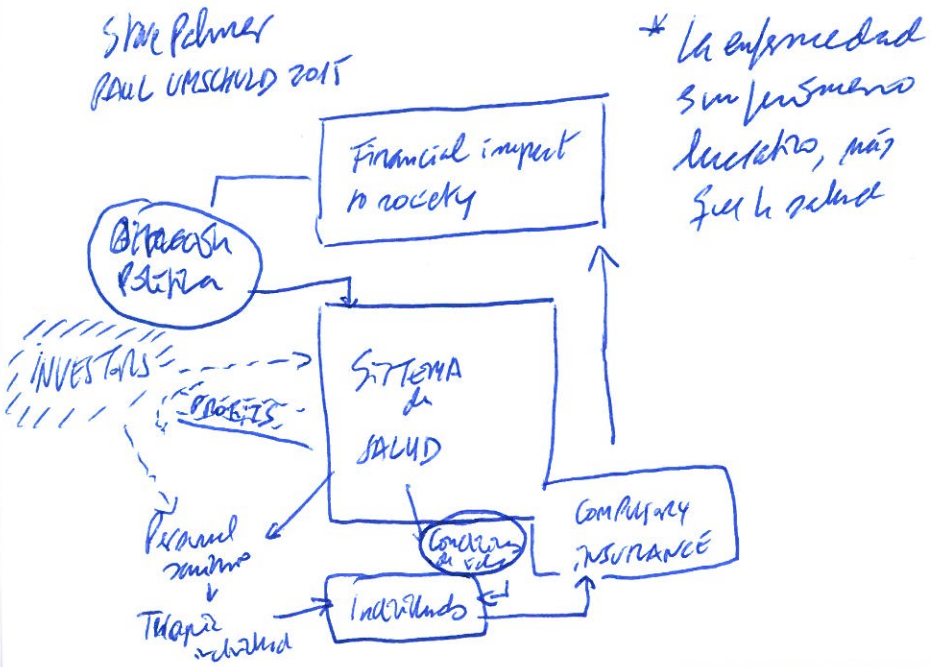
Chairperson: Iris Borowy

Greenway, Sophie
A clash of values: The Family Health Club Housing Association and the legislative separation of environment from health in post-war Britain

Campbell Gosling, George
Gender and Civic Duty: Breadwinners as Paying Patients in British Healthcare before the National Health Service

Hartmann, Annika
Between the Health Centre and the Village Marketplace - Family Planning in Cold War Guatemala (1960s to 1980s)

16:15 **Coffee Break**



16:45 **Panels 8 - 10**

> Panel 8 / Forum

Between Autonomy and Accountability. Transformations in the Governance of Medicine After WW2

Chairperson: Frank Huisman

Bertens, Roland
Medical Law: Curbing or Codifying Medical Autonomy?

Jacobs, Noortje
Inspection! Compliance! Accountability! Ethics committees?

Bolt, Timo C.
Evidence-Based Medicine: a Doctor's Order?

> Panel 9 / Oratorium

Financing health care

Chairperson: Jonathan Reinarz

Dross, Fritz
Managing a budget for the beyond: hospital finances before medicalization

Jones, Claire C. / Dupree, M. / Rafferty, A. / Hutchison, I.
The Costs of Infection Control in British Hospitals, c. 1870-1970

Nelson, Marie C.
Ideals and the Cost of Care: Debating the costs of hospital care in Sweden around 1900

Buda, Octavian
Financing Medical Research in Bucharest, Romania and Liège, Belgium by end of 19th century - a comparative study

> Panel 10 / MTI

Advertising Medicine

Chairperson: Friedrich Moll

Borge, Jessica
Brand Equity and Commercial Contraceptives in the mid-20th Century

Foxhall, Katherine
Medical Advertising and the History of Patients: The case of Migraine

Haushofer, Lisa
A 'participation economy?' Letter writing for medicinal consumer products

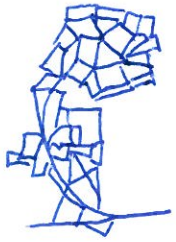
Serviant-Fine, Thibaut / Simon, Jonathan
Rational Drug Design: Science and innovation in the pharmaceutical industry

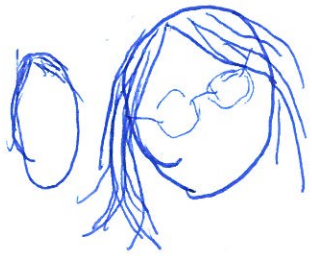
CCNSC 1961 screening programs!

18:45 **(Forum)**
Short film: *Man and His Health* (1967, 18 mins.)
A Major Work of Medical Cinema, presented by the director, Robert Cordier.

19:30 **(Forum)**
SSHM and EAHMH Post-graduate students meeting

19:30 **Guided Tour Romano-Germanic Museum (optional 20 participants)**





Friday, September 4

context: The mirrored body of medical history ?
2014
Cochrane 1971 Effectiveness and Efficiency
- Timelines linked to historical works or sources

09:30 **(Forum)**
Virchow Lecture
Virginia Berridge: "Thinking in time: a new Whig history?"

11:00 **Coffee Break**

11:15 **Panels: 11 - 14**

> Panel 11 / Forum

At what cost? Professional and patient perspectives on Australian health in the 20th century

Chairperson: ~~Friedrich Moll~~ Michael Knipper

Mody, Fallon
Aliens and alliances: immigrant doctors and state-subsidised health care in Australia, 1930-1960

McMeeken, Joan
How would they have managed without us? Poliomyelitis and the physiotherapy volunteers in Victoria, Australia

Henrich, Eureka
An investment in 'magnificent human material': how constructions of health shaped the design and experience of Australia's post-war immigration programme, 1947 – 1971

> Panel 12 / Oratorium

Inequality

Chairperson: Anne Hardy

Kessler, Sebastian
A conceptual history of social inequality in health in the Federal Republic of Germany

Borowy, Iris
The Preston Curve revisited: When does more national income harm health?

Jones, Esyllt
Economic variables of poor relief options in Évora in the 17th and 18th centuries

Serviant-Fine, Thibaut / Simon, Jonathan
The Political Economy of Rural Health Inequality: Socialized Models of Care in Canada and the US, 1937-1951

> Panel 13 / Frauenklinik

Promoting Medicine and Health

Chairperson: Astri Andresen

Palmer, Steven
Health and Community on Starship Expo: The Spectacle of Medical Progress at the Montreal Universal and International Exposition, 1967

Adams, Jane
Nature-cure for the masses: entrepreneurs, brands and niche marketing in Britain 1900-1940

Frampton, Sally
'We Cannot Undertake the Risk': The Business of Medical Publishing in Nineteenth-Century Britain.

Mold, Alex
Cash or Care? Configuring 'Cost' in Public Health Education in Britain, 1950-1980s

> Panel 14 / MTI

Money and Medicine before and after Birth

Chairperson: Hilary Marland

Adams, Jane Michelle
"Paying for Test-Tube Babies" - the establishment of in vitro fertilisation in New Zealand in the 1980s

Davis, Angela
Cash and care in the case of the 'Eggs Affair': reproductive technologies in early twenty-first-century Israel

Lagerlöf Nilsson, Ulrika
The Economics of Scientific Births: Conditions and limitations for Swedish midwifery during the late 1800s

13:15 **Lunch**

SSHM – Board Meeting (Forum)

14:30 **Panels: 15 - 18**

> Panel 15 / Forum

Beyond the body…

Chairperson: Laurinda Abreu

Claes, Tinne
The end of the body as payment in late nineteenth-century Brussels

Deblon, Veronique
Commercialized bodies. The trade in anatomical preparations in Belgium, 1830-1860

Stingl, Alexander
Auditing the Body in Medicine

> Panel 16 / Oratorium

Health and the Poor

Chairperson: Axel Karenberg

Ottosson, Anders
The market of philanthropy or the philanthropy market? The commercial and entrepreneurial organization and function of Sweden's sick- and poor relief ca 1870-1920

Ritch, Alistair
The Generosity of the Parsimonious Poor Law Guardians: Expenditure on Drugs in the Workhouses of Birmingham and Wolverhampton

Barona, Josep L.
Establishment and First Steps of the Health Service at the International Labour Office (ILO)

> Panel 17 / Frauenklinik

Health and Politics

Chairperson: Octavian Buda

Huisman, Frank
Discussing the Principles of Health Care: Dutch Parliamentary Debates of the 1860s

Ellis, Rob
London County Council, its Mental Health Policy and the Politics of International Consultation

Martínez-Antonio, Francisco Javier
Unprofitable profit: the failed role of the Pasteur Institute of Tangier in French public health in Morocco (1911-1929)

Wall, Rosemary
'The British Red Cross Still Exists': adaptation to the post-war NHS era

> Panel 18 / MTI

Value of Therapy and Disease

Chairperson: Iris Borowy

Reinarz, Jonathan
From isolation to integration: the institutional treatment of burns patients in Britain, c.1845-1950

Stoyannidis, Yannis
Making profit out of 'thin air': Sanatoriums and the invention of health tourism in Athens, 1880-1939

16:15 **Coffee Break**

16:30 **Panels: 19 - 22**

> Panel 19 / Forum

Money and Madness

Chairperson: Cornelius Borck

Smith, Leonard
An unprincipled trade in Insanity?? Private Madhouses in England, 1730-1815

Smith, Matthew
'A preventive psychiatry': The social turn in American psychiatry

Cox, Catherine / Marland, Hilary
Disordered in morals and mind: prisoners, mental illness and cost in late nineteenth-century England

> Panel 20 / Oratorium

Global Perspectives, Migration and Health

Chairperson: Jonathan Simon

Nowak, Katarzyna
Healthy New Citizens. Biopolitics in Screening Procedures for Displaced Persons Resettlement Schemes (1946-1950)

Snow, Stephanie
Global Paradigms and Local Practices: Costs, Capital and Values in the History of Stroke Since the 1990s

> Panel 21 / Frauenklinik

Cash, Medicine and Gender

Chairperson: Anne Hardy

Fiorilli, Olivia / Aboim, Sofia
The political economy of gender politics in trans-related healthcare

Rentetzi, Maria
Radium for men: a medical market specifically for male consumers

Castenbrandt, Helene
Sick from work – Sickness absence among men and women in Sweden 1892-1955

> Panel 22 / MTI

Cash and care in ancient and medieval Mediterranean

Chairperson: Daniel Schäfer

Israelowich, Ido
The economy of medical practice in the Roman Empire

Moog, Ferdinand
Becoming a Gladiator from a Patient's Perspective

Salmón, Fernando
The value of trust in medieval medicine

18:30 **Keynote Nancy Tomes 'Historical Reflections on the 'Doctor Shopper' (Chair: Carsten Timmermann)**

20:15 **Conference dinner, EAHMH Book award**

Saturday, September 5

09:30 **Keynote Wendy Kline "The Business of Birth and the Politics of Place"**

11:00 **Coffee Break**

11:15 **Panels: 23 - 25**

> Panel 23 / Forum

The Costs of Abortion Services: Payment, Punishment, Reward

Chairperson: Hilary Marland

Davis, Gayle
From 'Go to Jail' to 'Take a Chance': The Costs of a Medical Monopoly on Abortion

Sethna, Christabelle
To and From:
Feminists, Doctors and the Costs of Abortion Services at Home and Abroad for Canadian Women

Ignaciuk, Agata
The Cost of Reproductive Choice in Spain, 1970-85

Bogic, Anna
Transferring the Cost of Abortion in The Transition to Democracy: The Case of Croatia and Serbia

> Panel 24 / Oratorium

Vaccines and Vaccination against smallpox and poliomyelitis: economies and values

Chairperson: Friedrich Moll

Porras, María-Isabel / Caballero, María-Victoria
Vaccines and Vaccination against smallpox and poliomyelitis: Economies and Values

Rodríguez-Ocaña, Esteban
Manufacturing Smallpox Vaccine and Building Virology in Spain, 1920-1960.

Báguena, María José / Mariño, Lourdes
Investing in health: the economic necessity and benefits of the eradication of smallpox in Spain through vaccination (1959-1982)

Martín-Espinosa, Noelia / Ballester, Rosa
Initiatives against Inequality in the Fight against Epidemics: The Store of Oral Polio Vaccines created by the WHO in 1964

> Panel 25 / Frauenklinik

Money and professionals

Chairperson: Axel Karenberg

Abreu, Laurinda
Similar care competences for lower costs: the competition between surgeons and physicians in Early Modern Portugal

Brookes, Barbara L.
Cashing in on a Medical Career: Dr. Ann Longshore Potts's Lectures to Ladies: 1870-1900

Dimitrova, Veronika
The social medicine and the debate about doctors' private practice in Bulgaria from the early twentieth century until World War II

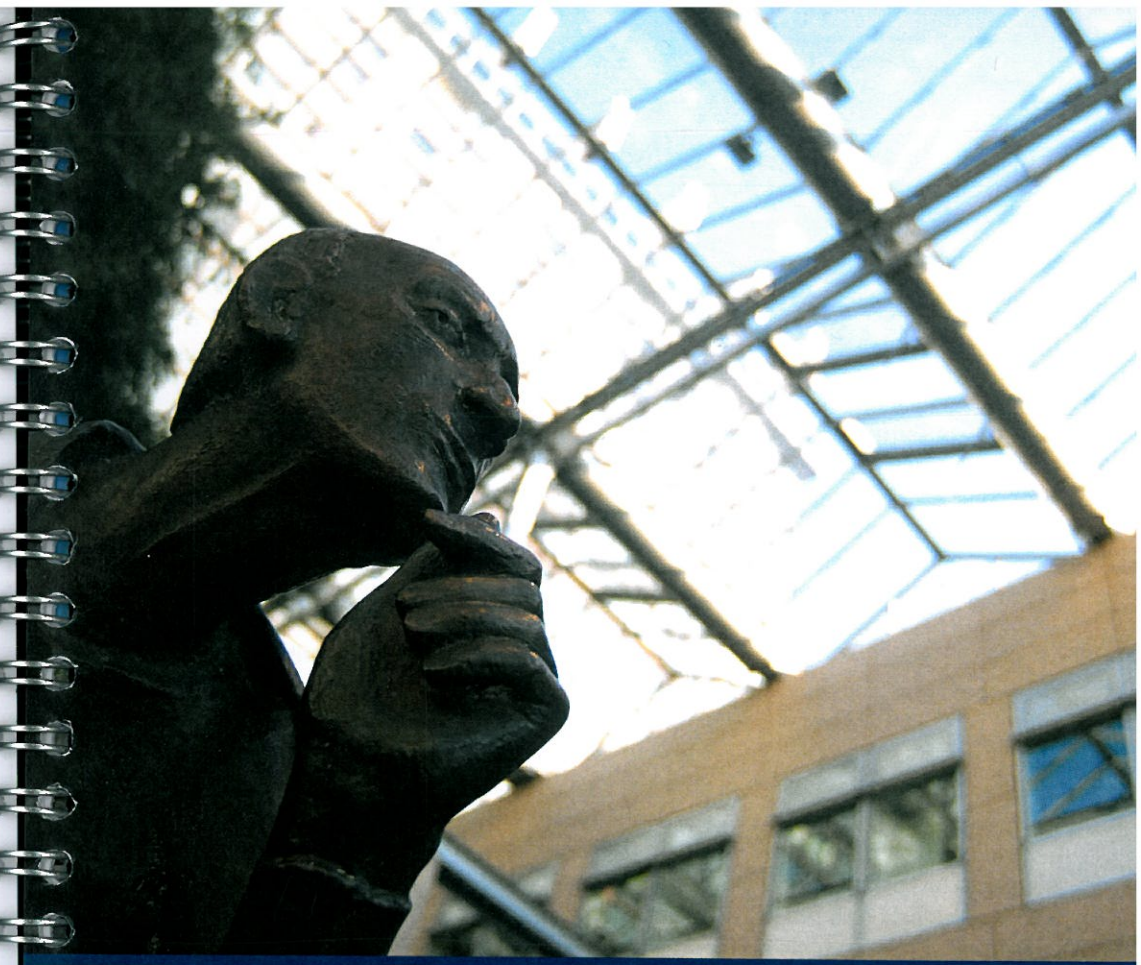
13:15 **Lunch Break (Forum)**

13:45 **General Assembly of the EAHMH – election of next president, topic and place of next meeting**
Van Foreest Student Award

16:00 **Guided Tour Cologne**

18:00 **Evening Panorama Boat Tour on the Rhine**

19:30 **Dinner and Farewell Party**



Thursday, September 3

Panels 1 - 10

> PANEL 1

The Political Economy of Health Care in the British NHS since 1948

The British National Health Service (NHS) is widely regarded as an archetypal health system, with its features of universal, tax-funded care under predominantly public provision. These distinguished it from the 'Bismarck' systems organised around health insurance, and the more pluralist approach typified by the United States. Recent decades have seen considerable criticism of the early NHS model, where it is depicted as the epitome of bureaucracy and rigidity. In this conventional wisdom it was only in the Thatcher years that a more responsive service emerged, thanks to the arrival of the new public management, with its private sector disciplines, and the 'internal market' with its injection of demand factors. However, such a perspective ignores the extent to which efficiency, effectiveness and fairness were actively pursued within the statist structure established in 1948.

In this session we present the results of new research into policy-making within the Ministry of Health/Department of Health and Social Security. Our papers aim to explore the ways in which a provider-led system could and did seek technical solutions to policy challenges. In so doing they draw out the eclectic mix of influences which fed into these, ranging from private sector industrial policy, to emergent academic disciplines of health economics and health services research, to policy-learning from other countries. Together they aim to illustrate how a NHS-style system could pursue both improved economic performance and more idealistic objectives of equity and justice. In 2015, with the goal of universal health coverage high on the agenda of the renewed Millennium Development Goals, such history is both salient and timely.

Promoting efficiency in the British National Health Service 1959-1966

Stephen Davies
London School of Hygiene and Tropical Medicine
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The drive to improve efficiency has been a perennial concern in the British NHS and was evident from its earliest years, when politicians and the Treasury were alarmed by rapid escalation in costs. These worries were exacerbated by low levels of confidence in the ability of the Ministry of Health to manage the enormous hospital budget in particular. As a witness to the Select Committee on the Estimates put it in 1957 "there is no sum as large as this which is subject to so little Treasury control". An early manifestation of such concerns was the Guillebaud Report on the cost of the NHS, published in 1956, which was critical of the lack of 'intelligence' capability at the Ministry and the absence of data that might be used to analyse hospital performance. The emergence of a political consensus that a major hospital investment programme was unavoidable, eventually finding expression in the Hospital Plan of 1962, created an additional imperative to analyse and intervene for a more efficient NHS.

This paper shows how, in the quest for efficiency, the Ministry of Health and the NHS embraced 'productivity science' and private sector know-how from an early date and how management techniques such as operational research, organisation and methods and work study were transferred into the NHS from the defence and private sectors. The focus for the paper is the NHS Advisory Council for Management Efficiency (England and Wales) [ACME], which was set up in 1959 and was based on a productivity council model widely adopted in British industry. The Council acted as a clearing house and champion for NHS efficiency initiatives until it was disbanded in 1966. Its legacy was the embedding of management services in the NHS and the emergence of a programme of operational and management research, commissioned by the Ministry of Health in collaboration with the hospital authorities. The paper also explores limits to the influence of the Advisory Council, which was reluctant to extend its reforming zeal to clinical practice because of the doctrine of clinical autonomy. Despite this reticence, sections of the medical profession also pursued the quest for efficiency in this period, through medical care research. The Royal College of Nursing was an early convert to productivity science, suggesting a multi-faceted professional response.

Keywords: hospitals, productivity, efficiency, management

'Resource allocation' for equity in the NHS: the roots of the RAWP. 1970-1986

Martin Gorsky
London School of Hygiene and Tropical Medicine
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Writing in 1972, the pioneer health systems scholar Odin Anderson wondered whether equity could ever be attainable in health policy. Was it perhaps just an 'endless search for the dream'? After all, the track record of Western nations in improving equality of access had not been impressive thus far. Yet the early 1970s also saw a head of steam building in Britain around the question of 'territorial justice' in the NHS. From different quarters commentators began to ask what had become of Aneurin Bevan's founding vision that the NHS would 'universalize the best'? His intention had been to abolish spatial variations in care caused by the 'caprice' of charity and uneven local government finance. Yet despite nationalisation, hierarchical control and incentives for doctors working in deprived areas, evidence was mounting that the goal remained elusive. Indeed, an 'inverse care law' obtained, whereby the parts of Britain with the greatest need for health services tended also to be the most thinly supplied.

This was the context for the work of the Resource Allocation Working Party (RAWP), which led in 1976 to the introduction of a new formula for distributing NHS funding according to need, and not historical precedent. Although sometimes dismissed as the zenith of technocratic planning by a bureaucratic state, the RAWP instilled in the NHS an enduring policy goal of equality of access to health care for people in equal need. Indeed it persisted through the years of neo-liberal welfare policy, and still informs funding flows today. This paper probes behind the RAWP's dry title and acronym to tell a story that speaks to the high idealism that has inspired the NHS, to the contentious political questions that always attended reform, and to the technical but intellectually absorbing debates about redistributive funding for health care. The RAWP also deserves historical attention for the insights it can offer into policy-making in the NHS, demonstrating the relative importance of party politics, the agency of high-profile ministers, internal agenda-setting by bureaucrats and incipient academic influences in the health policy arena. Drawing on oral history sources and newly available documentary archives, the paper illuminates the last enduring achievement of social democratic governance of the NHS, before Thatcherite retrenchment.

Keywords: equity; resource allocation; redistribution; spatial

Getting better, faster: the origins and implications of financial incentives to reduce lengths of hospital stay in the British National Health Service

Sally Sheard
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Attitudes to length of post-surgical hospital stays resonate with a shift in twentieth century society towards increased productivity and efficiency. After the basic science of physiological and psychological recovery had been established by the 1950s, post-surgical patient management (traditionally called convalescence) was increasingly viewed from an economic perspective. Medical, managerial and cultural expectations aligned so that recovery came to be seen as something to be achieved as fast as possible.

This paper examines how and why health economists and hospital administrators began to study factors influencing the length of stays for common procedures such as hernia repairs and hysterectomies in the 1960s. Models were developed for costing all aspects of hospital stays, using improvements in hospital data such as the British Hospital In-Patient Enquiry, introduced in 1974. Hospitals, under financial pressure during the 1970s OPEC crisis, were encouraged to experiment with 'five day wards', and allowing general managers to take decisions on patient discharges, traditionally the remit of clinicians. Britain also looked for comparison to countries that operated insurance-based health care systems, where the policy of unrestricted daily payments, which encouraged hospitals to keep patients in for longer, was being abandoned in favour of fee-per-item costings. Although average lengths of post-surgical hospital stay fell in Britain (inguinal hernia repair dropped from 7.3 days in 1974 to 4.9 days in 1984), there remained considerable regional variation. International comparisons were also used to stimulate further British improvement: in the US inguinal hernia patients had an average length of stay of 3.0 days in 1984.

Yet there are biological limits to speeding up the post-surgical recovery process. By the 1990s premature discharge from hospital was shown to result in an increase in re-admissions, particularly among elderly patients, who now had reduced access to local authority social services care. This paper examines the policy processes through which shorter post-surgical lengths of hospital stay became embedded in the British NHS, and the implications for wider issues such as medical authority in healthcare systems.

Keywords: hospitals; length of stay; NHS efficiency; (healthcare) costs

> PANEL 2

Interwar health services in municipal contexts

The Impact of the First World War on Provincial Hospital Finance in France

Barry Doyle
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In the interwar period the demand for hospital services increased substantially across the west. A combination of demographic change, growing confidence in medical services, developments associated with the War, such as advances in surgery, and the adoption of the 'hospital habit' by the general public put huge pressure on hospital capacity. It also severely stretched hospital finances as institutions struggled to meet demand, improve services, expand physically and hire and pay more and better staff. In France these problems were exacerbated in some parts of the country by the impact of the First World War. In northern cities war damage, lost income and inflation all added to these more general problems. Yet evidence by Tim Smith and others suggests that elsewhere in France the effect of the war was broadly positive, promoting a collectivist desire to challenge parochial penny pinching and expand access and provision.

This paper will draw on evidence from the war torn city of Lille and the generally prosperous Loire town of Nantes to explore the ways in which the legacy of the Great War had an impact on hospital services in these two places. In particular, it will assess the growth in demand for admission, changes in the source of income, especially the rise of subventions from the local and national state, alterations in patterns of institutional spending, for example between food, staff and medical costs and the political ramifications of these developments, especially conflicts between hospital administrations and the municipal authorities. Overall, it aims to present a more nuanced picture than that of recent North American and French histories, of the changes in institutional care in France during the crucial transition from locally financed and managed systems to the centrally funded welfare state. Central to this will be consideration of the long term damage to local finance of the First World War and the extent to which this may have created a barrier to the growth of collectivist health care services.

Keywords: Hospitals; France; Finance; Great War; Municipal Medicine

Interwar municipal health expenditure in Belfast: The impact of devolution, politics and religion

Sean Lucey
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This paper will examine municipal public health in Northern Ireland and concentrate specifically on Belfast in the inter-war period. Recent English and Welsh historiographical developments have argued that inter-war municipal public health was more vibrant and extensive than traditional negative perceptions have allowed. This paper explores if such positive understandings are applicable to inter-war Belfast. It will primarily focus on expenditure levels – often seen as a proxy for quality in health services – and investment on municipal personal health services that included provision for tuberculosis, mother and child welfare, mental health, infectious disease and venereal disease. Belfast and Northern Ireland's political, religious and administrative circumstances make it a unique case-study for understanding public health. In contrast to the majority of British cities, Belfast's politics was dominated by Irish nationalism and British unionism and the Labour Party was particularly weak. The city was also religiously divided and the ecclesiastical authorities had a significant impact on public policy. Unlike any other United Kingdom country, Northern Ireland had a fully devolved inter-war government that was established after Irish partition in 1922. This paper explores how such circumstances, which were not as evident in inter-war Britain, impacted on the investment choices made by Belfast Corporation. The paper will also explore the role of medical professionals and local population health and healthcare needs in determining Belfast's municipal health expenditure. In general, this paper's examination of Belfast tests the recent positive historiographical outlook on interwar municipal health in the United Kingdom. Its focus on the impact on public health expenditure of devolved government, nationalist/unionist politics and Catholic/Protestant religious fissures represent new insights into interwar municipal medicine.

Keywords: Northern Ireland, local/ central government relations, municipal health, inter-war, finance

Local democracy and spending on health in interwar London

Jane K Seymour
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Health legislation in interwar England and Wales followed a permissive and not a mandatory pattern. This meant that individual local authorities had a considerable degree of autonomy in what services they prioritised and how much they spent on different aspects of health care. Contemporaries considered this a strength of the English state, as local democracy was understood as being closer to the lives and needs of citizens than national politics.

This paper considers interwar London, where 28 metropolitan borough councils made separate decisions about spending on health. Analysis suggests that these decisions cannot easily be related to broad economic or party political causes and, therefore, that they were determined by specific, local circumstances. This paper will explore what were the factors driving the differential spending patterns of selected London boroughs. In particular, the role of the Medical Officer of Health (MOH) and of relations between the health department and the council will be considered. The role of the London County Council, as the overarching tier of local government in London, and of the Ministry of Health in guiding local health programmes will also be examined, in order to assess the truth of the perception that local health provision was closely tied to local democratic processes.

This paper will draw on novel work done with basic text mining programmes, using the digitised annual reports of the metropolitan Medical Officers of Health in the Wellcome Library's London's Pulse resource. The results of this analysis will be contextualised with more traditional textual research in official records held at The National Archives, particularly the MH66 series of reports and correspondence concerning local health services, and local archive sources, as well as a variety of published sources.

Keywords: interwar; London; Medical Officer of Health; local government; democracy

> PANEL 3

Coal, Steel, Work and Health

'Neither a Sick Man nor a Whole Man': Disability and Employment in the British Coal mines, 1880-1948

Mike Mantin
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Coalmining was one of the most dangerous and difficult industries in Britain, killing or permanently injuring an estimated quarter of a million miners between 1850 and 1950. Although major disasters were more commonly reported, everyday injuries in the mines were far more common, and workers caught in them regularly experienced disability for the rest of their lives. Although a large amount of miners never worked again, many returned to the mines. Utilising administrative sources both from within the coalmines and nationally, as well as newspapers and trade periodicals, this paper looks at the situation facing disabled miners who returned to work, and how it was affected by economic factors both personal and industrial.

A minority of disabled miners returned underground, but took part in 'light work' on the surface such as picking coal or staffing equipment rooms; these were often significantly lower in pay and status, caused major changes for workers' personal economic situations. Moreover, they were subject to major uncertainty in times of economic difficulty for the industry. As the industry declined in the years after World War I, disabled miners' jobs became ever more vulnerable, and if their pit closed then the chances of finding alternatives were slim. Those who did continue their 'light work' often ran into major difficulties continuing any form of compensation. The process of medical certification, work and loss of work created a subtle form of dehumanisation for those in the process, encapsulated by an MP's declaration in 1934 that those taking part in the cycle were 'neither a sick man nor a whole man'.

Keywords: disability, coalmining, work, labour

Safety First? Debates on the costs of health and safety in the German Iron and Steel Industry in the 1920s and 1950s

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Manpower is an existential interest of workers as well as a valuable economic resource for companies. At the same time the growing commitment in work safety led to a rising cost factor for enterprises in the 20th century. Accident numbers and accident cost can therefore be identified as a continuous but ambivalent argument in the institutionalization of health and safety at work.

The paper asks for the motivation for but also the boarders of occupational health and safety between economic and humanistic values. International debates of the 1920s and 1950s focused concisely on the question of direct and indirect accident cost. The mostly American arguments were soon adopted abroad, so that it became an equally European point of discussion.

With the help of an interdisciplinary approach between the history of medicine and health and business history, the paper questions the transfer of know-how in work safety. It links the macro-level of international debates with the micro-level of benefits and cost effectiveness in health and safety at the workplace itself: Who were the Stakeholders in health and safety? Who were the forcing actors in the cost debate? How was it received on a business level? In which way was it used as an argument for or against the development of occupational health and safety in the 1920s and 1950s?

The paper is a partial result of a broader doctoral thesis on occupational health and safety in the German iron and steel industry in the 20th century. It is based on published and non-published sources from the European Coal and Steel Community, labour unions and mainly selected German enterprises (e.g. GHH/HOAG, Thyssen, Hoesch).

Keywords: Occupational health and safety, accident cost, business history, Americanisation

The economic and social failure of the compulsory health insurance of Franco's dictatorship (1942-1967): the perspective of professionals and workers

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Between 1942 and 1967 the Spanish Seguro Obligatorio de Enfermedad (S.O.E. – Compulsory Health Insurance) was presented by Franco's regime as the main achievement of its social policy. Based on the models of Nazi Germany and Fascist Italy, the S.O.E. adopted the features of a mutualist system in which the -compulsory- payments were limited to employers and workers, and which excluded any state contributions. To a certain extent the S.O.E. was the "property" of the Ministry of Labour and was controlled by the Falange Española, the Fascist and national-syndicalist wing of Franco's single party.

In spite of the official discourse of the Regime on the benevolence of the S.O.E., its implementation was hindered both by doctors' salary and contract-related corporative interests and by the protests of workers. In industrialized areas such as Catalonia, there was already a plethora of mutual societies which were less expensive and provided better services. Once the S.O.E. had been implemented, and in spite of the censorship of the media, some professional groups began to point out what they considered the wasteful use of resources, for example in the high costs of pharmaceutical services. Other failings included the reduction in time spent on each patient, and the lowering of doctors' salaries and the problems of referring patients within the system. Criticism from the working classes was based on the repercussions of the charges on the gross costs of the workers.

Reports of the lack of transparency in the accounts of the S.O.E. and its financial failure, recently studied from the perspective of economic history, began to appear in official publications alongside praise for its achievements. At the same time warnings of inefficiency and waste in its services appeared in professional reports, letters to the editors of significant newspapers and in columns of non-specialist magazines. In the 1960s, personal testimonies of informants revealed the awareness among the clandestine trade unions of the economic unviability of the system.

Our aim in this paper is to demonstrate the existence of unofficial sources which will enable us to study the relatively transversal and early awareness of the costs of the social security system which was implemented in Spain. We are using general daily newspapers published in Madrid (ABC) and Barcelona (La Vanguardia), magazines targetting a general readership (Blanco and Negro, Destino), profesional press (Horizonte, Tribuna Médica, Noticias médicas), other sources published by a variety of authors, the magazine SER, published by the Health Board of the Falange, and documents of the Instituto Nacional de Previsión (the National Institute for Prevention), the organisation in charge of the management of the S.O.E.

The unviability of the system, although acknowledged, did not lead to reform until the 1963 Social Security Law, which did not come into effect until 1967 as a result of the internal debates with the Regime itself in a period of crisis for the sectors of the founding Falange and the growing hegemony of the Opus Dei technocrats in the government.

Cash and Care in the South Wales Coalfield: An Alternative Culture?

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This paper will examine the understandings and perceptions of cash and care in a particular context. It will focus on the proletarian public sphere in the South Wales Coalfield from the 1880s through to the Second World War and examine the values and ideas articulated in relation to the provision of workers' medical schemes, cottage hospitals, friendly societies, and a range of other, medical and health services. Due to the stunted nature of the middle class and the laissez faire attitudes of employers, south Wales was marked by a power vacuum which came to be filled by workers and their organisations, particularly trade unions, co-operative societies, and other forms of proletarian associational culture. By the interwar period, the labour movement had, in addition, captured most of the local authorities in the coalfield, through Labour Party majorities, and were able to add the provision of municipal services to the services it provided in the voluntary sphere. In various ways, public good was elevated above pecuniary considerations and mutualist means of provision utilised to expand and develop services.

Certain values and principles underpinned this provision and these were self-consciously defined and articulated in contrast to the hegemonic values of British society at that time. Close attention was paid to economic aspects of this provision, and careful management was necessary to husband resources, but, repeatedly, effort was made to extend provision to as many people as possible beyond what might have been considered financially advisable and, often, beyond strict rules of eligibility. Actuarial considerations were subordinated to public good and worth was defined in terms of the difference that could be made to people's well-being and quality of life. As Aneurin Bevan later wrote 'no society can call itself civilised if a sick person is denied medical aid because of lack of means', and it is clear that, through the influence of Bevan, the particular culture and values fostered in south Wales had a significant impact on the British welfare state in the period after the Second World War.

This focus on an alternative and oppositional culture coincides with a significant strand in the historiography of the labour movement in south Wales in which an alternative, proletarian culture is discerned in the 1920s and 1930s in which the social, political and cultural values of a Liberal hegemony were rejected in favour of a proletarian world-view

that included extra-legal, extra-Parliamentary and oppositional discourses and actions. At the same time, such challenges were not uncontroversial and furious ideological and political battles were fought over the provision of health, medical and welfare services, and the values that underpinned them.

The paper will consider the various forms of provision pioneered or supported by the labour movement, the conceptions of worth and value that were articulated within this proletarian public sphere, and the political battles waged to change the basis of provision and bring about a socialist commonwealth.

Key words: labour movement, mutualism, alternative, provision.

> PANEL 4

Money and Infection

Tuberculous cows and Salmonella-infected pigs: the tensions between cash and care in dealings with livestock-associated public health problems in the Netherlands (1890-1978)

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This paper will compare the tensions between economic and public health interests in dealings with infectious diseases shared by humans and livestock (zoonoses) in the Netherlands in two different time periods. The paper is based on two case studies: bovine tuberculosis (1890-1922) and salmonellosis (1955-1978), both part of a PhD research project on 20th century dealings with livestock-associated zoonoses. Public health experts turned bovine tuberculosis into a public health problem in the late 19th century, when they argued that tuberculous cows could infect people, primarily via milk and meat. During the 1950s, public health experts related a rise in human cases of salmonellosis to the quickly developing 'factory farming' of pigs and poultry. In both cases, plans made to control the animal diseases involved major interventions in agricultural practice, and sparked years of fundamental political debates on the responsibilities of private enterprise and the government. As a major producer and exporter of agricultural products, the Netherlands provide an interesting context to study how different stakeholders from the public health and agricultural domain related to each other in defining and dealing with these problems in two different periods in time. How did the tension between cash and care, between industry and public health authorities, and between the ministries responsible for agriculture and public health play out? How did this change over time? And what does it tell us about current dealings with livestock-associated zoonoses? These questions will be answered using archival documents, contemporary scientific publications, and, in the case of salmonellosis, oral history interviews.

Keywords: bovine tuberculosis, salmonellosis, public health, agriculture

'Payments', not 'Compensation': The Collective and Individual Costs of the British Pertussis Vaccine Scare, c. 1974-1980

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Historians have long argued that interventions in public health were aimed at increasing national efficiency by producing fit soldiers, workers and mothers. However, did individuals necessarily share these concerns when those interventions impacted negatively upon them? This public debate became particularly relevant in Britain in the 1970s during what was later termed 'the pertussis vaccine scare'. Reports emerged that alleged a link between the Diphtheria-Tetanus-Pertussis (DTP) vaccine and brain damage in children. As the national authorities continued to assert the vaccine's safety and national health benefits, the Association of Parents of Vaccine Damaged Children waged a public campaign to secure compensation. This culminated in the Vaccine Damage Payments Act 1979, passed months before Margaret Thatcher took office.

This paper asks 'how were the potential "costs" of state vaccination policy viewed by different public bodies?' It uses biographies from leading campaigners, media coverage, Parliamentary debates and civil service documents from the National Archives, and draws on the wider project at the London School of Hygiene and Tropical Medicine on the place of the concept of "the public" within British post-war public health. It uses a qualitative approach and documentary analysis, and attempts to understand the pertussis vaccine and vaccination damage in terms the policy actors at this time would have understood them. For it bears emphasising that it was not undisputed that the pertussis vaccine was safe, and this debate came on the back of the medical scandal of the thalidomide court case, as exposed by the Sunday Times.

Focusing on the theme of the conference – 'economics and values in the history of medicine and health' – this paper examines not just the financial costs of vaccine damage to the state and to families, but also the impact upon more subjective – but, perhaps, equally valuable – concepts such as "public confidence" in vaccination and the medical profession, and the "civil rights" of patients and parents. This is important because precious little study has been conducted on the Vaccine Damage Payments Act. Indeed, vaccination policy and its effects after the 1950s are very rarely tackled by historians.

I believe this paper fits into a number of concepts being addressed by this conference. The 'relationship between physicians, institutions, organizations and clinical authorities' is key to explaining how scientific evidence was mobilized by all sides of this public debate. It is also essential in understanding the power dynamics between physicians, the parents and the Department of Health and Social Security. Similarly, it touches on 'historical debates about medical ethics, justice and economy', as the state pondered upon its duties towards those it had allegedly damaged through its vaccination policies. 'Trust and the rhetorics of healing' are also central themes, since public faith in the vaccination programme was seen as essential to its success. Indeed, declining vaccination rates were seen both at the time and in later analyses by public health professionals as a sign of weakness or failure on the behalf of central government and their advisory bodies.

Keywords: Vaccination, Compensation, Risk, Rights

Lunch-Session: Text Mining for Medical Historians: Big Data, Big Questions

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Why and how should historians of medicine use new digital humanities tools like text mining? What can – and what can't – such tools do? This talk addresses these questions through an overview of the Mining the History of Medicine (MHM) project. This project, a research collaboration between the University of Manchester's Centre for the History of Science, Technology and Medicine (CHSTM) and the National Centre for Text Mining (NaCTeM), was funded by the UK's Arts and Humanities Research Council in 2014. Our goal has been to explore how text mining might allow historians of medicine to use large full-text corpora innovatively, to pose new questions and to address existing questions in new ways.

We begin by describing the semantic annotation scheme we have developed to identify entities and relationships in typical 19th and 20th century medical and public health texts. Using automated natural language processing methods, we've applied this annotation scheme to two large corpora: the Wellcome Library's London's Pulse collection of Medical Officer of Health reports, 1848-1972, and the British Medical Journal from 1840 to the 1970s. Semantic annotation makes it possible to search large corpora not just for specific terms, but whole classes of terms, concepts and entities, and to explore and visualize typical and atypical relationships between these. These results can provide a jumping off point for further analysis or reveal relationships that have been difficult to 'see' in texts previously.

We will discuss some examples drawn from our preliminary results and findings, which have focused on the understanding, treatment, and prevention of respiratory conditions in modern Britain. We will also discuss some of the complications that have arisen in our project, namely the difficulties of working with a highly varied text base, especially complex semantic relationships, and the conflicted, variable, and changing nature of much medical language.

> PANEL 5

Cost, Time, and Care Management of Health

Since the 1970s the German health care system as in other European countries has increasingly come under economic pressure: health services have been cut, hospital stays shortened and some hospitals and other public-sector health institutes have been transformed into profit-oriented companies. Standardization, productivity, and efficiency have become key issues in health care systems. This institutional transformation of health care has – if not generated – at least sharpened the conflict between humanitarian and monetary values that existed already at the beginning of the 20th century. After 1900, new forms of management emerged to deal with the modern public health infrastructure and the complex and tense connection between health and economy that gained a new momentum at this time. New accounting techniques, hospitalization, and better health-care provision leading to higher life-expectancy, as well as ideas of body measuring and effective organization of labour, increased the pressure not only on hospitals but on the whole health care system to preserve health not only in an economical manner but for economic reasons.

In our session, we will investigate these different forms of management – those related to cost, time and care – in the first half of the 20th century. By considering these different management forms, we focus on the question how health and economics became entwined since the early 20th century and how these close ties gave rise to new institutional settings, new forms of paper technologies, new professional identities and not least promises of a modern (and healthy) society. The focus is on hospitals in Germany but some attention is on the US where "hospital industrial engineering" first emerged.

The three papers explore how new forms of management and record keeping changed the relationship between physicians, patients, institutions and clinical administration in the first half of the twentieth century. The first paper investigates the financial aspects and accounting of hospitals: funding and cost structure of hospitals, and how efficacy, productivity and standardization in EAHMH Conference: Cash and Care

public health services were debated. Analyzing how ideas of scientific management, division of labor and Taylorism shaped hospitals, the second paper addresses the issue of time management and time economies. It explores which professionals, argued for and undertook time studies in hospitals, how they did so, and for what reasons. The third paper focuses on the management of disease and health in diabetes therapy after

the development of insulin in 1922. The paper will show how the therapeutic approach to diabetes with its methods of balancing of accounts was related to overall economic questions, including those of impacts on hospital organization and care management. Dealing with time management in hospitals, financial management of hospitals and care management of patients (in hospitals), the papers in this session complement each other.

Keywords: time management, financial management, life management, hospitals

Accounting, Auditing, and Cost Management of Hospitals, 1890s-1930s

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Officials of the ministry of finance and chartered auditors inspected the accounting and bookkeeping of the Charité Hospital in Berlin in search of potential cost savings. The questioning of costs at the hospital was nothing new for the hospital management. Inquiries about costs, cost structures or harsh criticisms for the exceeding of budgets were normal and regular routine. But in this case, all departments, all processes and every position from head of department to the scrubwomen had been put on trial. At the end, the report proposed to cut hundreds of positions and to close departments. The report provoked an outcry of resistance – management, nursing staff and physicians fought side by side against the cost-cutting plans prophesying doom-and gloom scenarios that patient care would be neglected or teaching at the university hospital would cease. These events could have happened in the 1990s or in the first decade of the 21st century, but in fact, they date back to the early 1920s.

The accounting audit was possible because detailed and extensive accounting material, such as detailed annual budgets, standard costs and efficiency calculations had existed at the Charité Hospital in Berlin since the first half of the 19th century. What has changed since than and what is different between the bookkeeping of the hospital now and the audit report in the 1920s? On the basis of the accountancy files, publications of financial reports and public debates about financial issues, the paper will describe the accounting practices and the cost-related administrative papertechnologies in the Charité hospital in Berlin in the decades before and after 1900. The paper demonstrates that discussions about forced economisation in the health care system were not new at the end of the

20th century, but already a constant element at the beginning of the century. But since 1900, new economic knowledge about patients, hospital infrastructure, and health care has been achieved by cost-management and the re-evaluation of health that led to the abovementioned audit report. Values of human health have been subordinated to monetary values. Distinct from the accounting of cost and benefits as practiced in the 19th century, by the early 1920s the systematic search for cost savings was being done with the aim of minimizing, regulating and controlling cost. Finally, by using the example of the audit report, the paper argues not only that accounting and bookkeeping are a result of economisation, but also that paper technologies like the audit report enforce economisation and efficiency.

Keywords financial management, accounting, Charité Hospital, paper technologies

Diabetes and the Management of Life (1900-1950)

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Diabetes (mellitus) is a disease of the human metabolism which has been transformed over the course of the last hundred years from a rare but deadly to a widespread but chronic disease – with fundamental consequences on individual (therapy), societal (health- and life insurances) and economic (hospital organization and overall cost) issues. Especially the development of insulin and increasing numbers of patients have changed concerns about diabetes fundamentally and required a changed standard of therapy. Practically this has meant an exact balancing of the patient's metabolism, a setting of normative life rules concerning nutrition, (self-) care, and activity - or, to put it more straightforwardly, a sustainable management of the diabetic body. But efforts towards an effective diabetes therapy had – and still have – not only the well-being and therapeutic success of the patient in mind but also several economic reasons, notably reducing costs for the health-care system. The paper aims to show this connection between therapeutic and economic issues by asking a set of specific questions.

Starting from the mid-twenties of the 20th century the paper shall ask: In which ways and against what (social/economic) backdrop has diabetes therapy been developed, applied and justified? In which ways did diabetes change the hospital organization of care and cost management as well as the configuration of self-care provision within the hospital?

In what sense were efforts for the self-empowerment of patients to control their disease part of overall considerations to "outsource" hospital regimes into private practice? How has the treatment of diabetes affected more general contemporary discourses of self-care and prevention? In this sense the paper wants to shift the perspective from obvious treatment matters to the underlying aspect of economic issues. Drawing on statistical material from hospitals and insurance companies, handbooks, nutrition tables and items displaying documentation practices both of physicians and patients, the paper will illustrate the tensions between the requirements of successful therapy and the need to provide it at the lowest possible cost.

Keywords Diabetes, Therapy, Life-Balance, Regulation

Time Management: Hospital Industrial Engineering and Time Studies in the US (1911-1960)

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In 1911, the manufacturer Frederick Winslow Taylor published "Scientific Management." This book argued for new and efficient ways of optimizing work routines on assembly lines. Shortly thereafter, the psychologist Lilian Gilbreth and her husband, the management engineer Frank Gilbreth, presented their method of motion studies at the "Annual Meeting of the American Society of Mechanical Engineers." By offering a standardized analysis of the motion of workers, they hoped to save money, time, and energy on a macroeconomic level. From the outset Taylor and the Gilbreths recognized the potential of time and motion studies for the organization of hospitals. The Gilbreths in particular launched a new management branch: Hospital industrial engineering. To measure human work and calculate standard times, it was necessary to adapt and transfer these new scientific methods from standardized automated movements in the manufacturing world to personal services with a broader spread of activity-time profiles.

This paper analyzes the early stage of hospital industrial engineering in the US from the early works of the Gilbreths up until the late 1960s, a period characterized by the search for organizational, professional, and methodological standards. On an organizational level the focus is on forms of cooperation, resistance, and knowledge transfer between the different professional groups involved in the emergence of this new branch of man-

agement (trustees and engineers, doctors and, most importantly, nurses). In addition, the paper explores how the service sector adapted methods that had been developed in manufacturing industries.

The analysis is based on early scientific writings on hospital industrial engineering in handbooks and journals as well as authoritative time and motion studies carried out at different hospitals in the US. The paper argues that a wide range of normative considerations as articulated by each of the four professions involved shaped the standardization, rationalization, and optimization of hospital care no less than seemingly objective conclusions deduced from an ever-growing empirical data base.

Keywords hospital industrial engineering, time and motion study, time management, scientific management

> PANEL 6

Cost, Class, and Psychiatry in the United Kingdom

This panel will explore three different aspects of the intersection of cost, class, and mental health care in the United Kingdom from the late nineteenth to mid twentieth century.

Taming the 'Wild Horses': Private Treatments for Addiction in late Victorian and Edwardian Scotland

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Key Question: What motivated Victorian doctors to establish private medical institutions to treat drug and alcohol addiction?

The passing of the 1879 Habitual Drunkards Act enabled government licensing and regulation of private medical facilities for treating drug and alcohol addiction. Several of these institutions were established in Scotland and this paper analyses the treatment of patients within Invernith Lodge Retreat in Fife, which offered private medical care for middle and upper class gentlemen. In the late nineteenth century there was growing medical, political and public interest in treatments and 'cures' for drug and alcohol addiction. Private institutional care was expensive and therefore mainly targeted the wealthier sections of society. The records of Invernith Lodge provide detailed information on admissions, treatments and on the institutional regime. The paper argues that within the institution, medical concepts of drug and alcohol addiction were framed within broader class and gender values. Invernith Lodge was a lucrative business venture and its success was therefore dependent upon providing treatments for addiction that appealed to the wealthier classes.

Keywords: Medical Institutions, Private Care, Alcohol, Drugs

Health in the District Asylum: Soldiers, Civilians and the 'cost of care' in Great War Scotland

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1914 saw the beginnings of a fundamental transformation of State and Voluntary mental healthcare provision throughout Britain. During the First World War, asylums became part of a national cost-saving initiative that saw institutions transformed from civilian hospitals to an integral part of the war effort, with many being refashioned as War Hospitals commandeered for the physical and psychiatric treatment of servicemen.

Yet little is known about what this cost civil mental healthcare in Scotland during the Great War. Historians have widely debated the impact of the War upon public health, yet have neglected to assess its impact upon the health of institutional populations with the same scrutiny. This paper seeks to extend the discussion of the detrimental impact of wartime conditions upon mental healthcare, into a regionally comparative study of Scottish public asylums. Overcrowded conditions, the prioritisation of funds and resources for military institutions, the trauma experienced by those patients removed from the new War Hospitals, and the reduction and redistribution of human capital within the asylum system all contributed to a critical period in British asylum economy. Via an examination of institutional records including mortality and recovery rates and asylum expenditure, this paper shall assess the human cost of the 'cost-saving' asylum War Hospital scheme in the wider context of wartime economy.

Keywords: Great War, Scotland, Mental Health, Asylums
Key question: What impact did wartime conditions have on Scottish public asylums?

Class, Crime, and Child Psychiatry in the UK Since 1945

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Despite its central place in plans for the creation of the United Kingdom's National Health Service, mental health care has long been known as a 'Cinderella Service' – the poor step sister having to make do with very little. The marginalised place of mental health care within the NHS is doubly so when it comes to juvenile mental health. During and immediately following the Second World War, as the Welfare State was being established, there were significant concerns about juvenile delinquency as a result of the traumas suffered by children who were separated from their families, experienced the death of their caregivers, or were otherwise affected by the experience of war. These concerns were largely directed at children of the urban working classes, who were thought to be especially at risk of both mental health problems and delinquent behaviour. Therefore, mental health services, particularly child guidance clinics, were directed at these working-class children. This paper examines the role of stereotypes about class and concerns about funding in the creation of public juvenile mental health services in the post-war United Kingdom, especially the degree to which child guidance was or was not viewed as an investment in preventive care and reduction of delinquency.

Keywords: class, juvenile delinquency, child psychiatry, United Kingdom
Key question: What role did assumptions about class, degeneracy and crime have on investment in juvenile mental health services in the UK?

> PANEL 7

Money and Infection

A clash of values: The Family Health Club Housing Association as an alternative concept of healthy citizenship in post-war Britain

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This paper will use the case study of the financial and social viability of the Family Health Club Housing Association (FHC) to highlight how the establishment of the welfare state in Britain involved both the disempowerment of the citizen and the conceptual separation of environment from health. Founded in 1944 to put the ideals of the Pioneer Health Centre, Peckham (PHC), into practice in the reconstruction of Coventry, the FHC has fallen victim to the 'powerful versions of the inevitable' that have become attached to the post-war settlement overall, and to the NHS in particular.[1] Whereas the PHC had established a health and leisure centre in order to investigate the nature of health, the FHC's ambition was for citizens to be empowered through the process of planning and running their estate. Member committees chose modernist flats which would leave room for a well-equipped health and leisure centre, plenty of recreational space and land for organic farming. Members were in direct contact with the proposed environment in which their community was to be built, volunteering on the farms purchased in 1946. This small group of empowered citizens, in demonstrating the viability of their scheme, represented a potential threat to the government's use of central power. Planning permission was denied and the FHC was wound up in 1956. Financial records from the Registry of Friendly Societies will be used, along with oral histories, local newspapers and local authority records, to show how the FHC scheme was financially viable, that the planning decision was questionable, and that this unrealised scheme was not unrealistic.

[1] Kathryn J. Oberdeck, ‚Archives of the Unbuilt Environment: Documents and Discourses of Imagined Space in Twentieth-Century Kohler, Wisconsin', in Archive Stories, Facts, Fictions, and the Writing of History, ed. by Antoinette Burton (Durham, N.C.: Duke University Press, 2005), pp. 251-74 (p. 252).

The story of the FHC represents the combination of economic with social and human capital in a project which, if it had not jarred so intensely with Labour's values both locally and nationally, may have become a prominent example of an alternative approach to citizenship, health and the environment.

Keywords: Health, citizenship, environment, finance.

Gender and Civic Duty: Breadwinners as Paying Patients in British Healthcare before the National Health Service

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There were only thirty years in British history where it was the norm for patients to pay the hospital where they received treatment. These were the three decades from the end of the First World War until the inception of the National Health Service in 1948. This paper will examine the social meanings of such payment, looking beyond the function of payment schemes in funding the service to consider the gendered and civic implications of paying the hospital.

The arrival of payment in what had previously been almost entirely free public and voluntary hospital systems is part of a transition from institutions that served specific social and medical categories to those seeking to provide for the community as a whole. Within this shift, the emergence of the citizen patient, contributing financial towards the service they received, was a fundamental reinvention of the patient contract.

More important than money changing hands was the demonstration of willingness to make a financial contribution, to pay one's way. Equally important was that, for the working-class majority of patients, they should either do so through membership of a hospital contributory scheme – demonstrating thrift – or submit themselves to the assessment of a middle-class social worker – demonstrating deference. As a civic ritual, this new and seemingly commercial arrangement in practice served to ensure continuance of some of the key values of an older philanthropic culture.

Gender was also central, as the act of payment was cast in rhetoric and institutional policymaking as a duty of the breadwinner. The exclusion of maternity cases from hospital contributory served to underline this, with maternity hospitals experiencing a more consistently commercial arrangement than most general or specialist hospitals. The entanglement of notions of the paying patient and civic breadwinner will be identified as having been at the heart of a reinvention of the patient in interwar Britain.

This paper will present findings from research at the heart of a monograph –Payment and Philanthropy in British Healthcare, 1918-1948 – due to be published in Pickering and Chatto's social history of medicine series shortly after this conference takes place.

Between the Health Centre and the Village Marketplace - Family Planning in Cold War Guatemala (1960s to 1980s)

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Since the late 1950s, discussions about the 'population bomb' entered the global discourses on development and modernization. In order to confront envisioned dangers of 'overpopulation', a complex network of international development organizations, private foundations and academic centres started to support family planning programs in the 'Global South'. Promoting the use of new contraceptives as a means to achieve economic well-being and health prevention, transnational politics often concentrated on integrating family planning in public healthcare systems.

However, in some Third World countries these attempts turned out to be a rather frustrating experience for population control advocates who, consequently, often relied on the private sector to confront high birth rates. Hence, not only pharmacies and private family planning organizations, but also marketing research institutes as well as advertising agencies turned into important actors in the global struggle to control Third World populations, deeply influencing national discourses of healthcare and the concept of family planning.

Concentrating on the Guatemalan case, where, from the late 1960s on, public health officials turned their backs on family planning, this paper will examine the role that the private sector played in the field of family planning in Guatemala. Combining the analysis of international networks with a praxeological approach, this paper investigates how the gradual integration of market-oriented actors influenced medical mindsets and practices, transforming family planning into a commodity good, and in how far these new interpretations were challenged in a revolutionary context.

This paper is related to my doctoral thesis which examines the role that Guatemalan medical actors played in the production and circulation of 'westernized' knowledge of health, family planning, and population growth. It draws on a wide variety of published and archival material from US-American and Guatemalan Archives (National Archives, Smith College, Tulane University, Archivo de la Universidad de San Carlos de Guatemala). These include correspondence papers, field diaries and reports written by development agents, public health officials, and population experts.

Keywords: history of family planning, political economy of health care, marketing, health in the '3rd World'

> PANEL 8

Between Autonomy and Accountability. Transformations in the Governance of Medicine After WW2

This session explores the tension between professional autonomy and public accountability in Dutch medicine during the second half of the twentieth century, in relation to strong political concerns during this period over the financial (in)sustainability of the Dutch health care state.

Conventional wisdom has it that medical decision making underwent a significant transformation after the Second World War: i.e. particularly from the 1960s onwards, western governments are said to have realized a wide range of oversight mechanisms to bring medical practice and research under public scrutiny. This transition has often been referred to as a move from 'disciplinary' to 'mechanical' objectivity, typical of modern democracies. To large-scale voting publics (and tax payers), the existence of formalized procedures of external control was said to be more acceptable than the traditional paternalism of the physician at the bedside. What was more, in order to keep health care an affordable social good, government control was needed to ensure bureaucratic transparency and efficiency (thereby facilitating the optimal use of scarce resources).

By taking a closer look at three such mechanisms of public control – the realization of an unprecedented set of health laws after the 1970s; the widespread establishment of research ethics committees during the 1980s and the introduction of the Evidence-Based Medicine paradigm to curb health care costs in the early 1990s –, this session aims to rethink this perceived dichotomy between autonomy and accountability in the governance of post-war medicine.

The recent history of Dutch medicine will serve as a projection screen to explore these issues. Of course, any historical inquiry into the socio-political embedding of a profession is inevitably context-bound. At the same time, however, as a result of the globalization of health industries during this period, national governance structures also came to obtain a decisively international character. Using the Netherlands as a case-study, therefore, will hopefully serve as a springboard to debate the tension between professional autonomy and public accountability in different national contexts during the second half of the twentieth century.

Keywords: medical law, medical ethics, evidence-based medicine, autonomy, accountability

Medical Law: Curbing or Codifying Medical Autonomy?

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In the last decades of the twentieth century, individual health care in the Netherlands came to be confronted with the archetypal mechanism of external control: legislation. Not only did Dutch judges start ruling on the necessity of informed consent in medical procedures, but public and academic discussion pushed the Dutch government towards the creation of a legal framework putting individual health care on a different footing. In a relatively short period of time, many laws were realized which seemed to curb medical autonomy in profound ways. At the same time, litigation over medical malpractice seemed to become part and parcel of its everyday practice.

It is tempting to take the rise of such extensive legal regulation of health care as proof for a shift from 'disciplinary' to 'mechanical' forms of objectivity and accountability. Whereas in the 1950s doctors had enjoyed complete autonomy, only a few decades later it seemed that legislators and judges had become the arbiters to decide on the acceptability of their professional conduct.

This paper will question this narrative of a unilinear shift towards more external control over medical practice through legislation and jurisprudence by focusing on the case of patient rights. As it turns out, there was a profound difference between the proclamation of patient rights in inaugural addresses of the newly appointed professors in health law and patients' rights 'on the ground'. My argument will be twofold: first, that codified norms were open to interpretation and adaptation to as many cases as there were patients; and secondly, that health care professionals have been instrumental in shaping and applying legislation, turning the process of 'curbing' medical autonomy very much into a two-way street.

Inspection! Compliance! Accountability! Ethics committees?

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This paper examines the role of the Dutch government in the establishment of a new system of governance for human experimentation after the 1960s. From the mid-1970s onwards, in the Netherlands, the endowed governance tool to ensure ethical human research practices more and more became the 'Committee Medical Ethics', modelled after the American IRB. No longer could biomedical researchers start projects involving human experimentation, was the idea, if they had not acquired formal permission from the CME.

This shift in research ethics governance is often pointed to as one area in which ideals of professional autonomy were clearly replaced by those of public accountability. As one Dutch STS-researcher has argued recently, the establishment of CME should be understood 'as part of this effort to break the monopoly of doctors on medical decisions in the 1970s'. But who actually initiated this move towards institutionalized ethical evaluation of human experimentation in the Netherlands? And what was the precise role played by the national government – as representative of the Dutch people – in initiating and stimulating this regulatory change?

This paper will show that the Dutch realization of a national system of research ethics governance was one initiated primarily by those from within the Dutch biomedical sciences, who thought of themselves as moral and therapeutic reformers. In addition, it will show that it was the Dutch government who continued to forestall the effectuation of a legal framework for this new system in the 1980s and 1990s, thereby allowing the biomedical professions to play a defining role in the way clinical researchers in the Netherlands are nowadays held accountable.

Evidence-Based Medicine: a Doctor's Order?

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In the early 1990s a new concept was coined: Evidence-Based Medicine (EBM). In a short period of time, it became all-pervasive in health care in many western countries. The original motive of its proponents may have been to improve clinical decision-making, but soon EBM was also about cost containment, recourse allocation and distributive justice in health care. Many physicians feared that a tool had been created which appeared to facilitate intrusion by third parties.

However, I will argue that the rise of EBM in the Netherlands was not so much due to the efforts of non-medical 'third parties' to control medical practice, but rather to the attempts of an (academic) elite within the medical profession to control their 'peripheral' colleagues. Moreover, contrary to what is often believed, EBM served as a tool to enhance rather than limit professional (in particular: clinical) autonomy of physicians. Only to a very limited extent, the 'locus' of this clinical autonomy shifted from the individual physician to the medical profession as a whole.

These and other findings from this Dutch case study give testimony to the weakness of governments, insurers and medical reformers and their inability to control medical practice, even in the present age of transparency and accountability.

> PANEL 9

Financing health care

Managing a budget for the beyond: hospital finances before medicalization

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Hospital finances in the late medieval and early modern period economically were based on a complex deal mixing religious values and secular capital. Hospital foundations provided considerable funds to shelter and feed the poor and needy.

Funding the works of mercy by the founders was equalised to practising these. To extend the mechanics linking the wealth of the benefactors' soul to the charitable work of the hospital, capital investments allowed for income from capital which had been used for financing the hospitals' work. Clever investment of the endowment maintained the religious purposes as well as the charitable work itself. At least theoretically, investment, reinvestment and gaining the return of investment should perpetuate endlessly which finally meant that a charitable foundation also promised eternal commemoration of the founders' soul. Thus, hospital administration has predominantly been concerned with financial issues. Hospital management meant to generate the best possible return on the invested capital. In recent scholarship, the theoretical framework for the study of pre-modern hospital finances has been coined as „budget for the beyond" („comptabilité de l'audela"/ „mit dem Jenseits Rechnen") but we still lack sufficient knowledge of it's every day practise.

Having transcribed the account books of the Düsseldorf „Hubertus-Hospital" for the years 1542/43 the author surprisedly had to ascertain that within the expenses of these two years a huge issue was dedicated to just realising the revenues which afterwards could be spent to care for the sick and poor. Amongst other things, this meant travellingto the fields several times, first to negotiate the annuity agreement and to finally take home the crop. The proposed paper tackles the account books of the small „Hubertus-Hospital" in thetown of Düsseldorf in Western Germany. These accounts not only list expenditures for workmen, messengers, servants, nurses and healing personnel, food, clothes and coffins, but also the earnings of the hospital's holdings – according to the harvest of the year the subsequent profit gained by various agricultural products. Therefore, the account books allow for a close look into daily hospital life through the lense of its financial management and at the same time allow for evaluating the theoretical framework by means of the every day practises of managing a budget for the beyond.

The Costs of Infection Control in British Hospitals, c. 1870-1970

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Effective control of health care-associated infection is an important indicator of quality of care, especially in hospitals. Hospital organisation, governance and practices, alongside national policy, provide particularly important insights into ways in which the risk of spreading infections were, and are, minimized. Yet, while much historical research has focussed upon the debates and controversies surrounding competing ideas of the causes of infection (Ayliffe and English, 2003), what is less well understood is the impact of adhering to different theories of clinical practice and hospital management on the costs and workload associated with improved hospital hygiene. Waddington has commented on the general rise in costs generated by twentieth century reforms in nursing, but has not examined the specific costs of improvements in hygienic or infection control practice (Waddington, 2000).

Arising from a Leverhulme-funded project, 'From Microbes to Matrons: infection control in British hospitals, c. 1870-1970', this paper examines the costs of the workforce and material culture associated with infection control, their impact on hospital finance, and in turn, ways in which hospital funding shaped methods of infection control. It uses case studies based on the archives of four hospitals associated with Joseph Lister and Florence Nightingale, nineteenth-century pioneers of hospital infection control - King's College and St Thomas' Hospitals in London; and Glasgow and Edinburgh Royal Infirmaries in Scotland - in order to demonstrate that costs and labour associated with infection control practices were much higher than has hitherto been recognised. Analysis of the archives of King's College Hospital in the 1880s, for example, reveals that nursing was the single largest item of expenditure. With the addition of female domestic servants, male attendants, supplies (soap, plaster and lint) and washing, the total accounts for more than 60% of total hospital expenditure. Thus, nursing plus associated functions needed to maintain hygiene absorbed a significant proportion of hospital budgets at this time.

References:
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Waddington, K. (2000) Charity and the London Hospitals, 1850-1898. Royal Historical Society, Boydell Press.

Keywords: Hospital costs; health-care associated infection; hospital infection control; modern Britain

Ideals and the Cost of Care: Debating the costs of hospital care in Sweden around 1900

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The questions of who bears responsibility, who makes the decisions and who pays are questions that have plagued society over time in many areas, not least in the case of health care. During the last half of the 19th century fundamental reforms were carried out in the political structure in Sweden that eventually had a great effect on the structure of health care. One of these changes was the creation of regional government in the form of the landsting. This body was to deal with education, culture and health care, but its responsibility for health care soon dominated. At that time hospitals were growing in number, but not all were under the wing of the landsting. By looking at the financing of hospitals it is possible to illuminate some of the concerns and the philosophies that were governing the financing of health care.

This paper studies the variations in the financing of health care in Swedish county hospitals in the late 19th and early 20th centuries. When the organized struggle against tuberculosis got underway, the question of the financing the running expenses of the new institutions caused authorities and experts to investigate how existing hospitals were financed. These studies generated interesting source material, and revealed great differences. The archives of the hospitals and the regional governments as well as national investigative studies and government reports reveal a vast array of ideas concerning financing. Varying political philosophies are revealed in the arguments for and against various financial models. The role of these issues in the building of the welfare state is also considered.

Financing Medical Research in Bucharest, Romania and Liège, Belgium by end of 19th century - a comparative study

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In 1892, the Romanian Institute of Physiology was established in Bucharest. Director Alexander Vitzu (1852-1902), in his inaugural speech, carefully compared the financial situation of his Institute to the similar modern, state of the art Belgian Institute of the University of Liège, founded 1817. Vitzu was closely collaborating with Léon Frédéricq (1851-1935), who was succeeded Theodor Schwann (1810-1882) at the Physiology Chair in Liège and visited the Belgian Institute on the occasion of the Second International Physiology Congress, organized 1892 in Liège. A bursary of the Romanian State, Alexander Vitzu finished in Paris medical studies (Des grandes universitaires) as well as natural science in Sorbonne (1877-1882). A pupil of Henri de Lacase-Duthiers, Albert Dastre and Paul Bert, Vitzu was having also scientific contacts with Charles Édouard Brown-Séquard in Paris. The Romanian Institute is not only the first in Romania, but among the first in Europe. Vitzu was evaluating, from a late 19th century Romanian point of view, the maintenance costs of the main Institutes in Liège: the Anatomical Institute, Chemistry, Pathology, Zoology and Botanics. Comparisons of Romanian standards of financial investments in medical research were made by those in France (Strasbourg, Lyon) and Germany as well. Vitzu discusses how a Laboratory of Experimental Physiology can be transformed, through a cost-effective budget strategy, into an Institute with three main departments: biochemistry, physics, vivisections and functional morphology. This study provides an insight into the origins of modern clinical research and medical financing in Romania, and the contemporary personalities in Romanian and Eastern European medicine, like Mina and Nicolas Minovici (UEFISCDI - PCCA - PNII - 215/2012).

Keywords: Forensic Medicine, Eastern European History, Minovici Bros., Criminality, Anthropometry and Law Enforcement

> PANEL 10

Advertising Medicine

Brand Equity and Commercial Contraceptives in the mid-20th Century

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Mid Twentieth-Century contraceptives, even when they are examined through extant commercial materials such as advertisements, are frequently framed in terms of public health, rather than private enterprise. However, the commercial sale of contraceptives has historically outweighed public health or charitable provision. By the close of the 1960s, and despite the perceived threat of the 'population bomb', 98% of the world's birth control was sold via retail channels. But to what degree did the contraceptive brand, and brand equity, establish, maintain, or otherwise contribute to the retail success of mechanical and pharmaceutical contraceptives? What restrictions were in place on presenting branded contraceptives to the public? And how much value should historians attribute to the 'brand' as a measure of a method's successful uptake?

This paper will present case studies of commercial contraceptives that were available in the USA, Canada and England in the mid-20th Century, using a mixture of visual marketing collateral taken from the Wellcome Library, London, The Smithsonian National Museum of American History, Washington DC, and the Percy Skuy Contraceptive Collection, Dittrick Medical History Centre and Museum, Cleveland, Ohio. These primary sources will be examined with recourse to common medical marketing practices of the period. Overall, the aim of this paper is to make the case for the significance of the branded commercial contraceptive in examining the history of fertility control and consumption.

Keywords: Contraceptives, Marketing, Branding, Retailing.

Medical Advertising and the History of Patients: The case of Migraine

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Printed advertisements for migraine remedies appear in English language pamphlets and newspapers at least as early as the seventeenth century. By the nineteenth century, peripatetic salesmen such as Maurice Mené promoted their medical wares in widespread campaigns in national and regional newspapers. Jump forward to the late twentieth century, and between 1980 and 1987, the pharmaceutical company Boehringer Ingelheim sponsored four Migraine Art Competitions, in which entrants were invited to illustrate their own impressions of visual disturbance or the effect migraine has on their everyday lives. Entrants were overwhelmingly women, reflecting and reinforcing a highly-gendered market for migraine pharmaceuticals.

Historians of medicine have often considered medical advertising in terms of a war against quackery by an emerging medical profession. In the US, analysis of pharmaceutical marketing has largely been framed by debates about the regulation of direct-to-consumer advertising. Recently, scholars have also begun to consider adverts by attending to the "reading practices" of both medical practitioners and consumers.

In this paper, I take a different approach, using the long history of migraine-related medical advertising as a way to uncover (and critique) the history of patienthood. I examine the extent to which migraine remedy advertising practices both reflect and help constitute changing ideas about migraine and its sufferers. The history of advertising is important for migraine because it reveals a rich vernacular discourse about the disorder before it was taken seriously by the medical profession, but it is also significant more broadly, as source material for considering the history of gender, chronicity and the legitimacy of common disorders.

Keywords: migraine; medical advertising; patients; gender

A 'participation economy?' Letter writing for medicinal consumer products

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This paper examines the values of participation and evaluation in healthcare interactions occurring in a commercial context, taking inspiration from the recently developed concept of the "participation economy." In past years, historians of medicine like Nancy Tomes have challenged the institution-focused narrative of the rise of the medical profession, most famously proposed by Paul Starr, by calling attention to the seemingly paradoxical parallel rise of an increasingly emancipated and autonomous "consumer-patient." The role of consumer engagement around medicinal commercial products in eroding traditional health interactions, however, remains underexplored. In this paper, I will examine communications around a commercially-produced medicinal food product, Benger's Food, including letters written by lay consumers and medical professionals to the Benger's Food Company between 1880 and 1927. Some of these letters were used in testimonial advertisement of the product. I will argue that these communications embodied elements of the physician-patient relationship, but also engendered new kinds of relationships between food producers, physicians, and lay consumers, which relied on notions of the testimonial as evaluation and participation.

The investment consumers and physicians undertook in writing these letters and in willingly contributing to the advertisement, dissemination and evaluation of the product, will be assessed using insight from recent economic scholarship on the "participation economy," a term coined to highlight new demands for involvement and engagement by millennial consumers in the design and marketing of products. By paying attention to communications around medicinal products as an extension of traditional patient-physician interactions, this paper adds to the history of changing healthcare relationships in the 20th century, specifically suggesting that medicinal consumer products and the communications they provoked can be useful to understand the historical development of the consumer-patient role.

Keywords: consumption, patient-physician relationship, testimonial advertisement, participation economy

Rational Drug Design: Science and innovation in the pharmaceutical industry.

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Throughout its history the pharmaceutical industry has sought to make a profit from the treatment or prevention of illness. The history of the industry's development from the mass production of traditional recipes to the rise of innovative products linked to groundbreaking scientific research at the beginning of the twentieth century has already been widely studied. In this presentation, we will look at the origins of the concept of 'rational drug design' that has latterly become a reference for the industry. Thus, pharmaceutical firms now put the accent on the promise of perpetual innovation premised on investment in fundamental scientific research, rather than vaunting their large-scale screening projects aimed at uncovering (and patenting) nature's hidden therapeutic treasures. In brief, we take a historical look behind this rhetoric. Based on a study of the published and unpublished writings of Donald D. Woods and Paul Fildes in the early 1940s, we see how the initial conception of rational drug design was not only tied into both biochemical research on the metabolism of bacteria and the role of the vitamins in cellular function but was also linked to research on the mode of action of new drugs.

Indeed, Woods, Fildes and their colleagues developed their innovative and influential idea of antimetabolites while attempting to explain the antibacterial effect of sulfa drugs. They then expanded their initial idea into a wider theory based on this mechanism of action which would considerably stimulate pharmaceutical research over the following decades, albeit with mitigated success. Fildes devised a theory of antimetabolites that opened up the possibility of designing drugs to block the action of specific molecular targets. This was seen as a better way to find new drugs based, as it was, on the rational application of biochemical knowledge at the cellular and even molecular level. The story was not, however, straightforwardly one of the application of fundamental research in cellular biology to the ends of developing pharmaceutical leads. Fildes's research on bacteria developed out of an interest in the antibiotic action of the sulfa drugs, indicating that it was as much applied pharmaceutical research as it was fundamental. Although the subsequent development of useful antimetabolites proved more difficult than the researchers had anticipated, this process of turning biochemical research into new drugs triggered innovation at a number of different levels. We will use this episode to suggest some lessons that might be learned from the complex interaction and blurred frontiers between 'fundamental' and 'applied' research in pharmacy and biochemistry during and immediately after WWII. This distinction, which remains common currency even today, has been widely criticized for masking the complex entanglement between academic research and the pharmaceutical industry. Here we see how this distinction was already challenged by the researchers themselves. Furthermore, the pursuit of profit was not entirely excluded from the academic laboratories just as the pursuit of knowledge was not absent from the engagements of private pharmaceutical firms.

Keywords: antimetabolites; fundamental research; applied research; pharmacy

Short film

Man and His Health (1967, 18 mins.): A Major Work of Medical Cinema, presented by the director, Robert Cordier

The Health and Medicine pavilion at Expo 67 in Montreal, was built around a core exhibit, Meditheatre, a combined film and theatre show. The film, documenting six medical interventions in Montreal hospitals, is an extraordinary cinematic consideration of the marriage of humans and machines at vital medicalized moments. It was directed by Robert Cordier (Injun fender, 1974), who was then at the heart of the avant garde theatre, film and performance art scene in New York, as well as artistic director of a civil rights theatre project in the segregated South. The cinematographer was John Palmer (Ciao! Manhattan, 1972), "a gifted photographer and cinematographer in the Warhol Factory circle and participant in Jonas Mekas' Film-makers' Cooperative." The film Man and His Health, not seen for 48 years, was recently re-discovered in the film archive of Library and Archives Canada by historian of medicine, Steven Palmer. Robert Cordier will present the film and answer questions about it after the screening.

Friday, September 4

Panels 11 - 22

> PANEL 11

At what cost? Professional and patient perspectives on Australian health in the 20th century

Aliens and alliances: immigrant doctors and state-subsidised health care in Australia, 1930-1960

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The British Medical Association in Australia successfully defeated two attempts at introducing national health schemes, once in 1928 and again in 1938. Finally, in 1953 the newly elected conservative government brokered a scheme that protected the prevalent, private fee-for-practice structure.

Around the same period, 1930-1960, Australia accepted over 3,000 immigrant doctors. The local profession's reception of these doctors largely depended on their nationality and training: the approximately 2,500 British and Irish doctors were welcomed, while over 800 other continental European doctors were denied the right to practise for almost fifteen years. The local profession's attitude towards the latter group has largely been attributed to fear of competition or racial prejudice – continental European or 'alien' doctors were thought to be over-specialised and ill-equipped to suit the health care needs of Australians. The reception of and impact that the British and Irish doctors had on organised medicine, on the other hand, has not been studied in depth.

In this paper, I propose to use a prosopographical approach – drawing from archives from across Australia, the UK and Europe – to construct a narrative of immigrant doctors' lived experiences. In doing so, I will examine how the political and professional culture surrounding the provision of state-subsidised health care in Australia was shaped by or helped shape immigrant doctors' experiences; and the central, underlying role that economic considerations had on the relationships between local doctors, their immigrant counterparts and medical institutions.

Keywords: immigration; biography; Australia; national health schemes

How would they have managed without us? Poliomyelitis and the physiotherapy volunteers in Victoria, Australia

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Poliomyelitis epidemics raged in Australia throughout the first half of the twentieth century. The first epidemic in Victoria in 1908 coincided with the graduation of the first cohort of physiotherapists to receive formal education through the Australasian Massage Association and the University of Melbourne. The Children's Hospital desperately sought physiotherapists to volunteer to treat affected children since physiotherapy was the principal form of treatment. For some thirty years, much of this treatment was provided pro bono, reflecting a culture of volunteering that began with the first physiotherapists recorded in Melbourne's charity hospitals in the late nineteenth century. By developing collegial relationships with the hospital's honorary medical practitioners, physiotherapists hoped to obtain medical referrals for private patients from whom they would receive fees. In this paper I aim to determine the role that poliomyelitis played in the professionalisation and development of physiotherapy in Victoria, Australia.

People newly diagnosed with poliomyelitis were admitted to Fairfield Infectious Diseases and the Children's Hospitals. In 1925 the Melbourne City Council formed a Health Committee and gradually patients' services improved with some paid positions for physiotherapists. In 1931 the Children's Hospital commenced an Itinerant Physiotherapy Service. This Service enabled early discharge of patients and treatment in patient's homes. The largest epidemic of over 2000 cases of paralytic polio in 1937/38 required every graduating physiotherapist. World War 2 compounded such pressures. With post-war immigration, special arrangements were made for the treatment of the many migrant children with poliomyelitis. Finally in 1951 the State Government became responsible for funding physiotherapy services for adults as well as children.

The historiography of physiotherapy in Australia is limited and the experiences of the individuals have not been addressed. In this paper I will draw on the archived reflections of physiotherapists and those people with polio they treated. I contend that their work with poliomyelitis' patients profoundly influenced the professional development of physiotherapists. The professional independence and autonomy within the Itinerant Service became the forerunner of community care. As the incidence of poliomyelitis decreased the State Government Service expanded to include other long term disabling conditions and preventative programs. Physiotherapists began diagnosing and referring people to medical practitioners. This countermanded the medical referral ethic leading to it being rescinding. Such a change initially caused the World Confederation of Physical Therapy to consider expelling Australia from the world body. Now Australian physiotherapists receive worldwide approbation from their physiotherapy colleagues.

Keywords: physiotherapy; poliomyelitis; professionalisation; Australia

An investment in 'magnificent human material': how constructions of health shaped the design and experience of Australia's post-war immigration programme, 1947-1971

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In the quarter century following the Second World War, the newly-established Australian Department of Immigration embarked upon an unprecedented immigration programme that encouraged 2.5 million people to move to the other side of the world. Assisted passage agreements were brokered with Britain, the Netherlands, Italy, Germany, Austria, Greece, Turkey and Yugoslavia, as well as with the International Refugee Organisation, the latter which facilitated the journeys of more than 170,000 refugees from Central and Eastern Europe. These migrants were intended to increase national security by bolstering the Australian population, and to provide the essential labour for an expanding manufacturing sector, including a number of large-scale public works. Together with the Department of Information, the Department of Immigration orchestrated a publicity campaign to allay domestic fears about the arrival of so many 'Poms' and 'foreigners'. They emphasised the health and assimilability of these 'New Australians', portraying robust and friendly young workers keen to shake off their pasts and become fellow citizens. To attract migrants, an image of Australia as a 'healthy haven' was cultivated, with emphasis on quality of life and abundance of opportunities.

This paper will assert the centrality of health to the operation of Australia's post-war immigration programme by tracing the discourse connecting notions of health and assimilation in government sources, the writings of Australian health practitioners, and the memories of migrants themselves. Previous historical approaches to the subject of immigration and health in Australia have focused on a policy level, making plain the close relationship between the two areas in immigration restriction and quarantine legislation. In a departure from the emphasis in the literature on borders and barriers, this paper will ask how changing constructions of health shaped migrants lives after arrival in Australia, through a consideration of the gulf between their expectations, and the subsequent encounters that took place in spaces including migrant hostels, public hospitals and GP surgeries. The tripartite approach, encompassing the perspectives of policy makers, migrant patients and medical practitioners, aims to shed new light on the importance of health in the process of migrant settlement, and the mobilisation of ideals of health (national, familial and personal) in the selling of immigration to both prospective migrants and host populations.

Keywords: Australia, immigration, assimilation, post-war

> PANEL 12

Inequality

A conceptual history of social inequality in health in the Federal Republic of Germany

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In Germany inequality is a key concept in the three discourses of social epidemiology, political consulting and health policy. German scientific research on social inequality in health commences in 1975. The date is a turning point in a field of research that maintains socially disadvantaged people are more likely to fall ill.

The study reconstructs the relationship between political economy and the interventions chosen to decrease social inequality in health in Germany. 110 scientific papers, 14 surveys of the advisory board on the development of public health and the legislation on public health in Germany between 1975 and 2009 are analyzed by using the means of conceptual history and the sociology of knowledge approach to discourse.

The paper aims to contribute to the research on biopolitics by elucidating the historical phases in which inequality was shaped as a concept of knowledge and compares this with the interventions chosen to decrease these inequalities. The historical change and the reciprocal influence between the discourses are analyzed to better understand the concept of inequality in health. The reconstruction of the concept reveals the interdependence of denotation between social epidemiological research, political consulting and health political debate in the Federal Republic of Germany between 1975 and 2009. The research shows that the process of selection an intervention is more dependent on economical reasons than on the scientific knowledge.

Keywords: Social inequality in health, political economy of health care, Federal Republic of Germany, conceptual history

The Preston Curve revisited: When does more national income harm health?

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A positive relation between rising income and health improvements has usually been accepted as a given, and this idea was given scientific backing when, in 1975, Samuel Preston published a graph with curves demonstrating a positive correlation between per capita GDP and life expectancy. The concept continues to be cited as a major justification for ongoing efforts to spur economic growth, especially in low-income countries. However, this simplistic correlation has been challenged almost from the beginning. Preston himself pointed out that income was only one in several factors relevant to health and that its impact could be negative as much as positive. However, since 1975, world income has increased and so has life expectancy, both globally and in the vast majority of countries. In many ways, people have never been wealthier than today and have never lived longer and healthier lives, and so far, no case has been documented since the 1950s that rising income would coincide with deteriorating health. However, there is substantial evidence that some drivers of GDP improve economic well-being but affect other social determinants of health negatively. This finding begs the question to what extent, under what circumstances or whether at all health may be improving not because of but in spite of increasing national income. This question is particularly acute when considering transboundary and global effects of economic activities not caught by frames, such as the Preston curve, which take the individual states as reference points. Using transportation/car industry and the financial sector as case studies, this paper explores the health price paid for two major sectors of the international economy of recent decades and places them in context with their assumed health benefits. For a quantitative approach, this paper makes use of data regarding product transportation, road traffic injuries, pollution, greenhouse gas emissions as well as of income contribution and social inequality. In a more qualitative approach, it places the results in context with supposed but often unquantifiable positive and negative health repercussions of these sectors. Well documented findings regarding the social determinants of health serve as point of reference. The purpose of this paper is not to determine definite answers, considered impossible at this stage, but to present a contribution to new approaches to a reconsideration of recent global relations between income and health.

Keywords: Preston Curve, economic growth, social determinants of health, transportation

Economic variables of poor relief options in Évora in the 17th and 18th centuries

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In Poverty and poor relief in England[2] , Steven King, contemplates the issues of regional differences observed in England in the 18th century, namely the level of poor relief funding. This is indeed an ambitious theme due to its geographical dimension and difficult to develop in places where there are no studies promoting the comparison. In Évora, this is precisely what is lacking in the work that we have done, but it has been also inspired by the theoretical principles and ideas developed by King.

In a global analysis, I tried to find the typologies of poor relief in this city in the southern interior of Portugal. In a micro level analysis, I found that assistance to the poor was divided in Évora into an outdoor and indoor regime. The aim of this paper is to verify the funding options chosen by welfare administrators within these two types of assistance and contextualize them in an economic and financial perspective in the city and region of Évora. In other words, I intend to study the influence of the macro and micro economic environment in the poor relief options of the institutions providing assistance. In this context, it is also important to question the centrality and uniqueness of these variables, seeking to explain the role of others, such as demographic pressure, or the concept of poverty and the poor.

The sources used to prepare the paper will be primary, or rather, produced by the institutions providing assistance to the poor: mostly the Misericórdia de Évora (a lay confraternity under Crown protection) and the Évora Cathedral Chapter. Sources include poor relief income and expenses, hospital patient admittance registers, records of people's relief in an outdoor regime, and the costs involved.

Keywords: Évora, poor relief, outdoor/indoor assistance, welfare costs

[2] KING, Steven, Poverty and welfare in England (1700-1850): a regional perspective, Manchester, Manchester University Press, 2000.

The Political Economy of Rural Health Inequality: Socialized Models of Care in Canada and the US, 1937-1951

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This paper explores the relationship between rural political economy, health inequality, and socialized health care provision in the thought and experience of key health advocates whose transnational careers traversed "New Deal" era health politics in the United States, and the Cooperative Commonwealth Federation (CCF)'s early blueprint for medicare in Saskatchewan (commonly considered the model for universal health care in Canada). Employing biography, intellectual history, and network theory, and based upon published writings, speeches, and private and government correspondence, the paper discusses a network of health care advocates whose careers illustrate the period's growing awareness of rural health inequality, and the emergence of innovative rural health policies shared across the borders of nation states. Central to the paper will be the careers of two individuals who worked in both Canada and the US: Frederick Mott and Milton Roemer. Among historians of medicine, Roemer may be the better-known, as a student of Henry Sigerist, a health internationalist, and a widely-published scholar. It was Mott, however, whose career was spent building experimental health programs for farmers and unionized workers, from Washington to Saskatchewan, to the Appalachians, to Detroit.

In the pioneering Rural Health and Medical Care (1948), Mott and Roemer sought to re-define North American health politics through their critique of rural economies: a critique that forged a connection between capitalist agriculture and land inequality, rural ill health and poverty, and racial inequality. Their work argued that redistributive principles were necessary in order for a society to bear the cost of health care. In other words, it was actuarially impossible for impoverished farmers, even working on principles of cooperation, to square the circle of health care costs alone. Based upon data collected during a decade working with rural people in the Farm Security Administration, their work challenged public health's pre-occupation with the unhealthy urbanite. Mott, Roemer and their transnational network actively interrogated the myth of rural healthfulness, and promoted innovative socialized delivery models for rural people.

Keywords: rural health; transnational; New Deal; medicare

> PANEL 13

Promoting Medicine and Health

Health and Community on Starship Expo: The Spectacle of Medical Progress at the Montreal Universal and International Exposition, 1967

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The most successful world's fair of the 20th century, Montreal's Expo 67 showcased medicine and health at a time of great certainty about medical progress. Those in charge of producing the spectacle of health at Expo '67 were a "who's who" of Canada's eminent physicians, surgeons and medical researchers and they identified with a vision in which medical progress came from high technology and complex science – one that had strong commercial overtones. This did not satisfy, however, the grand humanistic and internationalist theme of "Man and His Health" that senior fair planners wished to convey. As a result, over the summer of 1967 an essentially techno-medical and commercial conception of progress in human health had to make room on the futuristic Expo site with displays of environmental health, primary care, and non-traditional medicine. Resting largely on the files of the Expo corporation, the paper will explore the Montreal world's fair as a vessel of hegemonic Western medical discourse in the mid 1960s, one struggling to accommodate counter-currents and alternative visions.

Keywords: international health, Expo 67, Canada, technomedicine

Nature-cure for the masses: entrepreneurs, brands and niche marketing in Britain 1900-1940

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This paper will examine evidence of entrepreneurial activity in the market for nature cures in early twentieth-century Britain in order to critically examine the current consensus that this period was one in which unorthodox healers suffered a relative decline in the face of increasing state support for orthodox medical practice (Saks, 1995; Nicholls, 2013). Analysis of the activities of selected medical publishers between 1900 and 1940 will be presented and the argument put forward that their initiatives demonstrate that this period was formative in the creation of a new mass market for natural therapies. The discussion will draw on little used sources including the lists of publishers C. W. Daniel and Co. and Health for All Publishing Co. and periodicals such as Health and Life, Herbs for Health and Health for All. A case will be made that entrepreneurs developed marketing techniques, retail methods and brands before the Second World War that created a flourishing niche market for natural healing products and approaches that pre-dated the interest in holistic healing associated with the counter-culture of the 1960s and 1970s. Case studies of selected naturopaths and herbalists show that unorthodox practitioners used these initiatives to underpin viable careers as healers, retailers, educators and authors and indicate that medical pluralism continued to be a characteristic of the British market for health care products and services in this period.

Keywords: naturopaths, herbalists, entrepreneurs, medical pluralism

'We Cannot Undertake the Risk': The Business of Medical Publishing in Nineteenth-Century Britain.

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In the nineteenth century the publishing of medical books and periodicals was a risky business. Books frequently failed to recoup the cost of their publication and periodicals were often launched and then discontinued in the space of only a year or two. Publishing companies that specialised in medical material frequently complained of the difficulty in obtaining large readerships for their works.

The men (as they predominantly were) and businesses who published medical monographs and periodicals have all but disappeared from history. Yet by examining their stories, a narrative of medical print culture is revealed that speaks to the consequences of financial pressure upon the authentication and circulation of medical knowledge. Using material collected from the rich archives of the Ballière, Tindall and Cox and Churchill publishing companies, I focus on medical periodicals to show how publishers' concerns regarding profitability – as expressed through issues such as pricing, audience and journal format - impacted on the content within. By doing so I raise two overlooked but potentially significant issues: first, the influence of publishers (rather than medical professionals) on the content of medical periodicals, and second, the role non-professionals might have had as consumers of these journals. Both underscore the fact that while medical periodicals were considered (as they are by historians now) lynchpins for the project of professionalization, they were also businesses reaching out for custom.

Given that areas such as open access, paywalls and the decline of the print journal are topics of much debate in present day medicine, it seems appropriate that historians begin to reflect more scrupulously upon the economics of medical publishing. By examining how medical knowledge, as projected by periodicals, was mediated by financial concerns, my paper argues for a joined up economic history of medicine, within which the influence of monetary objectives is understood as a pervasive feature of nineteenth-century medical culture, present even when its presence may not be overt.

Keywords: Publishing, periodicals, nineteenth century, Britain

Cash or Care? Configuring 'Cost' in Public Health Education in Britain, 1950-1980s

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In November 2014, the management consultancy firm McKinsey published a report outlining the economic cost of obesity. The study's headline grabbing finding was that obesity placed a greater financial burden on the UK economy than armed violence, war and terrorism. The McKinsey report is far from being the first publication to stress the financial implications of public health problems: economic imperatives and health concerns have often been bound together within public health policy and practice. However, in the second half of the twentieth century, the rise of 'lifestyle' related illnesses such as lung cancer, and obesity, together with the penetration of neo-liberal economics into health, brought about a new emphasis on cost within public health.

This paper will consider the ways in which cost was configured in health education and promotion in Britain from the 1950s to the 1980s, and what this tells us about public health and its relationship with the public during this period. Drawing on a collection of public health posters and films, it is argued that 'cost' was understood not just in financial terms, but also in relation to the cost to health of certain actions or inactions. In the 1950s, for instance, a campaign to encourage parents to immunise their children against diphtheria, asserted that 'diphtheria costs lives' whilst 'immunisation costs nothing'. By the mid 1960s, a slightly different interpretation of cost appeared to be coming to the fore. Anti-smoking campaigns did stress the damage to health caused by smoking, but some material also emphasised the damage to spending power. Public health promoters were increasingly appealing to citizens as consumers.

As a result, the economic costs of behaviours such as smoking and drug taking became a common feature of public health campaigns throughout the 1970s and 1980s. Yet, cost was never understood solely in financial terms. Anti-drug messages, for example, emphasised the personal cost of drug taking in relation to physical appearance and damage to the family, as well as the health and financial implications of prolonged drug use. Towards the end of the period, the social costs of behaviours like smoking, drug taking and over-eating began to achieve prominence.

'Cost' was a multi-faceted concept within public health campaigns, combining health, economic, social, personal, individual and collective concerns. It would seem that 'cash' cannot be separated easily from 'care', but the configuration of these apparently different imperatives tells us much about public health and its publics.

Keywords: public health, health education, consumption, lifestyle

> PANEL 14

Money and Medicine before and after Birth

'Paying for Test-Tube Babies' - the establishment of in vitro fertilisation in New Zealand in the 1980s

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In this paper I will focus upon the medico-political controversies associated with the introduction of in vitro fertilisation ('IVF') to New Zealand in the early 1980s. These early debates largely centred upon whether New Zealand's public health system could afford to finance its own IVF programme and form part of a wider – and ongoing - debate about public healthcare funding priorities in a country with a population of only 4 million. From the early 1980s, "stoic and affluent" infertile New Zealand couples had been flying to neighbouring Australia to obtain self-funded IVF treatment from Melbourne's world-leading IVF programmes. Opponents of a New Zealand IVF service argued that this particular form of "reproductive tourism" should just continue or at the very least, that infertile couples should fund an IVF service in New Zealand themselves. As one newspaper editor wrote, "the non-bearing of children can hardly be reckoned a threat to physical health". I will argue that the reframing of infertility in public discourse as a physical "disease" was ultimately a crucial factor in the relatively smooth establishment of New Zealand's IVF programmes. Working closely together, New Zealand's leading infertility specialists and consumer infertility groups vigorously lobbied to gain public acceptance for their "infertility-as-disease" model. They argued that infertility treatment (including IVF) was as worthy of taxpayer-funding as other recognised medical and surgical problems. The IVF programmes' early conservative approach towards IVF – which limited treatment eligibility to married heterosexual couples using their own gametes – was another important factor in IVF's public acceptance by the mid-1980s. In effect, the state was prepared to pay something towards "'test-tube"' babies but only on limited terms.

Keywords: infertility, reproductive medicine, disease, reproductive tourism

Cash and care in the case of the 'Eggs Affair': reproductive technologies in early twenty-first-century Israel

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The aim of this paper is to examine how pro-natalist policies are entwined with economic interests in the provision and consumption of artificial reproductive technologies in Israel. In order to explore the dynamics involved it focuses on a scandal that took place in the early- 2000s where eggs were harvested from patients undergoing fertility treatment without their consent to be sold to other infertile women. The paper considers this case within the wider history of reproductive technologies in Israel. Prior to the enactment of Israel's 2010 Eggs Donation Law, the IVF Regulations allowed egg cell donations only by women who were undergoing IVF as infertility treatment. The rationale was that the health risks could not be justified unless the intervention was undergone primarily for the donor's own benefit. Given the difficulty in obtaining human egg cells, however, infertility patients ordinarily prefer to fertilize and preserve for their own use all the eggs retrieved in a given cycle. The discrepancy between the reluctance of patients to donate eggs and the increasing demand for donations led to a so-called 'shortage'. Private clinics started offering economic inducements to infertility patients to donate eggs, by waiving certain costs of treatment if they would agree to 'share' their eggs with others. Such practices culminated in the 2000 scandal that came to be known as the 'eggs affair'. Professor Zion Ben-Raphael, one of Israel's leading fertility experts, was alleged to have submitted women to excessive hormonal stimulation, retrieved dozens of eggs from single treatment cycles, and used these eggs in the treatment of large numbers of recipients at a private clinic, without their informed consent. Following Lev Vygotsky, the paper adopts a sociocultural perspective to understand how forces of society and culture influence individuals' thoughts, feelings, and behaviours. It analyses different representations of the 'eggs' affair' in the Israeli media in order to explore how ideas about egg donation, artificial reproduction, and gender roles were transmitted to the wider Israeli public.

Keywords: Artificial reproduction, Egg donation, Gender roles, Israel

The Economics of Scientific Births: Conditions and limitations for Swedish midwifery during the late 1800s

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My paper discusses late nineteenth century debates between Swedish midwives and doctors about the economic resources and responsibilities for transforming obstetric science into obstetric practice. One of the central tensions involved determining who should be financially responsible for this project, the public government or the private midwife? Because they were both self-employed and subordinated to government regulation (National Midwifery Act), midwives were particularly invested in these debates. My paper examines midwives' advocacy for economic stability in context of the emerging bureaucratization and professionalization of the Swedish health care system.

Two factors are central to my discussion: One is the scientific aspect of the antiseptic breakthrough. Laboratory discovery of pathogens resulted in a new emphasis on the importance of obstetric hygiene and helped to reduce the high number of deaths in puerperal fever. The second factor is the economic conditions for the midwives. As self-employed providers, they had to pay for childbirth equipment, and a large part of the midwife's income was spent to fund these purchases. The solvency of this exchange was severally challenged by the expectation that a midwife now had to purchase expensive disinfectants. This generated a big debate among Swedish midwives, and was specially discussed in the Swedish Midwives' Association. The profession's journal, Jordemodern, published notices that showed the arguments presented for and against the scientific breakthrough and the financial responsibility it imposed on midwives to be able to translate science into practice. The debate demonstrated the complex relationship between the state and the midwives, and highlighted how self-employed providers responded to state regulation. The complications were most visible when it came to economic needs and medical duties. In addition to examining the midwife's views, I also examine Swedish parliamentary discussion of this issue. Their debates further demonstrate that the implementation of scientific birthing was ultimately dependent on financial resources. They also reveal the strong correlation between the individual midwife's economic status, her activities among rich or poor, and her location in urban or rural areas and her ability to implement scientific knowledge into a financially feasible birthing practice.

Keywords: Midwifery, antiseptic breakthrough, bureaucratization, professionalization process

> PANEL 15

Beyond the body...

The end of the body as payment in late nineteenth-century Brussels

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Inspired by Michel Foucault, medical historians have suggested that the nineteenth-century hospital operated according to what one might term a social contract. Care financed by the rich had to be repaid, either by financial or by natural means. Grégoire Chamayou has shown that indigent patients paid their debts with their 'cognitive surplus value'- the knowledge contained in their body*. The bodies of the poor could be used for medical experiments and clinical education, leading to an advancement of the medical sciences from which the rich profited in the long run. This logic did not end with death. In Brussels, regulations stated that families could not prevent the postmortem examination of a relative unless they paid for the treatment or funeral. The hospital asked 'the most expensive compensation' of the poor, who only obtained the right to health by completely donating their bodies to science. The corpse was considered no different from 'inherited furniture or jewelry', objects that could also be confiscated by the hospital, despite the sentimental value families might attach to them. In the late nineteenth century, however, the compulsory dissection of the bodies of the poor became increasingly controversial. The regulation concerning postmortem examinations was dismissed as an instance of class justice. Moreover, it was argued that the body could not be seen as an economic commodity. Under pressure from the public opinion, anatomists, hospital administrators, members of the city council and legal experts discussed the status of the indigent corpse. Who was the rightful owner of the pauper body? By analyzing this debate, I will show how the relation between the hospital and the indigent patient changed in the last decades of the nineteenth century. Patients gradually obtained the power of disposal of their own body.

Keywords: anatomy, body, property, social contract

* G. Chamayou, Les corps vils. Expérimenter sur les êtres humains aux XVIIIe et XIXe siècles (Paris 2008) 178.

Commercialized bodies. The trade in anatomical preparations in Belgium, 1830-1860.

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In 1832 the private collection of Guillaume Demanet, a Belgian surgeon, was auctioned after his death. The collection not only contained books and surgical instruments, as the collection catalogue stated, but also several anatomical preparations. Though (anatomical) collections became more and more institutionalized in the nineteenth century, anatomical specimens still formed part of private collections. Medical men who did not obtain the skills to prepare anatomical specimens, procured these specimens through auctions or naturalists' shops.

In the early modern period anatomical preparations functioned as luxurious consumer goods. The research of Daniel Margocsy has shown how preparations were credited for their commercial as well as their 'epistemic value'. Commercial motives played an important role in the diffusion of (anatomical) knowledge in the republic of letters.

'Scientific entrepreneurship' was still part of scientific culture in the nineteenth century. Anatomical specimens were sold by some naturalists. Other scientists received special certificates for the import or export of conservation procedures for anatomical specimens. In this paper I want to investigate how anatomy was commercialized in the nineteenth century through patented conservation procedures and the sale of anatomical specimens. Collections connected to universities were not only completed through the work and research of the anatomy professor, but were also expanded with several specimens available on the market. The trade in anatomical preparations partly defined scientific collections, and allowed scientists to explore new research fields. This was the case, for example, with research on preparations made from bodies of indigenous people. A focus on the commercial value of anatomical preparations allows us to determine how the commercialization of preparations also influenced (new) anatomical research.

Keywords: collection, anatomy, anatomical preparations, trade

Auditing the Body in Medicine

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The technological gaze in imaging technologies and visual representations of the human body in diagnostics and doctor-patient interaction is constituted by a complex history, which is filled with myths. The introduction and re-transformation (or lack thereof) of this discourse, represented by magnetic resonance imaging (MRI) and functional magnetic resonance imaging (fMRI) is only the latest chapter in along series of discursive transformations, which has been created on the long lasting myth of the possibility of rendering the body transparent (of making the interior and the trope of interioralization [Verinnerlichung] "visibile" and manipulable from the outside: intervention without actually venturing into the interior). Among others, Kelly Joyce and Amit Prasad's seminal historical accounts of the development and the symbolic forms of imaging technology are mostly a history of the development of MRI as a disputed territory over Nobel Prizes and patents. As a surface conflict it is, perhaps, of less importance in comparison to conflicts in clinical practice, where imaging technologies do not actually "produce" images directly; they produce a lot of data, some of which is result of time-lag reaction or discarded and filtered as "white noise". But the history of the cartography of the inside of the body with imaging technologies is also a capitalist cartography. Making the body transparent and pathology visible is also guided by economic interests. The capitalist aesthetic and the myth of transparency are inter-related. In this presentation, I will both engage this mode (co-)production, and show which conceptual tools historians of medicine can deploy effectively to connect historical analysis with the idea of effecting transformation.

Keywords: Imgaging, Cyborg Visuality, Audit Society, Capitalist Cartography

> PANEL 16

Health and the Poor

The market of philanthropy or the philanthropy market? The commercial and entrepreneurial organization and function of Sweden's sick- and poor relief ca 1870-1920.

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In the 1800s did the pre-industrial society's "sick- and poor relief system" begin to crumble. It got difficulties handling the century's new migration patterns, demographic changes and ongoing proletarianization process. The "social question" became a political and economic headache, which involved and affected all levels of the society (urban as rural). At the same time were the publicly funded hospitals and insurance system of the 20th century only a radical idea, if that. Nevertheless, was sick- and poor relief an economic burden. How then, in the absence of the "public", did "we" try to master the increasing problems in terms of funding? A general answer is, by necessity, that we had to rely on private initiatives very much dictated by an "open market". Consequently was Swedish sick- and poor relief, heath care and philanthropy (ca 1870-1920) also depended on market forces. Exaggerated for clarity had these activities a commercial function and organization. To get a grip on this amorphous yet very present organization is the aim of this paper. The otherwise well-researched field on Swedish sick- and poor relief has rarely, if ever, addressed this topic.

Empirical focus will be on the Spas, often situated in rural areas, which harbored an extensive sick- and poor relief despite being joint-stock-owned companies. How did they gain a "surplus" enabling them to carry out its ideal to be a "Paradise on Earth" for each and every one, regardless of social rank and economic standards? How did they drum up business and/or keep their economies in balance?

Keywords: medicine, philantropy, funding, sick- and poor relief

The Generosity of the Parsimonious Poor Law Guardians: Expenditure on Drugs in the Workhouses of Birmingham and Wolverhampton

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The literature on the financing of British institutional medicine has concentrated on charitable hospitals to the exclusion of the poor law medical service, despite it being the majority provider. For instance, in Gorsky and Sheard's volume, Financing Medicine, only one of the 13 essays is concerned with a poor law infirmary. The institution concerned is situated in London, which is also the focus of Waddington's study, Charity and the London Hospitals. The historical perception of poor law guardians in nineteenth-century England was that of parsimonious and penny-pinching individuals, who put the interests of the ratepayers above those of workhouse inmates, including the sick. For instance, they rarely provided adequate numbers of medical officers and nursing staff, relying on inmates to carry out nursing duties. When the central authority prohibited this practice, guardians replaced them with probationers (nurses in training), rather than the more expensive fully trained nurse. Standards of treatment in workhouse infirmaries were frequently lower than in voluntary hospitals. Historians have criticised guardians for not approving medical and surgical treatment ordered by medical officers and for denying sick inmates the benefit of anaesthesia during surgery. In addition, therapeutic treatment in the nineteenth century was widely assumed to be ineffective, and so a waste of money.

Although staffing levels in Birmingham and Wolverhampton Unions were minimal, the guardians in these Unions were unusual in that they met the cost prescribed drugs (rather than by the medical officers) and so would have been expected to be more restrictive in authorising expenditure on them. However, when Birmingham guardians' attention was drawn to the increased cost of drugs for a six-month period in 1887 of just over £217 compared with the same period the year before, they concluded that the additional outlay had achieved satisfactory results on the basis of the proportion of discharges increasing by 36% and the mortality rate decreasing by 13%. They were satisfied that sick inmates were being 'fully treated up to the scientific attainments of the present day'. In 1846, Wolverhampton guardians debated the increased expenditure on drugs over the previous three years despite little change in the number of sick inmates and concluded that 'not a remedy' should be withheld.

This paper will analyse the expenditure on the medical treatment of sick inmates, utilising the minutes of the meetings of the Boards of Guardians and those of the Boards' committees, plus reports of the meetings in the local press. In addition, it will draw in material from studies in other provincial towns, such as Newcastle-upon-Tyne and Nottingham. The parsimony of the guardians in terms of staffing will be contrasted with their attitude to the expenditure on drugs and alcohol, the latter being the most frequently prescribed medicinal remedy and the mainstay in the treatment of fevers. The paper will demonstrate a more generous attitude on the part of the guardians to the management of patients in the infirmaries than would be expected from those responsible for keeping workhouse running costs to a minimum.

Keywords: drugs, medical treatment, sick inmates, workhouse infirmaries

Establishment and First Steps of the Health Service at the International Labour Office (ILO)

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The international relations were deeply impaired during the Interwar years and the economic depression affected the living standards of the population in many European countries. The problems stemming from the deterioration of health conditions featured prominently, as the authorities had to deal with the deep social crisis: war, famine and unemployment worsened health indicators and this affected more specifically the working classes. The challenge was of such magnitude that made useless traditional control strategies against epidemics and infectious diseases. In this context social medicine became part of public policy.

To address the deteriorating standards of living, occupational diseases and unemployment the ILO established a Health Service working together with other national and international institutions, as a reference of expertise.

The growing influence of the international organizations as a reference for national policies emphasized the role of the Health Organization of the League of Nations and the International Labor Office in the promotion of social medicine with active participation of other agencies such as the International Office of Public Health, the Rockefeller Foundation, the National Federation of the Red Cross, the International Institute of Agriculture as important agents.

Along with epidemics, infectious diseases, maternal and child mortality and hunger, occupational diseases and accidents focused activism and demands of the international labor movement, as an essential tool to restore social peace. It was a political commitment to compensate workers after the Great War.

The adoption of standard legislation became essential in industrialized countries, to improve working conditions and to extend progressively several initiatives of social insurance, including those intended to deal with the damage arising from working activities. On the other hand, the technical studies of the ILO contributed to provide scientific legitimacy to the workers aspirations and to extend the awareness of new occupational hazards among some sectors of the medical profession.

The First International Labor Conference (Washington, 1919) recommended the establishment of a Health Service at the International Labor Office at the suggestion of the Commission on Unhealthy Processes. Its objective was to deal with unhealthy processes, occupational diseases and hygiene of labor. The Service started carrying its duties since September 1920 as a part of the Research Division. The Health Service published some "Studies and Reports" regarding several outstanding topics such as statistical records, anthrax, occupational diseases and industrialization, disinfection, among others.

Research question and methodology: taking as point of departure the above mentioned international health context and the important role played by international organizations, this papers discuss this paper proposes a discussion on the first steps and lines of action undertaken by the Health Service of the ILO during the early 1920s, analyzing agents, issues, negotiations and results, as well as the cooperative initiative with other international and national institutions. The research is based on documents and reports, statistics and other archival sources of the International Labor Office and League of Nations Archives (Geneva).

> PANEL 17

Health and Politics

Discussing the Principles of Health Care: Dutch Parliamentary Debates of the 1860s

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From the 1990s onwards, The Netherlands have seen heated public and political debates about the organisation and financing of health care. One of the key questions included the extent to which the state can be held responsible for the health of citizens and the practice of medicine. Critics of the welfare state argued that it had led to passive and dependent individuals relying on care from the cradle to the grave and to over-expenditure. Neoliberals were convinced that the state should withdraw from the social domain. Collective arrangements were being critically reconsidered, reformed or transferred to 'the market'. Health managers were brought in, taking over control from professionals. The prefix 'neo' suggests that contemporary neoliberal reformers are harking back to the principles of classical liberalism, which emerged as a product of the Enlightenment ideal of natural human rights. It was all about individual freedom and equality of opportunity. In classical liberalism, the state was not a goal in itself, but rather an instrument that should safeguard the individual's autonomy and self-development in private life and civil society. How did it set out to accomplish this? Where did it go wrong? Does it still serve as an inspiration to modern reformers?

This paper is looking at the historical roots of neoliberalism in Dutch health care by analysing the arguments which were exchanged during the parliamentary debates in the 1860s on four bills with regard to national health care. They had been proposed by the liberal Minister J.R. Thorbecke, a towering lawyer-philosopher-politician who had first drafted the Dutch Constitution (1848) and who then went on to outline the principles of Dutch health care (1865).

Keywords: liberalism, health care, neoliberalism, parliamentary debates

London County Council, its Mental Health Policy and the Politics of International Consultation

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The aim of this paper to consider the development of London County Council's [LCC's] lunatic asylum building programme following the passing of the Local Government Act [LGA] in 1888. While the management and politics of asylums has been well served, the impact of the LGA on mental health policy has remained largely overlooked. Similarly, while studies of the LCC have examined its impact in a range of areas, much less has been done in terms of its work on mental health. These oversights are significant, not least because while the city was internationally recognisable to outsiders, the new County's responsibilities for what was existing asylum stock represented both a series of opportunities and challenges for the 'new' LCC to negotiate. Central to this has been the tensions between cost and the demand for care and the sense within the existing historiography that the LCC became a 'master builder of barracks'. Yet, evidence from the LCC archives reveal that other, cheaper barrack style alternatives were available. Decisions about the building programme were informed not just by an apparently increasing 'lunatic' population but also by an apparently similar rise in aged cases. How then were considerations made to the rate paying electorate balanced with the longer term responsibility for the care of the deserving poor – reiterated by the Lunacy Act of 1890? To answer this question, this paper will not just address the local, regional and national considerations informing the role of the LCC, it will also explore the Council's active participation in transnational dialogues concerning the 'future' of care. Using the largely unexplored records of the LCC, it will consider the politics of international consultation and its origin in the debates surrounding cost and care. Supplementing LCC's own archive materials with international sources it will consider how LCC's own efforts were viewed abroad. Ultimately it will seek to consider whether the assessments of LCC and its asylums were based on the Council's active role in the management of its institutional stock, and its ability to strike the appropriate balance between cost and care, or whether it was based on international views of the metropolis more generally.

Keywords: London County Council, Local Government Act, Asylums, Lunatics

Unprofitable profit: the failed role of the Pasteur Institute of Tangier in French public health in Morocco (1911-1929)

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The Pasteur Institute of Tangier (PIT) was founded in 1911 with the expected goal of becoming the technical center of public health in a Morocco soon to fall under French control. As a landmark of French influence, it received a relevant yearly sum from the Ministry of Foreign Affairs, although, following the traditional model of the Parisian motherhouse and of its counterparts in Algeria and Tunisia, the center was expected to raise a part of its annual income from selling vaccines and sera, performing analyses and providing other paying services to individuals, hospitals and health administrations. However, in 1912, Tangier became an international city outside the newly-established French and Spanish Protectorates in Morocco. The new peripheral status of the institute explained that the initial government provision was kept unchanged for almost 15 years in spite of the sharp depreciation of currency following WWI. As a result, the PIT had to fight for French hegemony and prestige mostly on the basis of private revenues, an uncomfortable position as political and scientific goals were often in tension with financial needs. For example, the institute's director, Dr. Paul Remlinger, regularly complained to the Institute Pasteur of Paris that the paying analyses left him with little time for serious research while providing neither interesting cases of study, nor enough money for expanding the center's meagre personnel and equipment. On the other hand, Spanish representatives, direct competitors of the French in Morocco and also in Tangier through a bacteriological laboratory opened in 1913, accused the PIT of hiding the bad quality of the city's water-supply for protecting the French-owned Société Marocaine de Distribution d'Eau, de Gaz et d'Electricité which had won the concession in 1919. In sum, this paper intends to analyze how the growing private profit of the PIT became in the long term an unprofitable business for French hegemony and ultimately for the scientific and public health activities of the institute. Sources for this work include records from the Pasteur Institute archive in Paris (annual reports, correspondence, institutional records), archival documents held in the Spanish and French ministries of Foreign Affairs (technical and political reports) as well as primary medical bibliography (Remlinger's publications) and newspaper clips from France, Spain and Tangier.

Keywords: Pasteur Institute, Tangier, 20th century, imperialism, private revenues.

'The British Red Cross Still Exists': adaptation to the post-war NHS era

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In 1947, the British Red Cross Society's Public Relations Department issued a statement that the public needed to know that the 'British Red Cross still exists', detailing a mechanism for 'a smooth machine for the handling of the news'. The introduction to the 1947 annual report reflected that people did not understand why the British Red Cross Society (BRCS) needed to raise money, considering that the Red Cross and St John Fund had raised £63 million during the Second World War. Yet this money had been allocated to supporting wounded servicemen, released camp internees, civilians suffering from the war, and the provision of welfare officers at home and overseas. The BRCS appealed for further funds for wounded servicemen, the hospital library service, the St John and Red Cross ambulance service which had begun during the First World War, and for training activities. Further influencing fundraising and activities, the provision of many BRCS services would now be led by the new National Health Service which was launched in July 1948.

Since the First World War the BRCS had been active in utilising philanthropy in order to establish ambulance networks and provision for first aid for road traffic accidents, a blood donation service and support for people with disabilities, for example. In 1947, the BRCS prepared for the 'appointed day' of the launch of the NHS by compiling data regarding the extent of services which would be handed over to the nation. Following strict guidelines, twenty hospitals and clinics were relinquished, highlighting some of the provision which the BRCS contributed to the interwar voluntary health sector. Ambulances and the blood donation service were now to be led by the NHS, although the BRCS would still provide assistance for the blood transfusion service and would provide a hospital car service.
The BRCS adapted by developing a range of activities in order to support the new health service. These included assistance with the shortage of staff for the new NHS through a variety of creative means. First aid posts were provided at events such as the 1948 Olympics in addition to the continuing provision of roadside first aid posts. Other activities included training of first aiders, hospital and lantern slide libraries, homes for the elderly, aid for children and people with disabilities, and invalid food. This led to a reframing of the charity's status and aims; in particular, humanitarian relief work at home and overseas increased in the aftermath of war, furthering the post-First World War pledge to mitigate suffering beyond wartime contexts.

Despite the BRCS's continuing support of national health the role of the Society has not been recognised in key histories of the NHS. Utilising the archive of the British Red Cross, this paper furthers the historiography of the financing of interwar health services and that of the introduction of the National Health Service by highlighting the important role of the BRCS from the 1920s to the 1950s. It examines the contribution which the BRCS made to interwar voluntary health services and the economic challenges which the charity faced in the late 1940s and the 1950s when the aims of the Society had to be realigned to support the National Health Service rather than being a leader of provision of services.

Keywords: Red Cross, voluntarism, philanthropy, post-war Britain

> PANEL 18

Value of Therapy and Disease

From isolation to integration: the institutional treatment of burns patients in Britain, c.1845-1950

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The history of hospital care for burns cases can be summed up neatly by the terms 'isolation' and 'integration'. With the establishment of British voluntary hospitals in the eighteenth century, ever greater numbers of domestic accidents and industrial injuries, including burns, were treated in medical institutions. Not all cases, however, were so fortunate. Children, 'women heavy with child', the mentally ill and those with venereal diseases were just some of those who were famously excluded from general hospitals. The high mortality associated with serious burns necessitated treatment in hospitals, however, such cases were deemed as potentially disruptive and requiring a disproportionate investment in resources. As a result, the first separate burns unit was set up in Edinburgh in 1845. Gradually, and reluctantly, other institutions open their doors to these serious, yet also potentially 'expensive', cases.

In the 20th century, separate, yet strategically located, burns units became the norm in Europe and North America. It became apparent that burns were more than just injuries to the skin and potentially impacted upon many of the body's systems. In the First World War, burns victims' vulnerability to shock was slowly recognised, and teams of ENT and dental surgeons undertook some pioneering reconstructive surgery in this field. The political economy of burns care noticeably shifted with greater numbers of cases coming from the military as opposed to mines, for example. By the 1930s, units gained cardiologists, renal and liver specialists to deal with, for example, the impact of hypermetabolism precipitated by serious burns. In the 1940s and 50s, infection control was prioritised and the case was made for burns victims to remain isolated in separate and expensive burns units. With survival rates increasing significantly in the late 1940s, the focus turned to the full psychological recovery of those suffering severe burns, and psychologists joined these uniquely integrated trauma teams. In more recent years, social workers, orthopaedic

surgeons and physiotherapists have augmented these teams which assist and reintegrate patients into former communities, and ideally 'productive' roles. This paper will explore the historical development of multi-disciplinary teamwork in British burns units, which remain highly integrated, yet equally isolated within the provisions of institutional medicine.

Making profit out of 'thin air': Sanatoriums and the invention of health tourism in Athens, 1880-1939.

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Since the early 19th c. medicine practitioners had focused and revisited the healing power of climate. Patients in Britain and America were advised to embark on ships and join therapeutic sea-routes. The introduction of climatic therapy in the medical rhetoric transformed once and for all the world map by introducing medical geographies. The patients along with doctors started searching for healing places across their homelands and the civilized west. Across Europe, America and Oceania healing lands appeared and healing cities were founded. Sanatoria -a new type of healthcare foundation- expanded rapidly in Greece during the first decades of the 20th c. and represented the appliance of medical climatology. The foundation of sanatoria extended the early modern comprehension of locus through the notions of inclusion, exclusion and healing, while at the same time these foundations incorporated technological and architectural innovations. The sanatorium movement and the economic development that followed it introduced to the patients areas, which used to serve as confined islands in the urban plan.

The rhetoric of fear against the contagious bacillus vs. enthusiasm for the promised economic growth placed the inhabitants of those therapeutic lands in the center of a long-lasting public discussion. This paper will explore the case of an Athenian suburb, which attracted rich and poor tubercular patients for decades (1880-1930). There will be a focus on the variability of patients' approaches to the healing lands. Workers resided in tents inside the forests, bourgeois rented rooms, locals made profit out of their hope for cure and doctors placed their gaze on this still formless economy.

The next step was the transformation of the neighbouring mountain of Penteli into a health park consisted of public and private sanatoriums. This is the outcome of a doctoral research conducted in public archives and private archives (sanatorium archives, local administration archives, ministries' archives, legal texts, doctors' treatises) in Athens. The idea of the sanatorium is being approached as a new business venture inside the socio-political context of its era. The paper aims to discuss apart from the evolution of climatic therapy into an economic practice which affected doctors, patients, the role of a disease and patients in the making of urban space in contemporary Athens.

Keywords: health tourism, tuberculosis, medical climatology, sanatorium

> PANEL 19

Money and Madness

An unprincipled trade in insanity? Private Madhouses in England 1730-1815

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Few historical entities epitomise the commercialisation of care more than the private lunatic asylum, or madhouse. William Parry-Jones' classic 1972 study, evocatively entitled The Trade in Lunacy, demonstrated the significant role of madhouses in the evolution of British psychiatry. Whilst presenting a differentiated picture of institutions that varied markedly in size, operational practices, and therapeutic standards, the overall image portrayed was of places where the pursuit of commercial gain predominated over aspirations to ensure 'care' and effective treatment for people experiencing serious mental disorders.

Forty years later, it may now be time to reconsider the place and nature of the private madhouse. The bulk of Parry-Jones' material, and especially the depiction of poor conditions and abuses, related to the nineteenth century. Roy Porter's seminal work on the 'long' eighteenth century, Mind Forg'd Manacles, showed that whilst some madhouses and their proprietors were clearly exploitative in approach, others offered relatively enlightened practices in comfortable settings. This paper aims to reflect on the nature of the Georgian madhouse as represented in some local manuscript sources, notably the 1763 diary of Joseph Mason of Bristol, and the 1770s correspondence between Samuel Proud of Bilston and the family of his patient Ann Pembury.

Madhouse proprietors were essentially men of business. Nevertheless, most recognised clearly that a profitable enterprise depended on achieving a good reputation within their locality and beyond, determined by the standards of comfort offered, achievement of recoveries, and the relationships forged between practitioners, patients and their relatives. These elements are evident in the documents, which illustrate that a successful practice involved the participation of the proprietor and his family in establishing a homely, domestic environment, and facilitating a supportive and therapeutic regime.

Several developments gradually altered the terrain in which the madhouse operated, shifting the balance between 'cash' and 'care'. The regulatory legislation of 1774 had some effects in upholding basic standards. It also reinforced an increasing professionalization of 'mad-doctoring'. Most significantly, the dynamic pressures consequent on population growth, industrialisation and urbanisation precipitated a growing demand for placement of parish pauper lunatics, leading to change in the composition of some madhouses' clientele and the character of their provision. Some new houses were established, geared toward admitting large numbers of paupers at discount rates. The small family-run madhouse was increasingly being eclipsed by the larger more commercially-orientated private lunatic asylum.

[The sources referred to in the text are held in Bristol University Library, Bristol Record Office, and Shropshire Archives. Other source material is from Staffordshire County Record Office; Birmingham Archives; Select Committee on Madhouses, 1814/15 and 1816, evidence of Thomas Bakewell and William Ricketts].

Keywords: insanity; madhouses; commercialisation; England

'A preventive psychiatry': The social turn in American psychiatry

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In his 1963 'Message to Congress on Mental Illness and Retardation', John F. Kennedy declared that while modern medicine had largely taken care of 'infectious diseases' and most of the 'major diseases of the body ... the public understanding, treatment and prevention of mental disabilities have not made comparable progress since the earliest days of modern history'. Rather than getting to grips with mental illness, however, 800,000 Americans languished in 'antiquated, vastly overcrowded, chain of custodial State institutions', which nevertheless cost the tax payer billions. For Kennedy, and for many American psychiatrists, the alternative to institutionalization was not psychotherapy, nor psychopharmacology, but, instead, was to 'seek out the causes of mental illness and mental retardation and eradicate them'. The solution was social psychiatry.

Social psychiatry, which posited that mental illness was rooted in socioeconomic problems, such as poverty, overcrowding, violence and social exclusion, was primarily 'a preventive psychiatry', as well as a social movement. Despite being largely forgotten today, social psychiatry was a major force within American psychiatry, as Kennedy's speech indicates. Emerging out of the mental hygiene and child guidance movements of the early twentieth century, social psychiatry took root during and after the Second World War, and influenced the creation and early objectives of the National Institutes of Mental Health. The aim of this paper is to address the relationship between social psychiatry and the deinstitutionalization movement in the United States. How did social psychiatrists envision preventing the sort of mental disorder that landed patients in psychiatric hospitals? What was the relationship between preventive psychiatry and community care for the mentally ill? And, most importantly, what exactly did social psychiatrists think would happen to patients who were released from such institutions? By utilising a qualitative analysis of archival evidence (including the American Psychiatric Association Archives), contemporary psychiatric literature (including American Journal of Psychiatry and Social Psychiatry) and public mental health legislation (including documents such as Action for Mental Health), the paper suggests that while economic considerations borne out of a preventive ethos may have inspired social psychiatrists and their supporters, economic issues also contributed significantly to the movement's ultimate failure.

Keywords: psychiatry, socioeconomic issues, prevention, deinstitutionalisation

Disordered in morals and mind: prisoners, mental illness and cost in late nineteenth-century England

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From the early nineteenth century to the current day reformers, policy makers, prison governors and medical officers have grappled with relentlessly high levels of mental illness among prisoners. Since the creation of 'modern' and specialised prisons and prison regimes, contemporaries have contested the detrimental impact of prison regimes and conditions – the separate system, solitary confinement and overcrowding – on the mental health of their inmates. Many inmates arrived at the prison gates already suffering from mental illness, and the passage of prisoners from prison to asylum and back, was a frequent occurrence. This paper explores the management of prisoners with mental illness in English prisons in the late nineteenth century, focusing particularly on the Liverpool Borough Prison. Managing these prisoners – male and female – became a significant part of the prison surgeons' workload and a financial drain on the prison services. Many prisoners were transferred to the more expensive county asylums. Those whose 'insanity' was doubted – malingers – remained in or were returned to the prison system. Even as the prison at Liverpool was being transformed into a new 'model' institution, it struggled with problems of overcrowding; in the Female Prison large numbers of Catholic – Irish – women were committed as prostitutes, who became a particular target of reform. Some of these women – 'disorderly prostitutes' – ended up in Rainhill and other Lancashire asylums time and again as the effects of their 'low-living' – alcoholism as well as prostitution – took its toll on their mental state. Drawing on underexploited prison archives, official papers, medical literature, and lunatic asylum casebooks, this paper examines the resources – human and financial – invested by the prison services and state in coping with mental illness among prison populations, and ideas about the entitlement of prisoners, including recent migrants, to care and treatment.

Keywords: prison, insanity, provision, cost

> PANEL 20

Global Perspectives, Migration and Health

Healthy New Citizens. Biopolitics in Screening Procedures for Displaced Persons Resettlement Schemes (1946-1950)

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There were millions Displaced Persons in Europe in the aftermath of II World War. Allies decided to direct them to "assembly centres" which from a temporary solution became longterm refugee camps. Their aims was to stop humanitarian crisis and assist refugees in the process of rehabilitation to help them become economically and socially valuable citizens. The camps became the centres of repatriation and resettlement operations. Displaced Persons started to be seen as an economical potential that would help to solve the problem of shortage of manpower. At the same time, many countries enforced eugenic criteria into the immigration policy to assure that newcomers will be fastly assimilated and will become desirable citizens according to existing standards. People interested in resettlement were subjected to complex screening procedures which took places in the DPs camps. The social and medical personnel aimed to choose possibly the best "human stock", as the members of Royal Commision named it. Among the countries most active in acquiring new healthy citizens was Canada, United Kingdom, Australia, Belgium, Sweden and Turkey.

This paper analyses the screening procedures for DPs resettlement schemes in terms of the Foucauldian concept of biopolitics. I will focus on chosen resettlement schemes, including few big operation like 'Baltic Cygnet' and 'Westward Ho!', as well as some smaller initiatives like famous case of 'Flying Virgins'. The comparison of selection criteria for different countries will provide the material for describing "the desirable body" of immigrants. I will try to show how the screening procedures were conducted to achieve this aim and to choose potential good citizens by evaluating how much healthy, fit, strong and young there are and how their race, religion, gender, marital status, moral condition match the expectations. People who were sick, old, disabled, with dependants or inappropriate in the other ways were rejected. I would like also to research their attitudes for the routine for resettlement schemes and what psychological effects these procedures had on them. The sources includes political statements, newspaper, DPs camps administrative documents, screening questionnaires, DPs memoirs and other personal documents.

Global Paradigms and Local Practices: Costs, Capital and Values in the History of Stroke Since the 1990s

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Since the 1970s and in most countries, stroke has been the third commonest cause of death and the greatest cause of adult neurological disability. In the mid-1990s new therapies for acute ischemic stroke were discovered. These have radically altered the understanding of stroke from a terminal to a treatable condition and established new paradigms for research and treatment. As a consequence new configurations of emergency stroke services, new diagnostic tools and new public education campaigns have been established worldwide.

Public, political and professional discourses around stroke over this period have been structured by arguments intertwining elements of the human cost of stroke, loss of social capital through disability and the economic and social value gained from treating patients. This paper explores the interactions between these political, economic and social threads through a series of local case-studies spanning different settings across the UK, the US, Sweden, Hong Kong and Australia in the 1990s and 2000s.

It draws on around 50 interviews with health professionals, policymakers and patient groups undertaken in the course of ongoing research into the global history of stroke, supplemented by documents. The material gathered enables the exploration of relations between universal features such as the calculation of costs to benefits ratio of providing patients with stroke treatments and services and local contingencies which have shaped service and practice development at local level. It shows how global discourses about the economic and social burden of stroke were woven into local priorities determined by social factors such as health and political systems, geographies, working cultures and professional identities. It identifies broad universal contestations between the new paradigms of stroke as an acute emergency and historically embedded notions of stroke as

an untreatable condition of the elderly which suggests how the value placed on patients' lives fluctuates according to the condition and patient demographics. It also interrogates the political and professional bias within medicine and health services to conditions perceived to be open to interventions.

The paper speaks to the key themes of this conference by linking local and global actors, events and processes around the new paradigms for stroke medicine in order to explore the commonalities and differences in the configuration of discourses in different geographical settings and communities. It suggests that although there is a shared global discourse around the economic and social burden of stroke, the elements of capital, concepts and values have taken different forms in different settings, determined by the social specificities of the particular local context. This encourages us to construct the age-old conflicts between humanitarian and monetary goals as dynamic and contingent. Finally it illustrates the rich value of a historical approach which seeks to bring the global and the local into the same lens for analysis though by no means underplays the additional complexities this creates for the historian.

Keywords: stroke; health services; oral history; health policy

> PANEL 21

Cash, Medicine and Gender

The political economy of gender politics in trans-related healthcare

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This paper will address the issue of "cash and care" in the history of medicine and health from a perspective that is apparently marginal but indeed revealing, namely that of the access to health care related to "gender change" or, more appropriately, "gender affirmation*". Nowhere as in the history of healthcare related to gender affirmation the relationship between "economics and values" has been so multifaceted and non-linear. Since medical technologies such as feminizing and masculinizing hormonal therapies and surgeries, started to become available and relatively safe in some countries during the 1950s, the possibility of having access to them has been claimed by many trans and gender variant people. From the moment when the first medical protocols were established the access to gender affirming procedures has been progressively facilitated for some people, namely those responding to the diagnostic criteria of "transsexualism" and "gender identity disorder" (substituted by "gender dysphoria" in DSM V), while - at the same time - made more costly, difficult or simply impossible for those who did not correspond to the general expectation regarding "transsexual people" or did not display "appropriate" forms of masculinity and femininity.

The development of psychiatric categories related to gender variance and of rigid protocols for "gender change" has thus made (some) gender affirmation procedures eligible for economic coverage by national health systems and health insurances. At the same time it filtered and regulated people's access to care, eliciting what a medical survey on gender clinics' policies would define as "seemingly interminable expressions of discontent voiced by patients (...) shopping for the path of least resistance"**. As the last phrase makes clear, the possibility of finding "paths of least resistance" must also be considered an issue of money and class. The policies (and politics) of access to gender affirming procedures must indeed be analysed from the perspective of bodily and gender self determination as well as from that of political economy and social justice.

Drawing on data collected in the frame of the ERC funded project *TRANSRIGHTS: Gender citizenship and sexual rights in Europe: Transgender lives in transnational perspective* (http://transrightseurope.wordpress.com/), this paper will explore, through a connected history approach, the relationship between "cash and care" in the development and transformation of institutional protocols and standards of care for the "treatment of transsexualism" in two European countries: France and Portugal. The evolution of diagnostic policies and criteria used to determine people's eligibility for accessing state-funded trans-related healthcare and the development of institutional protocols for the "treatment of transsexualism" will be examined. The aim is to assess under what circumstances barriers to the exercise of the right to health care and bodily selfdetermination may have been produced. The paper will resort to psychiatric and medical literature, international reports and recommendations (European Union, World Health Organization, World Professional Association for Transgender Health etc.), international and national surveys on transrelated, as well as health care reports of the policies adopted by medical teams and, recommendations issued by public institutions in both France and Portugal. The paper will also consider the claims of organizations, groups, associations and activists advocating for a better and more inclusive trans-related health care.

* M. Petersen, R. Dickey, "Surgical Sex Reassignment: A Comparative Survey of International Centers", Archives of Sexual Behaviours, 24 (2), 1995

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Keywords: trans-related health care, right to health, diagnosis, gender politics

Radium for men: a medical market specifically for male consumers.

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Some time ago I stumbled upon a photo album that contained a collection of photographs relating to the operation of the Standard Chemical Company, major radium producer in the US during the early 20th century. The picture that captured my attention was an unusual depiction of male gathering: ten men, some of them middle aged and some older, were sitting one across each other inside something that looked like a big camper tent. In the middle there was a big glass bottle and a couple of smaller ones placed on a small table. From the men's faces one could conclude that they were feeling comfortable while most of them reading. The photo's caption reads "Interior view- Standard Radium Emanatorium; patients being treated."

Throughout this period drinking radioactive water, inhaling radium emanations, and bathing in radioactive spas was suggested to men and women alike. However, I was struck by the picture from the Standard Chemical's emanatorium and the fact that all patients that appear were men; middle and old aged men. Similarly, a picture that depicts the Horseshoe Bathhouse at Hot Spring--the most known radioactive spas in the country--shows a handful of men that had just taken their bath. A reasonable question arises: could there be a radium market specifically for men? This paper looks through the fascination and the powerful allure of the science of radioactivity in order to see the origin of the connection between men and radium emanations and, in general, between masculinity and "lost manhood" kind of radium-based products. Very often radium companies capitalized scientific and medical findings. A number of radium devices became widely available to consumers by producers who had no medical approval or any medical staff in their scheme and equally often they were promoted by regular physicians. The focus here is on the complex ways--more often coded and camouflaged--that men have been invited to use radium products and devices in order to cure signs of impotence.

Keywords: radium, radon, male impotence, medical devices

Sick from work – Sickness absence among men and women in Sweden 1892-1955

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Before 1955, Swedish sickness benefit was organized through a variety of private health insurance societies (friendly societies/sickness funds). In 1891 a new law was adopted stating that the government would partially subsidize funds that agreed to be registered and ruled by official legislations. Thereafter several new laws were adopted until compulsory health insurance was introduced in 1955. This paper aims at studying morbidity by looking at sickness claims from two Swedish sickness funds during the period 1892-1954. It pays attention to individual sickness experiences during working life. Material from the sickness funds include membership data and information about the sickness benefits applied for by each member. All together data from approximately 3.000 male and female members will be collected. The paper aims at looking at age and gender differences as well as changes over time regarding sickness claims. However, as for analyzing, compared with statistics on mortality, data on morbidity is a lot harder to interpret. It has been questioned whether or not such data tells us something about changes in morbidity or if it is just evidence on sickness absence. Thereby highlighting the economic conditions, suggesting that economics may have had a greater impact on changes in sickness withdrawals than morbidity had. Therefore, the economic conditions for sickness funds become a vital issue for the analyzing of this data.

> PANEL 22

Cash and care in ancient and medieval Mediterranean

The economy of medical practice in the Roman Empire

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The practice of medicine and professional physicians were commonplace in the city of Rome from the middle of the third century BCE. However it was not until the decline of the Roman Republic and the foundation of the Principate that the Roman institutions took notice of medical practice. When Augustus established the Empire he encouraged foreign doctors to migrate to Rome by offering foreign doctors Roman citizenship and immunity from taxes. The policy of relieving doctors from civic taxes continued throughout the history of the Roman Empire for more than five centuries. In my paper I will examine the various pieces of legislation, which related to the economy of medical practice. I will ask when, how, and why these statutes were introduced. More specifically, I will be interested in learning why this new form of government assigned a higher economic value to human life, by financially supporting medical practice. This examination will place taxation policy regarding doctors in the broader context of the health related policy of the Roman emperors, which included new infrastructure of the water system, the foundation of public bath houses, and health considerations in civic planning. I hope to demonstrate that while it might seem on first sight that this concern to the well being of the Roman population was motivated by the emperor's care of his subject, more sinister considerations were in play.

Keywords: Economy, Law, Taxation, Roman Empire

Becoming a Gladiator from a Patient's Perspective

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Most of the gladiators in ancient Rome were prisoners of war or slaves. They were instructed for their bloody job in a gladiator's school (ludus) which had elements of a prison, barracks and a training centre. In the early Roman Empire more and more free Roman citizens and even noblemen went to the ludus and so enlarged the number of the gladiators, so that they were called 'auctorati'. They submitted themselves to the strong regime of gladiator's education, waived for a defined time by contract and oath on their legal rights as Roman citizens, and got the status of a kind of slave. The number of these auctorati was so immense, that the entrance to a ludus was even restricted by legal measures and orders of the emperors. You might e. g. relate to the prescriptions on the Tabula Larinas from AD 19. The motives of these Roman volunteers are discussed among scholars concerned with the ancient world in quite different ways. Some believe that the auctorati were led into the arena by bloodthirstiness or the spirit of adventure. But social and economic aspects might also have been strong motives: A total financial ruin could be compensated by becoming a gladiator, because salaries for special fights and especially at the end of the career of a gladiator – if the volunteer survived! – could be exorbitant. And for the whole time of their gladiatorial lives the auctorati got one of the best medical treatments a Roman could imagine. For instance the bestiarii of Corinth praise their team-physician Trophimos for his medical care on the base of a statue dedicated to him (IG IV 365), and excavated bones of gladiators show a high quality of fracture-treatment in the ludus. Did Roman citizens go into the arena to enjoy a kind of a health insurance? This particular question will be discussed on the basis of literary sources, inscriptions, Roman Law, and archaeological remains. Further aspects concerning other preventive measures against economic problems in the case of illness or accident known in the Roman Empire will also be taken into account.

Keywords: Ancient Medicine, gladiator, Roman Law, health insurance.

The value of trust in medieval medicine

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By 1300 medicine had become one of the four branches of institutional knowledge taught and learnt at the European Studia. Notwithstanding variations due to local traditions and evolution over time, the teaching of medicine at the medieval university adopted the syllabus that was established since the twelfth century around a set of works that later became known as the Articella or Ars commentata. The collection was complemented with Arabic works in Latin translation, and by the second half of the thirteenth century, in various university centres, a wide use is evident of a number of works by Galen that had not been extensively used in medical teaching before.

Apart from technical tracts on urines and pulses, there were no handbooks among these texts on how to behave at the bedside. Despite this fact, various traditions of pre-salernitan and Salernitan literature on medical manners -characterised by its highly defensive bias- were not incorporated at the university syllabuses but eliminated from academic discussion. Instead, novel readings of old materials –Aphorisms and Prognostics- were offered at the new medical centres to promote an idealized image of the medical manners that would structure the healing relationship around trust.

In this paper I would like to explore the value of trust as part of the non- monetary exchanges that characterised the healing encounter. I will do so by addressing not the actual practice of medicine but its teaching, because that provides witness to an idealized image of the healing exchange that the medieval university wanted to standardize and promote.

Sources used: Pre-Salernitan and Salernitan texts and commentaries in modern edition. The Articella collection in Renaissance edition and commentaries from the medical Schools of Montpellier, Paris, Siena, Bologna and Padua dating from 1250 to 1348 extant in manuscript.

Keywords: Medieval medicine, Trust, Articella, Healing encounter.

Saturday, September 5

Panels 23 - 25

> PANEL 23

The Costs of Abortion Services: Payment, Punishment, Reward

Abortion has constituted a controversial and emotive subject in the later twentieth century. The passage of abortion laws has triggered fierce debate about whether or not termination of pregnancy is morally acceptable, what kind of decision-making process is appropriate, and who should perform or facilitate the procedure. This panel will explore the perceived 'costs' of abortion, including the financial and emotional costs of private healthcare and abortion travel, the resourcing costs to providers, and the moral costs to anyone associated with the practice. Each paper has its own geographical focus, allowing a fruitful comparison of the political and reproductive healthcare systems of Western Europe, Eastern Europe and North America.

From 'Go to Jail' to 'Take a Chance': The Costs of a Medical Monopoly on Abortion

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In twentieth-century Britain, the economic and social costs of abortion featured prominently in medical, political and popular debates surrounding the termination of pregnancy. Prior to 1967, only women of some financial means could find a doctor willing to offer an abortion. Even then, doctors were liable to prosecution if commercial, rather than clearly therapeutic, motivations were discerned. The 1967 Abortion Act liberalised access to abortion but required two doctors to certify that appropriate indications existed, and allowed the operation to be performed only in a National Health Service (NHS) hospital or other officially-approved location.

This enforced medical monopoly, and the absence of a woman's 'right to choose', differentiated Britain from many countries' approach to abortion. Nor did it make abortion freely or consistently available across Britain. Far from it, it sparked complex debates about the cost implications to the NHS in resourcing terms, and the ethical price to be paid by obstetricians and midwives, who considered abortion the antithesis of their responsibility to bring life into the world. Local practice varied considerably over the next decade: the private medical sector adopted a prominent position in England, amidst widespread NHS reluctance, while NHS provision dominated in Scotland, since the private sector felt its reputation would be tarnished by association with the 'immoral earnings' of commercial abortion provision.

Using a range of medical, legal and governmental files, supplemented by oral testimony, this paper will explore, compare and contrast the perceived 'costs' to the medical profession and pregnant women of the 'medicalization' of abortion in 1960s and 1970s England and Scotland. It will argue that the conventional historiography largely stereotypes the response of the British medical community towards abortion, and suggest the need for a more nuanced approach which captures the diversity and ambiguities that characterised the community's response to this enforced medical monopolization across Britain

Keywords: abortion; medicalization; national health service; private sector

To and From: Feminists, Doctors and the Costs of Abortion Services at Home and Abroad for Canadian Women

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When the British Parliament passed the Abortion Act of 1967, the lack of residency requirements meant that women from all over the world, Canadian women among them, travelled to London to access abortion services. Although the Canadian government legalized abortion in 1969, the restrictive nature of the new abortion law meant that Canadian women continued to travel to London. Nascent women's liberation groups organized around their dislike of the 1969 abortion law, citing not only its uneven application across the country but also its unfairness; only a few Canadian women were able to afford or to borrow the money to finance the transatlantic journey, medical consultation, surgery, medication, nursing care, meals and accommodation. While the considerable economic costs of travelling to access abortion services abroad received a great deal of attention in feminist circles, it occurred against the backdrop of the Canadian medical profession's larger conversation about the moral costs of abortion at home and abroad. In the complex discursive interplay between feminists and doctors, women seeking pregnancy termination and doctors providing abortion services at home and abroad were alternately positioned as victims, heroes or villains, bringing into broad relief the conflict between the financial and moral costs of abortion. This paper draws upon archival research, medical journals and government reports.

Keywords: abortion services; 1969 Canadian Abortion Law; feminists; doctors; travel

The Cost of Reproductive Choice in Spain, 1970-85

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During Franco's dictatorship (1939-75), the Spanish Penal Code defined abortion as a crime against the person, and penalized with incarceration and fines both those who performed the procedure and the women who underwent it. The same article of the Penal Code also banned the circulation of any form of contraceptive propaganda. Only in 1978, three years after Franco's death, was the sale and advertisement of contraception decriminalized, and it took a further seven years to decriminalize therapeutic abortion. Banning abortion and contraception was a crucial component of the pronatalist ideology of the national-catholic regime. The financial and emotional costs of this ideology were paid by women who, despite the significant legal obstacles faced during both the dictatorship and the subsequent period of democratic transition, sought to control their own fertility.

Abortion 'tourism' of well-off women to clinics in London was at the centre of press representations of this issue, as it began to surface in public discourse in the later 1970s. In fact, England was only one of many foreign destinations to which women travelled for abortions, including the Netherlands, Portugal and Morocco. However, many women were unwilling or unable to travel, particularly for economic reasons, and thus relied on local providers, including gynaecologists offering an illegal procedure and feminist self-help clinics, which started to be set up in Spain after 1975. Some of these clinics offered abortion services, while others mobilized their networks to support women in organizing a more affordable abortion abroad.

The purpose of this paper is to explore the history of abortion in Spain during the final years of Franco's dictatorship and the democratic transition (1970-85), focusing on the experience of women, feminist abortion networks, and abortion providers. Through an analysis of the general press and oral history interviews, it will demonstrate the ways in which women's choices regarding unwanted pregnancies were affected by the cost of domestic and foreign abortion services. This cost is understood both as the financial impact of the procedure and associated travel, and the emotional distress caused, particularly by a journey abroad. The paper will also consider how Spanish illegal abortion providers and British clinics that specialised in treating Spanish women set the prices for their services.

Keywords: illegal abortion; Francoist Spain; Spanish democratic transition; travel

Transferring the Cost of Abortion in the Transition to Democracy: The Case of Croatia and Serbia

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Starting in 1989 and through the early 1990s during the so-called transition from socialism to democracy and market economy in Eastern Europe, a shift occurred that transferred the cost of women's reproductive health, specifically abortion, away from the state and onto women. This transition brought on a paradigm in which women not only had to provide a monetary payment for abortion services, which were previously covered by the universal health care system, but also had to deal with stricter abortion laws. My paper focuses on two former Yugoslav republics, Croatia and Serbia, where the transition from socialism to democracy translated into greater costs for women's reproductive health, further dividing women along socio-economic class lines. Due to pressure exerted by the Catholic Church (Croatia), the Orthodox Church (Serbia), and the nationalist political scene, as well as economic and health reform brought on by the (neoliberal) transition, both the Croatian and Serbian governments introduced new stricter laws on abortion, monetary payments, and a national registry collecting information on abortion patients (Serbia). In addition to documenting these historical changes in women's reproductive health policies, this paper will provide a brief example of one response by feminists and their attempt to raise women's consciousness by translating a pro-choice feminist text, Our Bodies, Ourselves.

Keywords: abortion laws; women's reproductive rights; Croatia; Serbia

> PANEL 24

Vaccines and Vaccination against smallpox and poliomyelitis: Economies and Values[4]

Bearing in mind the economic perspective and the extra-economic values of human health, the main aim of the session is to analyse these aspects, at a national and international level, in four different ways:

1) The importance of manufacturing vaccines as a crucial element not only in preventive and curative care but also in the development of virology and special research laboratories at a national level.
2) The economic and extra-economic values of the international strategy of smallpox eradication at a national level.
3) The role of philanthropic foundations and pharmaceutical laboratories in the development of vaccines.
4) The effect of inequalities and vaccination and the reactions and solutions to this situation.

Sources: 1) Medical journals and monographs; 2) Archive sources: World Health Organization, Pasteur Institute, Rockefeller Foundation, Instituto de Salud Carlos III, Spanish Patent Office- (correspondence, unpublished reports, administrative and legislative sources); 3) international surveys and reports from international health bodies; and 4) Documentation and journals of pharmaceutical laboratories.

Keywords: Smallpox vaccination, poliomyelitis vaccination, Pierre Lépine's poliomyelitis vaccine, World Health Organisation, 20th century, Spain, France

4. This research was supported by the Spanish Ministry of Economy and Competitiveness. References: HAR2012-39655-C04-02 (called "La erradicación de la polio en el contexto internacional y de otras enfermedades víricas: el papel del laboratorio, la investigación epidemiológica y los factores socioeconómicos") and HAR2012-39655-C04-01 (called "El reto de la erradicación de la poliomielitis y la amenaza del síndrome post-polio: estrategias nacionales y acciones globales en la lucha contra la enfermedad y la discapacidad (1963-2010)").

Development and manufacture of Pierre Lépine's vaccine against poliomyelitis

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Some European countries decided to produce their own vaccine against polio instead of using the Salk inactivated vaccine. One of these was France, thanks to the research carried out in the Pasteur Institute by Pierre Lépine, then Director of the virology department of the institute. The vaccine became available in 1956 and was produced not only in the Pasteur Institute but also in the Mérieux Institute in Lyon. The need to produce millions of doses called for comprehensive changes in both centres. Bearing in mind the economic perspective and the extra-economic values, our main aims are: to study the development of the Pierre Lépine vaccine in the Pasteur Institute (Paris); to analyse the transformation carried out in this Institute in order to have the capacity to mass-produce millions of doses; to identify Charles Mérieux's main reasons for taking the decision to produce the Lépine vaccine; to analyse the economic and extra-economic benefits for the Mérieux Institute; to investigate whether the Pasteur or Mérieux Institutes asked to register their poliomyelitis vaccines in Spain. Our main sources are: Documents of the Archive of the Pasteur Institute of Paris (scientific and private correspondence, unpublished reports, etc.); French medical journals; international reports from international health bodies; documents of the Spanish Patent Office.

Keywords: Pierre Lépine's poliomyelitis vaccine; Pasteur Institute; Mérieux Institute; France; 20th century

Manufacturing Smallpox Vaccine and Building Virology in Spain, 1920-1960.

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Beginning the 20th century, the manufacture of smallpox vaccine in Spain was one of the main tasks of the newly founded (1899) Institute for Serotherapy, Vaccination and Bacteriology Alphonse 13rd (from 1931 on, called National Institute of Health, NIH). The particular Section of the Institute under Ramón Serret (1852-1926) followed the Napolitan style of vaccine production through series of calves. From the late 1910s, new health officers in charge, Luis Rodríguez Illera particularly, tried to overcome the by then well-known disadvantages on the production and distribution of this dermovaccine and in so doing they opened a straight way to the development of general virology in Spain. This paper deals with such initiatives and especially focus on the applied research made by Eduardo Gallardo Martínez (1879-1964), deputy (1920s) and head (1932-1949) of the Vaccine Section of the INH, a visitor to the New York Medical Research Institute thanks to the support of the Rockefeller foundation in 1933 and visitor again in 1947 to the Rocky Mountain Laboratory (USPHS) and to the Hooper Foundation at San Francisco (UCSF). His adaptation of in vitro methods (ie, not implying whole animals) of cultivation of the smallpox virus put him in a leading position to face the urgencies of the postwar typhus epidemic and to develop fruitful lines of research concerning general virology. This was to be implemented at the new Higher Council for Scientific Research (HCSR), founded in 1941, in a sub-section of the Histo-pathology Institute, Ramon y Cajal's heritage, and after 1949 in a full new Microbiology Institute.

Keywords: smallpox vaccine, virus cultivation, dermo-vaccine, neuro-vaccine, chicken egg

Investing in health: the economic necessity and benefits of the eradication of smallpox in Spain through vaccination (1959-1982)

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In 1959 the technical report of the WHO Study Group on Requirements for Smallpox Vaccine was published, followed in 1964 by the first report of the WHO Expert Committee on Smallpox. With the aim of eradicating the disease, they defined the characteristics of the manufacture of the vaccine, of tests to prove its effectiveness, and of methods of storage and distribution. The objective of this paper is to study the application of these recommendations in Spain from the economic point of view: investment in the stabling of animals, and the equipment of public and private laboratories; economic investment in the 1965 vaccination campaign, and the involvement of the foreign pharmaceutical industry by means of applications for patents. It will also analyse the cost of the vaccine to the person vaccinated, the benefit obtained by the population in health terms, and its profitability for the laboratories. The study will go up to 1982, when production ceased. The principal sources used are the documentation of the Instituto de Salud Carlos III (ICIII), of the private laboratories involved in the initiative, that of the Archives of the Spanish Patent Office, and medical journals.

Keywords: smallpox eradication; smallpox vaccine; Spain, 20th century

Initiatives against inequality in the fight against Epidemics: The Store of Oral Polio Vaccines created by the WHO in 1964

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Unequal access to vaccination and the social implications this situation might have for the fight against infectious diseases and the containment of epidemics was the principal reason that prompted the World Health Organization to take countermeasures to try to resolve the problem. The main aim of this paper is to study the initiative taken by the agency in 1964 to create a strategic reserve of one and half million doses of oral polio vaccine to send to underdeveloped areas of the world that might have to tackle epidemics of this disease without sufficient financial resources to purchase vaccines. Our specific objectives are: the analysis of the whole process of creation of the warehouse, the arguments used to justify it, and the requirements and conditions of use; to identify the pharmaceutical laboratories that participated in it; to study the economic and non-economic effects that this initiative might have had for the progress of the pharmaceutical companies involved; to investigate similar initiatives that WHO may have developed for other diseases before or since. The main sources used are documentation from the historical archive of the World Health Organization (correspondence, unpublished reports, etc.) and its journals.

Keywords: poliomyelitis vaccine store; unequal access vaccines; World Health Organization; 20th century

> PANEL 25

Money and professionals

Similar care competences for lower costs: the competition between surgeons and physicians in Early Modern Portugal

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The variety of professional backgrounds of healers in early modern Europe is well-established and doesn't seem to vary much from one place to another. Likewise, we can see repeated patterns in professional hierarchies, especially the pre-eminence of physicians and their superiority discourses concerning surgeons. However, in daily life, surgeons had wider social acceptance, were less expensive and could use the same remedies and curative techniques as physicians. In a battle with surgeons during the whole early modern period, the discourse of the Portuguese medical community, organized around the Faculty of Medicine of the University of Coimbra, was almost entirely based on economic arguments, competing for patients and places in public administration bodies.

How close to reality was the medical narrative to the dominance of surgeons? Were the authorities responsible for the apprentice-trained practitioners' corruptness, as suggested by the University of Coimbra that accused them of selling licenses to those who were not prepared to practise? Was it possible to buy professional mobility moving from one category to another, for instance, from barber to surgeon or/and from surgeon to physicians? These are some of the research questions posed in the documents supporting this paper: a relational prosopographic database (c. 20,000 individual records) that brings together surgeons, physicians trained abroad, apothecaries and other practitioners who received a formal license to practice from the First Physician (Físico-mor), responsible for the official recognition of all healthcare professionals trained outside the university, between 1515 to 1825.

Keywords: surgeons; physicians; Early Modern Portugal; medical costs

Cashing in on a Medical Career: Dr Ann Longshore Potts's Lectures to Ladies: 1870-1900.

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This paper addresses medicine as a business for a women physician in the years 1870 to 1900. It does so through a biographical approach, exploring the career of a travelling American, Dr Anna Longshore Potts, using archival, newspaper and court records. One of the first graduates from the Female Medical College of Philadelphia in 1851, Dr Potts built an international career in the late nineteenth century performing medicine on stage. She gave public lectures to mixed and female-only audiences, supplemented by private consultations for women. Unlike general practice, the lecture circuit proved welcoming and profitable for Dr Potts and she toured much of the English-speaking world. Her charismatic lecturing style (and the novelty of hearing from a woman doctor) attracted large audiences. Dr Potts engendered trust in women who, in many of the places she visited, only had access to male doctors. She then used this trust to attract women to private consultations where they might purchase her medications, self-published books, or patented pessary designed for uterine support. Such was her financial success that, in 1883, she was able to fund the building of a fifty-room sanatarium in San Diego which she operated as a successful business for some years while maintaining her lecturing career. Dr Potts raised the ire of the regular profession in parts of the United States and in Australia, New Zealand, Hawaii, Ireland, and England. She was accused of charlatanism while she portrayed herself as a Quaker missionary of health, allowing women to access knowledge long denied them. Her success relied on her novelty as a woman doctor, her theatrical skills, and her business acumen. Dr Potts's career illustrates that women doctors, who often found it difficult to survive in general practice at this time, could use their gender in innovative ways to carve out alternative and lucrative careers. Women doctors were not only inspired by sympathy and science, I argue, but also by financial rewards.

Keywords: Performance, Charlatanism, Gender, Health

The social medicine and the debate about doctors' private practice in Bulgaria from the early twentieth century until World War II

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This report will present part of my dissertation research on the history of medicine in Bulgaria. A particular focus of the work will be the debate between the three movements in the Bulgarian medicine – the Orahovists, the Rusevists and the social hygienists about the role of the doctors in relation to the socialization of the medical profession of the early twentieth century until World War II. The idea of the social medicine is crystallized in these debates after World War I, when the territories between the public health and the healing are redistributed, and when the ideas of the public hygiene start to organize and dominate treatment. This is the beginning of the debate about the role of the doctor towards the ideas of the social medicine - socialization of the profession, the public duty, the rejection of fees and state maintenance of the doctors and the equal distribution of doctors on the territory of Bulgaria. These debates are particularly important for strengthening the role of the doctor and stigmatization of doctors' private practice - doctors who earn due to their patients' illnesses.

One can say that there is a discursive rule of denying the private practice in these debates, but in practice it doesn't lead to its crystallization in practice, because the 20s and the 30s are marked by lack of budget financing on public health and hospital care. Thus the problems in healthcare are actually financial. However, it can be said that the adopted points in the debates as the distribution of doctors in rural areas, and etc., are applied after the World War II by the socialist government through the formation of the official position of the general practitioners.

Studied sources: the main sources are the major medical journals in Bulgaria and the debates in the protocols of the Supreme Medical Council at the Main Directorate of Public Health, as well as the discussions in Bulgarian Medical Association.

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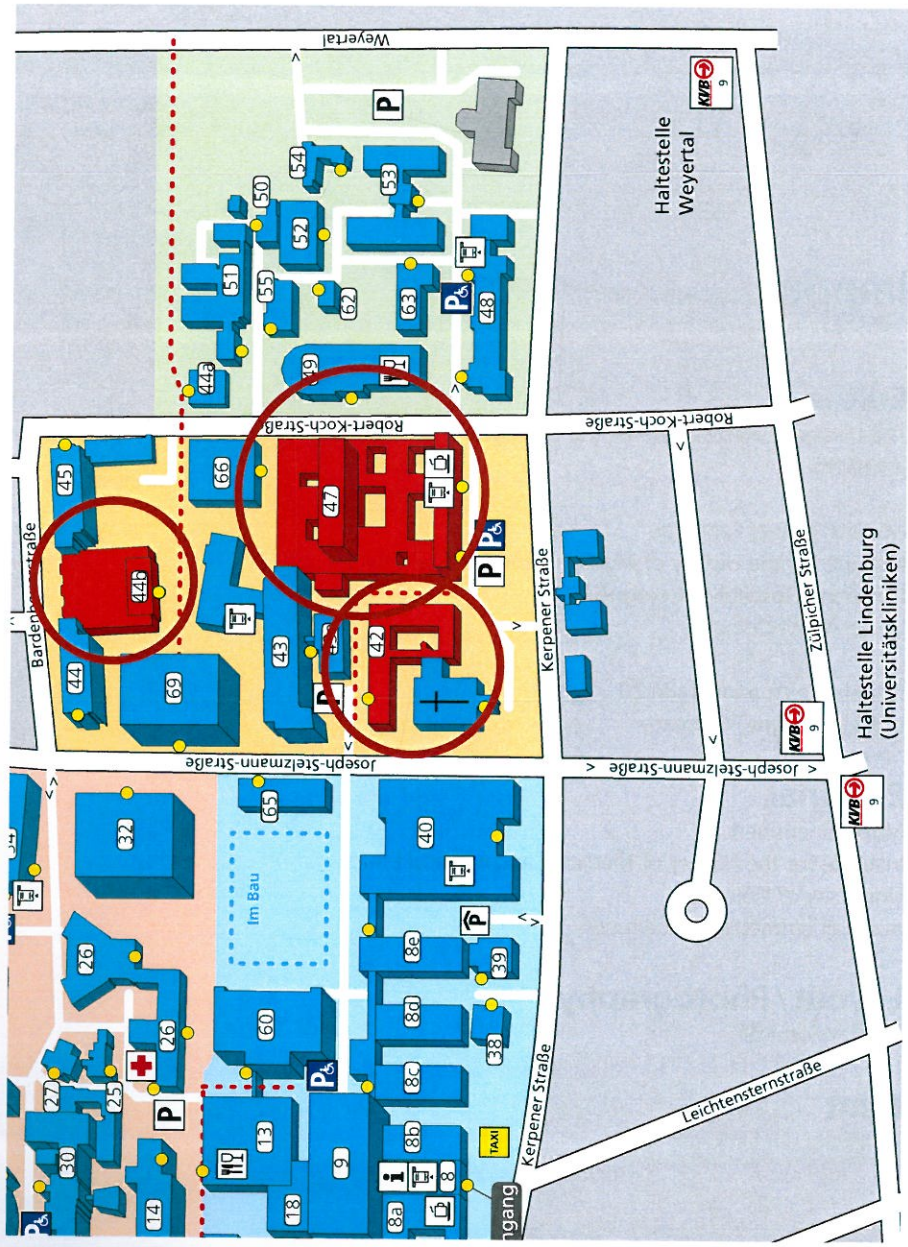

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