# THE GUARDIAN OF LIFE AND HEALTH

The creation of a welfare municipality in Amsterdam, 1919-1937.


Pim Sierink

4300246


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Utrecht University

Supervisor: Dr. Joost Vijselaar

Second reader: Prof. dr. Frank Huisman

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# ABSTRACT

In this thesis, a case is made for the use of a historiographical concept that helps describe Dutch society in the interwar years. This concept is the *welfare municipality*, a supplement to the well-known and often used idea of the *welfare state*. This notion of the welfare municipality attempts to fill a gap in Dutch literature regarding the creation of the welfare state after the Second World War. The welfare state did not emerge out of a clear blue sky but should instead be partially attributed to the municipalities that experimented with welfare organization in the two decades before the war. By taking a new perspective, this thesis wants to complement existing literature. Focusing on the philosophy and mentality behind municipal welfare organization, this thesis concludes that the interwar municipality felt increasingly responsible for the general wellbeing of its citizens, slowly becoming the 'guardian of life and health' by appropriating and creating welfare services. As such, the municipality slowly became the center around which all societal welfare was organized. In Amsterdam, one individual symbolizes the welfare municipality, and that was Louis Heijermans, director of the Amsterdam Municipal Medical & Health Service. His principles for a long life in good health function as useful appellations for explicating the idea of the welfare municipality.

*To my grandparents*

*“Doch bij het zoeken naar het nieuwe leven, dat opkwam, vergat men licht, dat in de geschiedenis als in de natuur het sterven en het geboren worden eeuwig gelijken tred houden.”*

- Johan Huizinga, *Herfsttij der Middeleeuwen*, 1919

*“De voorschriften — van de persoonlijke gezondheidszorg — kunnen echter pas opgevolgd worden, wanneer de middelen daartoe aanwezig zijn: ontbreekt het servies, dan kan de tafel niet gedekt worden.”*

- Louis Heijermans, *Gemeentelijke Gezondheidszorg*, 1929

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# INTRODUCTION
## An exposition of coincidental thoughts

*Figure 1. Consultation bureau of the Amsterdam Municipal Medical & Health Service at the Keizergracht.*

SYNOPSIS
In this introduction, the thesis' ambitions and intentions, methods and approaches, outlooks and assumptions, and the contents and chapters are presented.

## i. AN OPENING BY LOUIS HEIJERMANS

In 1929, ten years into his tenure as a director of the Amsterdam *Gemeentelijke Geneeskundige & Gezondheidsdienst* (Municipal Medical and Health Service), Louis Heijermans published a how-to report on municipal healthcare, a document that would become a manual for healthcare organizations, municipal councils and associations across the Netherlands.[1] In this 500-page report called *Gemeentelijke Gezondheidszorg in Nederland*, Heijermans not only outlined a practical and quantitative look into Amsterdam's local healthcare plans and organization, but also offered its readers a strong analysis of the national government's role. By criticizing the national government's lack of financial support for municipalities and their apparent unfavorable, ideological views of a state-facilitated public health system, Heijermans positioned the municipality in opposition to the national state. He posited:

> The difficult financial circumstances of municipalities, in which many find themselves nowadays, notwithstanding the high taxes that are not or hardly able to achieve a balanced budget, are everyday business. On the one hand a greater demand comes from the awareness of workers and small folk, who can no longer endure the undignified conditions of their daily lives, who refuse to live in shacks and slums, and increasingly follow the routines of hygiene, assume higher standards of living, and in greater number want to learn the arts and sciences — on the other hand there is a central government, who attempts to pass on financial burdens to the municipalities and makes laws that, however needed and well-made, have the effect that it complicates the financial obligations of the municipal treasury. [...] It gives the impression that this governmental course is followed deliberately, as to force the larger municipalities to, in their financial distress, cut on her social initiatives, in order to avoid that these are expanded when the financial difficulties are lessened by equal tax-division. If this assumption is right, it would come down to a desire to reduce the municipal social initiatives obliquely, in which case, ultimately, the social hygienist has no choice but to see it as a threat to public health. One can hardly imagine a municipality that spends its money on social-hygienical measures unnecessarily. Who believes that, either does not understand the great benefit of this care, or is, for reasons outlined above, troubled by these provisions.[2]

Heijermans, who was himself a strongheaded member of the Dutch social-democratic party—the *Sociaal-Democratische Arbeiderspartij* (Social Democratic Workers' Party, *SDAP*)—, envisioned a different role for the municipal government, and he pointed at Amsterdam and the municipal medical and health services to show the virtues of such a role. The Amsterdam municipality

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[1] Louis Heijermans, *Gemeentelijke Gezondheidszorg in Nederland* (Amsterdam; 1929), 7.

[2] Ibidem, 27, 28. This is a translation of the following Dutch quote: 'Aan de orde van den dag is de moeilijke financieele toestand, waarin thans vele gemeenten zich bevinden, welke niettegenstaande hooge belastingen niet of nauwelijks in staat zijn, sluitende begrootingen te maken. Eenerzijds komt steeds grooter drang door de bewustwording der arbeiders en kleine luiden, die het niet langer verdragen in onwaardige levensomstandigheden te leven, weigeren in krotten en sloppen te wonen, en de lessen der gezondheidsleer in stijgende mate volgen, hoogere levensvormen aannemen, zich in groeiend aantal kunstzinnig en wetenschappelijk trachten bij te werken — anderzijds is het de regeering, welke de financieele lasten tracht af te wentelen op de schouders der gemeenten, en wetten maakt, welke, hoe gewenscht en fraai ook, nog al eens de uitwerking hebben, dat zij de geldelijke verplichtingen der gemeentelijke schatkist verzwaren. [...] Het maakt den indruk, alsof van rijkswege opzettelijk deze koers gevolgd wordt, om de grootere gemeenten te dwingen, door geldnood, hare sociale bemoeiingen te drukken, ten einde de kans te ontloopen, dat deze verder uitgebouwd zullen worden, als de geldnood door gelijkmatige belastingverdeeling zou verminderen. Indien deze veronderstelling juist is, zou dit neerkomen op een streven naar besnoeiing van sociale bemoeiingen langs indirecten weg, en hierin kan de sociaalhygiënist in laatste instantie niet anders zien dan een bedreiging van de volksgezondheid. Men kan toch moeilijk uitgaan van de veronderstelling, dat een gemeente onnoodig geld zal uitgeven voor sociaal-hygiënische doeleinden. Wie dat meent, begrijpt of niet het groote nut van deze zorg, of is van deze voorziening om bovengeschetste redenen niet gediend.'

functioned as a showcase for the impact of the municipal government on matters such as public health, an impact Heijermans deemed significant and important.

By the 1920s, Amsterdam, the largest city in the Netherlands had become a playground for social-democratic idealism. The city's councilors and a growing number of autonomous-minded municipal directors like Heijermans merged their personal beliefs of the municipal-facilitated emancipation of the working classes with the city's need to account for the ever more bulging mass of people. Having doubled its population between 1880 and 1920 to a rough 650.000 people, matters such as housing, employment and healthcare became more urgent.[3] An uninvolved municipality simply was no longer an option. Instead, the municipality had to take responsibility for the general health and basic needs of its citizens. And from an ideological and political point of view, that municipal role was increasingly seen as a justified means to achieve such social change. The municipality was to become the 'guardian of life and health'.[4]

## ii. POSITING A HYPOTHESIS

The guardianship of the Amsterdam municipality is central to the theme of this thesis. I examine and explore the hypothesis of the *welfare municipality* (*verzorgingsgemeente*) by analyzing the emergence of a municipal public health and social welfare system in Amsterdam between 1919 and 1937. This concept of the welfare municipality, by alluding to the widespread idea of the *welfare state,* emphasizes governmental initiatives of welfare creation, but from a municipal level. It amounts to a form of governmental organization in which the municipality protects and promotes the well-being of its citizens, as well as having the responsibility for citizens unable to avail themselves of the minimal provisions for a long life in good health, by providing in housing, labor and healthcare. The concept of the welfare municipality is a historiographical tool, then, but one that is yet of much importance in Dutch literature on public health and state history.[5] Neither is it an actors' category.[6] However, the municipality deserves a more prominent place in early twentieth-century public health history, as it can be argued to be the earliest governmental layer that stepped into the welfare arena. The idea of the welfare municipality, then, is used to better understand the emergence of the Dutch welfare state in the 1950s. Did the Dutch welfare municipality of Amsterdam anticipate the Dutch welfare state?

As the example of Heijermans and the report on municipal healthcare shows, the direct need of the city municipality to act on public health and emancipatory issues, and the inability of the Dutch national government to appreciate and understand that need, led to a serious

[3] Gemeente Amsterdam, Afdeling voor Onderzoek, Information en Statistiek, 2.1a Jaarboek 2021, *Bevolking Amsterdam 1 januari 1900-2021*, consulted on 1st of June 2021.
[4] As taken from: Tom Hulme, 'Putting the City Back into Citizenship. Civics Education and Local Government in Britain, 1918–45, *Twentieth Century British History*, vol. 26, no.1 (2015), 26-51.
[5] It has a prominent position in Scandinavian historiography on welfare policy, highlighting, as does this thesis, the interplay between central policy and local autonomy. See for example: Gun-Britt Trydegård and Mats Thorslund, 'One Uniform Welfare State or a Multitude of Welfare Municipalities? The evolution of local variation in Swedish elder care', *Social Policy and Administration*, vol. 44, no. 4 (2010), 495-511; Teppo Kröger, 'Local Government in Scandinavia: autonomous or integrated into the welfare state?', J. Sipilä (ed.), *Social Care Services: The Key to the Scandinavian Welfare Model* (1997), 95–108; Teppo Kröger, 'Retuning the Nordic Welfare Municipality: Central regulation of social care under change in Finland', *International Journal of Sociology and Social Policy*, vol. 31, no. 3/4 (2011), 148-159; Jan-Inge Hanssen, Per Arnt Pettersen, 'Welfare municipalities: economic resources or party politics? Norwegian local government social programs of the 1920s', *International Journal of Social Welfare* (2001), 27-44.
[6] Meaning the term 'welfare municipality' was not used by the historical people of the interwar period, but is an analytic tool used by the historian.

disagreement between national and local politics. In the case of the Netherlands, this divide was furthermore colored by a very specific political and societal system, namely that of *verzuiling* (pillarization).[7] Since the late 1890s, Dutch society was politically and socially segregated along ideological lines, a kind of balancing act of society where people generally lived within ones' own cultural group—be it Catholics, Protestants, socialists, or liberals—, and often these groups barely interacted with each other.[8] Each group had their own "pillar" of organizations, private safety nets, traditions, clubs, sport events, radio programs, etc.[9] Moreover, historian Frits Boterman writes in his newly published book *Tussen Crisis en Utopie,* pillarized society saw its heyday in the interwar years.[10] Where the national, political arena of the 1920s and 1930s was characterized by a pillarized structure dominated by confessionalist parties that emphasized Christian, privatized care, larger cities in the early twentieth century, such as Amsterdam, Rotterdam or Groningen, became increasingly dominated by social democrats, shifting the local, political balance greatly.[11] Moreover, as we will see, the emergence of the Amsterdam welfare municipality in the interwar years can be largely ascribed to the specific political balance of the city in those years; years when social democrats gained a small foothold in the political landscape and pushed their agendas of government-facilitated public services.[12] While the social democrats were not all-powerful, their presence within the municipal council and as municipal directors fundamentally challenged the older political balance of the city.

A further sharpening of our concept of the welfare municipality, however, is required. A look into existing welfare state historiography provides a useful tool for conceptualizing the welfare municipality. Acknowledged sociologist Abram de Swaan's concept of the national welfare state,

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[7] For some general literature on the subject, see: Arend Lijphart, *Verzuiling, pacificatie en kentering in de Nederlandse politiek* (Haarlem; 1990); Siep Stuurman, *Verzuiling, kapitalisme en patriarchaat. Aspecten van de ontwikkeling van de moderne staat in Nederland* (Nijmegen, 1983); Paul Pennings, *Verzuiling en ontzuiling. De lokale verschillen. Opbouw, instandhouding en neergang van plaatselijke zuilen in verschillende delen van Nederland na 1880* (Kampen, 1991); Marcel Hoogenboom, *Een miskende democratie - Een andere visie op verzuiling en politieke samenwerking in Nederland* (Leiden; 1996); Piet de Rooy, *Republiek van rivaliteiten. Nederland sinds 1813* (Amsterdam; 2005); Piet de Rooy, *Ons Stipje op de Waereldkaart. De politieke cultuur van modern Nederland* (Amsterdam; 2014).

[8] De Rooy, *Ons Stipje op de Waereldkaart.*

[9] See for example: Jan Meilof, *Een Wereld Licht en Vrij. Het culturele werk van de AJC, 1918-1959* (Amsterdam; 1999); Karel Dibbets, 'Het Taboe Van De Nederlandse Filmcultuur: Neutraal in Een Verzuild Land', *TMG Journal for Media History* vol. 9, no. 2, (2015), 46–64; Jan van Miert, 'Verdeeldheid en Binding. Over lokale, verzuilde en nationale loyaliteiten', *BMGN,* vol. 57, no. 4 (1992), 670-689; Hans van den Heuvel, *Nationaal of Verzuild. De strijd om het Nederlandse omroepstelsel in de periode 1923-1947* (Baarn; 1976).

[10] Boterman outlines the Dutch interwar years as a period of the 'pluralization of society'. The pillarized construction of society reached the peak of its influence, with citizens wielding more political power than before. In 1922, active universal suffrage was implemented in the Netherlands. Consequently, the pillarized structure of society was strengthened rather than weakened: Frits Boterman, *Tussen Crisis en Utopie. Nederland in het interbellum, 1918-1940* (Amsterdam; 2021).

[11] On Groningen: Geert Bruintjes, Wouter Hugenholtz, Paul van Tongeren, Homme Wedman, 'De Opkomst van de Arbeidersbeweging in de Provincie Groningen', *Groniek* (1976), 46-54; Homme Wedman, 'De Ordening van de Deugd', *Groniek* (1981), 2-7; On Rotterdam: Harm Kaal, 'Bewogen benoemingen: vier Rotterdamse burgemeestersbenoemingen in de eerste helft van de twintigste eeuw', *Rotterdams jaarboekje*, vol. 8 (2008), 154-182; Harm Kaal, 'Running the big city: the Dutch prewar mayoralty under construction', *European Review of History*, vol. 16, no. 4 (2009), 437-452.

[12] In Dutch this era is known as *wethouderssocialisme*. See: P.F.G. Depla and J.S. Monasch, 'Het wethouderssocialisme. De PvdA en de lokale democratie', P.W. Tops, A.F.A. Korsten & C.A.T. Schalken (eds.), *De wethouder. Positie en functioneren in een veranderend bestuur* (Den Haag; 1994), 255-267; Rik Reussing, 'Spraakmakende lokale bestuurders en grensverleggend lokaal bestuur', *Bestuurswetenschappen*, vol. 72, no. 2 (2018), 40-71.

which he defined in his magnum opus *In Care of the State* as a 'compulsory arrangement under public management', serves as a good set of requirements that can be translated to the municipality too.[13] The emergence of the welfare state according to De Swaan is best summarized as a process of increasing *collectivization*.[14] De Swaan describes this as a slow process from private to public management of society, a gradually developing phenomenon that, over the course of centuries, would ultimately come to be the basis of the modern day welfare state.[15] This happens in three dimensions: (1) an increase in *scale* that would include more and more citizens; (2) an increase in the *collective character* of welfare arrangements, which increasingly dependent not on individual contribution, but mutual contribution and regulation; and (3) an increasingly central position of a *public body* executing that collective arrangement.[16] The *welfare municipality*, then, can possibly be seen as part of the gradual development towards the welfare state, which in the Netherlands would ultimately come into existence in the 1950s.

The *welfare municipality*, however, has a slightly different connotation than the welfare state, therefore it is necessary to narrow the concept down to fit the scope of this thesis. While following De Swaan's general idea of a scaling collectivization, the welfare municipality in this thesis is also characterized by a specific municipal culture that increasingly emphasizes a municipal *responsibility of care*, expressed in the ideological beliefs of political parties and municipal directors who pursued municipal healthcare and social welfare creation. The idealism and intentions of the historical actor's involved in the creation of municipal welfare services in Amsterdam shall be the focus of analysis in this thesis, specifically analyzing social-democratic beliefs. This responsibility of care, the philosophy and ideology of municipal interference in welfare creation, is essential to the concept of a welfare municipality.

Considering this, the overarching research question of this thesis is as follows:

*To what extent can the Amsterdam municipality of the 1920s and 1930s be regarded as a welfare municipality?*

The answer to this research question will be found in breaking it down into multiple sub-discussions that are highlighted in the subsequent chapters: what ideals and beliefs impacted municipal welfare policy? Who were the municipal visionaries of Amsterdam? And how did they shape the municipality's welfare system? Special attention is given to two case studies that help answer the research question in more detail: (1) the Amsterdam Municipal Medical and Health Service and its director Louis Heijermans, and (2) the emergence of socio-psychiatric care in Amsterdam, on which I will elaborate below.

### iii. AMBITIONS AND INTENTIONS

There are multiple examples of Dutch history which this thesis tries to augment. Most importantly, this thesis wants to complement historian Stefan Couperus' work *De Machinerie van de Stad*, an appealing exploration of the ideas and practicalities of early twentieth-century city

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[13] Abram de Swaan, in his famous work *Zorg en de Staat* (English: *In Care of the State*), wrote of the welfare state as a: 'dwingend arrangement onder openbaar beheer'; Abram de Swaan, *Zorg en de Staat. Welzijn, onderwijs en gezondheidszorg in Europa en de Verenigde Staten in de nieuwe tijd* (Amsterdam; 2004), 140.
[14] Ibidem, 13.
[15] Ibidem, 9.
[16] Ibidem, 19.

administration in Amsterdam.[17] Quoting Amsterdam SDAP-councilor Floor Wibaut, Couperus posits that the municipality had become 'the center where the whole life of the modern human being is reflected and forced into activity'.[18] It is my goal to further develop this research. My contribution lies in providing an addition to the term *welvaartsgemeente*, coined by Couperus, but more thoroughly emphasizes the *mindset of responsibility* on matters of health, hygiene and care. Therefore, the welfare municipality I envision roughly translates to mean *verzorgingsgemeente*. The municipal medical and health services sprouting in the larger Dutch cities in the first half of the twentieth century form an interesting study in that regard. Chapter two is dedicated to this.[19] Amsterdam, by far the largest city in the Netherlands, is a logical and convenient starting point of that research. In Amsterdam, the municipality became the guardian of life and health.

Lastly, it is my ambition to explore the historical roots of the current-day healthcare system of the Netherlands, which since 2015 is fundamentally based on a local, municipal system. Today, the Dutch healthcare system is concentrated within the *Wet Langdurige Zorg,* or Wlz, part of the larger *Participatiewet* (Participation Law) and *Wet Maatschappelijke Ondersteuning* (Social Support Law).[20] Now no longer organized along national lines, Dutch long-term care-seekers are treated within municipal or district borders and therefore limited to the care contracted by the municipality and health insurance companies within which they are registered.[21] Specifically directed at long-term care, the Wlz primarily concerns geriatric, youth, psychiatric or general disability care, which takes the bulk of healthcare expenditure. The idea behind the new Wlz is that municipalities often have a better view of the needs of its own citizens than is possible within a national system, thus increasing the quality of care.

A negative consequence of the new Wlz, however, is the great discrepancy between municipalities in the care that is being offered. This brings about a paradox within the Wlz, as municipalities with an extended healthcare system attract the more care-dependent population, while municipalities with a lesser healthcare system see the care-dependent population move out, as such bypassing the high costs of that care. What we now see happen in the Netherlands is the existence of a financial incentive for municipalities not to invest in public healthcare at all—or only the bare minimum—, while other municipalities have great difficulty closing their books.[22] This, however, is not at all new in Dutch healthcare history. In fact, a similar thing happened in the early twentieth century in Amsterdam.

In the memorandum of the 2015 law written to the Dutch Parliament, it reads that the new Wlz 'marks a fundamental discontinuity with the past'.[23] Such statements always catch the eye of the historian. An exploration of the welfare municipality in the interwar years, namely,

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[17] Stefan Couperus, *De Machinerie van de Stad: stadsbestuur als idee en praktijk, Nederland en Amsterdam 1900-1940* (Amsterdam; 2009).
[18] Ibidem, 1. This is a translation of the following: 'De Gemeente is geworden het middelpunt waar het geheele leven van de modernen mensch tot uiting komt en haar tot werkzaamheid dwingt.' Taken from: F.M. Wibaut, 'Internationale gemeentepolitiek', *Haagsch Maandblad*, vol. 11 (1929), 484-495, p. 494.
[19] Another interesting work in that regard is: Marius Jan van Lieburg, *De Geschiedenis van de Gemeentelijke Gezondheidsdienst te Rotterdam*, *1919-1994* (Rotterdam; 1994).
[20] On a clear summarization of the participation law, see: https://wetten.overheid.nl/BWBR0015703/2021-01-01, consulted on June 8th 2021.
[21] See: Tweede Kamer der Staten-Generaal, 'Regels inzake de verzekering van zorg aan mensen die zijn aangewezen op langdurige zorg (Wet langdurige zorg)', *Memorie van Toelichting*, no. 33 891.
[22] Lotje van den Dungen, Belia Heilbron and Karlijn Kuijpers, '"We zijn geen Swiebertjes. Ongewensten en gemeentegrenzen', *De Groene Amsterdammer* vol. 145, no. 1 (2021), 22-27.
[23] Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 7. This is a translation of the following: 'De Wlz markeert een fundamentele trendbreuk met het verleden'.

exemplifies the opposite of the claim in the memorandum. Rather, the Wlz marks a *continuity* with the past, putting the municipality back at the center of welfare organization.

### iv. METHODS AND APPROACHES

As said, this thesis drives on municipal history.[24] It is—as it centers around Amsterdam—primarily a municipal history and only secondly a history that is applicable to Dutch governance in general. That said, an important perspective this thesis wants to offer is the possible anticipatory role Amsterdam played in Dutch welfare state history, especially when it comes to the far-reaching welfare projects initiated at the municipal level. That makes this thesis a hybrid: where the healthcare measures taken by the Amsterdam municipality were merely local and—logically—focused on the city of Amsterdam, the political context of the first half of the twentieth century necessarily related the municipality to national policy. As the capital and largest city in the Netherlands, Amsterdam significantly influenced national politics, but the city was not immune to national policy either, and Amsterdam's often opposing stance to national policy meant compromise was ultimately par for the course.[25]

Apart from the local perspective, inspiration for this historical analysis is taken from the history of ideas and institutional theory: the first regards the role of values, belief-systems and judgement in cultures, the second concerns the historical analysis of institutions and bureaucracies.[26] Both approaches provide the right insight in answering the overarching research question: *To what extent can the Amsterdam municipality of the 1920s and 1930s be regarded as a welfare municipality?*

A history of ideas regards the emancipatory and civilizing beliefs and ideas of the public sphere and citizenship in the Amsterdam welfare creation, focusing on hygiene, public health beliefs and emancipation of the working class.[27] This perspective helps us answer to what degree

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[24] How are the municipality and the city related in history writing? For literature on this ambiguous topic, see: Mordecai Lee, 'The History of Municipal Public Reporting', *International Journal of Public Administration*, vol. 29, no. 4-6 (2006), 453-476; Pierre-Yves Saunier, 'Changing the city: urban international information and the Lyon municipality, 1900-1940', *Planning Perspectives,* vol. 14, no. 1 (1999), 19-48.

[25] The ultimate coalescing attempt between the central government and the municipalities in the interwar years can be attributed to 1929 and the creation of the municipal funds (*gemeentefonds*). See: B. van den Berg, 'Nieuwe Regeling der Financieele Verhouding Tusschen het Rijk en de Gemeenten', *Maandblad voor Accountancy en Bedrijfshuishoudkunde* (1930), 135-136; A.F.V. Sickenga, 'De Financieele Verhouding Tusschen Rijk en Gemeenten, *De Economist,* vol. 86, no. 1 (1937), 409-434.

[26] Regarding literature on the theory behind the history of ideas, see: Quentin Skinner, 'Meaning and Understanding in the History of Ideas', *History and Theory*, vol. 8, no. 1 (1969), 3-53; Mark Bevir, 'The Logic of the History of Ideas', *The Journal of Theory and Practice*, vol. 4, no. 3 (2000), 295-300; Anthony Grafton, 'The History of Ideas: precept and practice, 1950-2000 and beyond', *Journal of the History of Ideas*, vol. 67, no. 1 (2006), 1-32. Regarding literature on the theory behind institutional history, see: Roy Suddaby, 'Can Institutional Theory be Critical?', *Journal of Management Inquiry*, vol. 24, no. 1 (2015), 93-95; Roy Suddaby, 'Challenges for Institutional Theory', *Journal of Management Inquiry*, vol. 19, no. 1 (2010), 14-20; Richard Scott, 'Institutional Theory: contributing to a theoretical research program', Ken Smith and Michael Hitt (eds.), *Great Minds in Management: The Process of Theory Development* (Oxford; 2004).

[27] Hygiene and health played essential parts in early twentieth-century ideas about Dutch citizenship. See, for example: Harry Oosterhuis, 'Mental Health as Civic Virtue: Psychological Definitions of Citizenship in the Netherlands, 1900–1985', Kerstin Brückweh, Dirk Schumann, Richard F. Wetzell, Benjamin Ziemann (eds.), *Engineering Society. The Role of the Human and Social Sciences in Modern Societies, 1880–1980* (London; 2012); Frank Huisman and Harry Oosterhuis (eds.), *Health and Citizenship. Political Cultures of*

the Amsterdam municipality felt responsible for the care of its citizens, positioning moral trends in the context of the political and societal situation of Amsterdam. Institutional theory considers the emergence of the welfare organizations and institutions in the municipal arena, such as Heijermans' Municipal Medical and Health Service.

## v. OUTLOOKS AND ASSUMPTIONS

Having now hinted at the central role of the *local* in Dutch healthcare histories and showcased this thesis' approaches, this brings me to a few assumptions I hold based on the broader historical context of the interwar period.

The first is that I consider the *local political situation* of the Netherlands in the first half of the twentieth century as the driving force of political change. That assumption is based mostly on the specific Dutch situation of pillarization, as mentioned on page 8 and 9. On the national political level, the pillarized segregation of society resulted in a *status quo* where rapid social change was impossible due to the specific power balance of that time and age.[28] This specific balance on the national scale, however, did not exist in the same manner on the local political level. Here, some municipalities housed stronger catholic organizations, others stronger protestant organizations, or otherwise. Since the 1900s, the large cities increasingly had a stronger socialist pillar.[29] Consequently, the *status quo* of the national political arena did not exist on the municipal level, where belief-systems were dependent on local demography. Added to the divergent pillarized composition was the strong, locally organized Dutch system of law and administration, with municipalities already being responsible for, for example, poor relief, and it becomes clear why it was local politics that had such significant societal influence in early twentieth-century Netherlands.[30] It is at the municipal level that we should seek the groundbreaking governmental welfare initiatives that would be translated to encompass the totality of the Netherlands in the 1950s.[31]

A second assumption regards an important aspect of this thesis' approach to healthcare history, namely that the *mindset* of a people is the driving force of public health, hygiene and healthcare.[32] The mindset is an essential and underlying part of action, reaction and agency, and

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*Health in Modern Europe* (London; 2014); Joseph L. Barona, *Health Policies in Interwar Europe. A Transnational Perspective (*New York; 2019).

[28] Frank H. Aarebrot, 'The Netherlands: Early Compromise and Democratic Stability', Dirk Berg-Schlosser, Jeremy Mitchell (eds.), *Conditions of Democracy in Europe, 1919-39*. *Systematic case studies* (London; 2000); Paul Luykx and Hans Rigthart (eds.), *Van de Pastorie naar het Torentje. Een eeuw confessionele politiek* (Den Haag; 1991); Marcel Hoogenboom, *Standenstrijd en Zekerheid. Een geschiedenis van oude orde en sociale zorg in Nederland* (Amsterdam; 2004), Roland Bertens, *Liberal Solidarity. Guaranteeing Access to Dutch Health Care Under the Banner of Private Initiative, 1848-2015* (Utrecht; 2021); Marco Strik and Nel Knols, 'Public Health, Private Concern. The organizational development of public health in the Netherlands at the beginning of the twentieth century', *European Journal of Public Health*, vol. 6, no. 2 (1996), 81–86.

[29] Adriaan Pieter van Veldhuizen, *De Partij. Over het politieke leven in de vroege SDAP* (Amsterdam; 2015).

[30] I am referencing to the House of Thorbecke, with its tripartite structure of national government, province and municipality. For a thorough account on this, see: Laurens Marie Raijmakers, *Leidende Motieven bij Decentralisatie. Discours, doelstelling en daad in het Huis van Thorbecke* (Leiden; 2014).

[31] Rik Reussing, 'Spraakmakende lokale bestuurders en grensverleggend lokaal bestuur', 40-71; Nico Wauters, *Mayoral Collaboration under Nazi Occupation in Belgium, the Netherlands and France, 1938-46* (Cham; 2016), 11-31. These pages include the first chapter on pre-war local autonomy and municipal elections.

[32] See, for example: McKeown, *The Role of Medicine. Dream, mirage, or nemesis?* (Princeton; 1979); J.A. Verdoorn, *Het Gezondheidswezen in Amsterdam in de 19^e eeuw* (Nijmegen; 1981).

should be subjected to the historical analysis of public health.[33] It is my belief that, in order to thoroughly capture the reasons behind the societal development of public health and the rise of the government, one should investigate the people's mindset that underlies the specific reasoning of their actions and decisions.[34] To examine the mindset underlying the creation of the welfare municipality in Amsterdam, we shall ask: what belief-system lay at the foundation of healthcare and welfare measures in the Amsterdam municipality?

This brings me to the third and final assumption, and that regards the central place of social democrats within Amsterdam's local healthcare history. It is my outlook that, for the specific creation of the welfare municipality in the Amsterdam interwar years, the social democrats played a crucial role. While not being all-powerful, their presence within the council was forceful and they provided many strong-headed and notable councilors and municipal directors, such as Floor Wibaut, Salomon (Monne) Rodrigues de Mirande, Louis Heijermans, Arie Keppler, Frederik Salomon Meijers and Arie Querido.[35] These men were driven by a strong belief in the municipality and in the emancipation and civilization of the working classes. That begs to question: was the municipality a continuation of, and a means to, their civilizing efforts?

### vi. CONTENTS AND CHAPTERS

This thesis is subdivided in three chapters, each of which address and individually answers part of the main research question. Consequently, each chapter also answers a sub-question. The chapters are set up from the following questions:

*What healthcare historiography presently exists and where does this thesis fit in the public health lexicon?* The first chapter aims to place this thesis within existing literature and define the welfare municipality. It becomes clear that the Netherlands are often seen as a *welfare laggard*, meaning that it only started to seriously institutionalize welfare after the Second World War, when the pillarized private organizations that had characterized care on the local level started to dwindle. This view is nuanced by introducing literature on Dutch local, municipal administration and culture, then followed by positioning this thesis within that existing local history. Couperus' work is exemplary, but not the only work dedicated to the municipality.[36]

*In what ways did Louis Heijermans drive the establishment of the Amsterdam Municipal Medical and Health Service and how does he symbolize the welfare municipality?* Chapter two takes the concept of the welfare municipality and zooms in on Amsterdam. Specifically, the chapter is dedicated to Louis Heijermans and the Amsterdam Municipal Medical and Health Service. In the interwar period, Heijermans, a strong-headed SDAP member, was director of the organization

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[33] This is closely related to McNeill's notion on worldviews as one of the principal views in public affairs. See: William Hardy McNeill, 'History and the Scientific Worldview,' *History and Theory,* vol. 37, no. 1 (1998), 1–13.

[34] Pim den Boer, 'Mentaliteitsgeschiedenis. Een begripsbepaling', *BMGN,* vol. 98, no. 3 (1983), 318-337.

[35] Reussing, 'Spraakmakende lokale bestuurders en grensverleggend lokaal bestuur', *Bestuurswetenschappen*; Frank Smit, *Arie Keppler. Woninghervormer in hart en nieren* (Bussum; 2001); Gilles Borrie, *Monne de Miranda. Een biografie* (Den Haag; 1993); Gilles Borrie, *F.M. Wibaut. Mens en magistraat* (Amsterdam; 1968); Herman de Liagre Böhl, *Wibaut de Machtige. Een biografie* (Amsterdam; 2013).

[36] See, for example: Harm Kaal, 'Religion, Politics, and Modern Culture in Interwar Amsterdam', *Journal of Urban History*, vol. 37, no. 6 (2011), 897-910; Petrus Franciscus Maas, *Sociaal-Democratische Gemeentepolitiek in Katholiek Nijmegen, 1894-1927* (Nijmegen, 1974); Stefan Couperus, 'Parceling out municipal administration and power in Amsterdam 1880-1940', Barry M Doyle and Anthony McElligott (eds.), *The International Journal of Regional and Local Studies*, vol. 6, no. 2 (2011), 63-87.

and would expand the organization of municipal healthcare to his judgement.[37] As an independent-minded civil servant, the influence of Heijermans' idealism and intentions should not be underestimated, but rather emphasized. In this chapter, it becomes clear how Heijermans considered the municipality to be responsible for the general care and well-being of its citizens.

*How did social psychiatric practice emerge from welfare municipality efforts?* Chapter three narrows down the welfare municipality concept even further by zooming in on the emergence of socio-psychiatric practice in Amsterdam. Social psychiatry—a branch of the psychiatric discipline that emphasizes societal influence and the environment in relation to the individual's mental health—was an emerging municipal practice in the 1920s and 1930s.[38] The Amsterdam municipality paid for its psychiatric patients and therefore the municipality had a (financial) incentive to find a solution to the growing amount of long-term psychiatric patients in its hospitals. In fact, social psychiatry as a practice became an important section of the Municipal Medical and Health Services of Heijermans long before it was an academic branch of psychiatry. In this chapter, it becomes clear how the practice of social psychiatry was based on the mentality of a caring municipality.

## vii. A CLOSING REMARK BY LOUIS HEIJERMANS

In the introduction of his report on municipal healthcare, Louis Heijermans posits his views of a long life in good health, capturing the scope and goal of the welfare municipality. Heijermans writes:

> The principles for a long life in good health can be summarized in a few lines: good housing, correct nutrition, healthy labor, and hygiene of body and morals. [39]

In this thesis, words such as *good housing*, *correct nutrition*, *healthy labor* and *hygiene of body and morals* shall function as reminders and labels for the concept of the welfare municipality. Heijermans had very specific ideas about these requirements and the role the municipality played in providing them. By taking these words as useful handles, the concept of the welfare municipality will come to life through these words and the consequent actions of the people who used them.

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[37] Han Israëls and Annet Mooij, *Aan de Achtergracht. Honderd jaar gg&gd Amsterdam* (Amsterdam; 2001).

[38] For a general outline of psychiatric practice and the idea of mental hygiene, see: Leonie de Goei, *De Psychohygienisten. Psychiatrie, cultuurkritiek en de beweging voor geestelijke volksgezondheid in Nederland, 1924-1970* (Amsterdam; 2001).

[39] Heijermans, *Gemeentelijke Gezondheidszorg*, 9. This is a translation of the following: 'De voorschriften om lang in goede gezondheid te leven kunnen samengevat worden in enkele regels:
goede woning, juiste voeding, gezonde arbeid, reinheid van lichaam en zeden.'

# CHAPTER ONE
# The historiography behind the welfare municipality

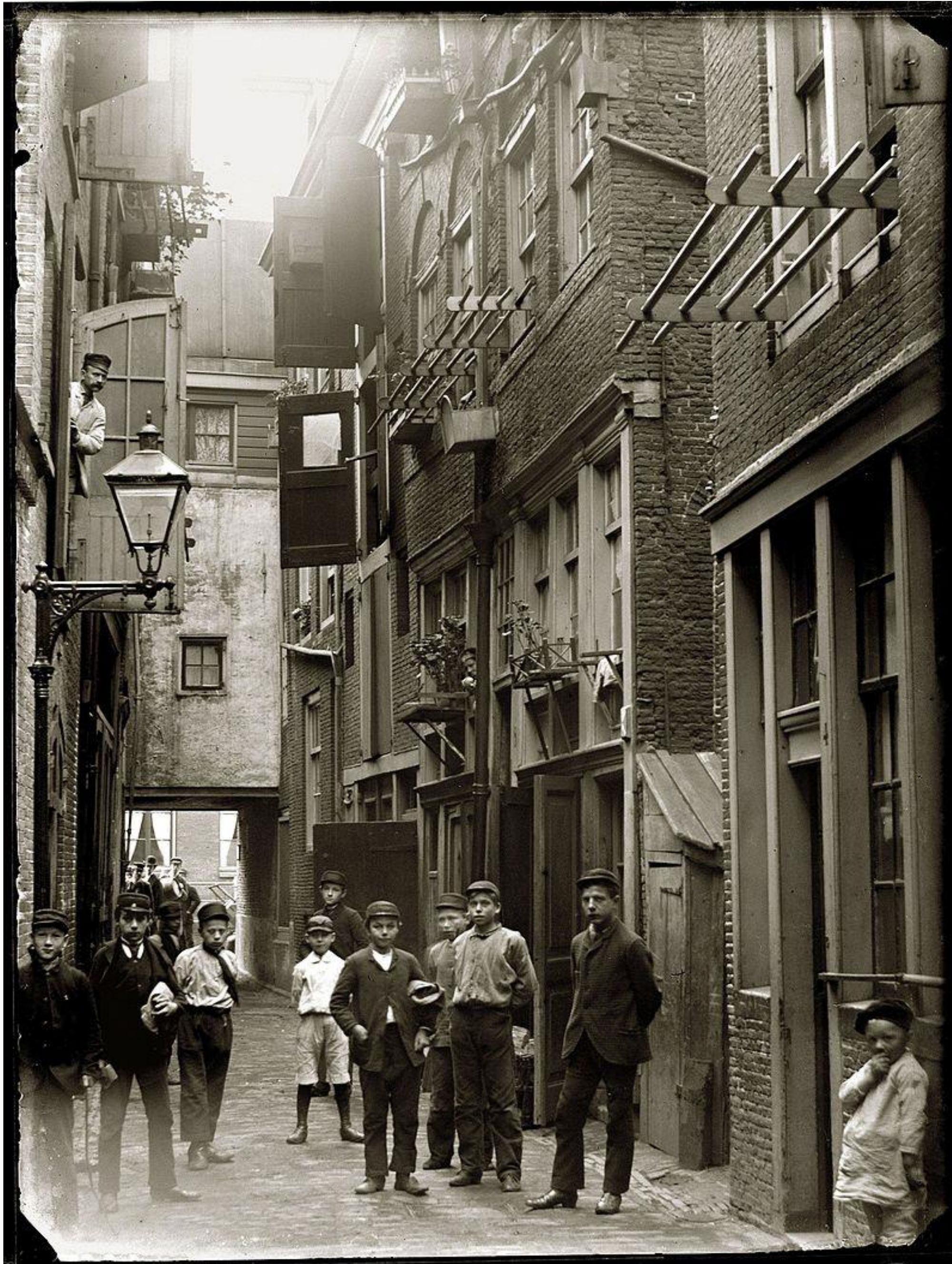

*Figure 2. Picture by Jacbo Olie,* Gebed zonder End*, 1892.*

SYNOPSIS

In this chapter, the notion of the welfare municipality is introduced and placed within current historiographical debates on the Dutch welfare state and public health system. The chapter attempts to complement these histories by charting the unexplored elements of local welfare systems in the early twentieth century.

### i. AN INTRODUCTION: FROM NATIONAL STATE TO MUNICIPALITY

Histories of the Western welfare state are abundant. Being such an elementary notion for understanding Western society and culture, the welfare state as a historical development has been subject to debate by a whole range of scholars, be it historians, philosophers, economists, sociologists, scholars of political science, administration, public policy, law and healthcare.[40] The academic debates and narratives created by these scholars, albeit different in approach, style and goal, all center around the need to take the welfare state as a central framework for the historical development of the Western world in its many different facets and forms.[41]

Within the history of twentieth-century public health the framework of the modern welfare state claims a central position as well. The welfare state framework is used by historians of public health to explain the gradual development of a central government into a position of dominant caregiver of society. Historians often trace this movement back to the Great Depression and the aftermath of both World Wars.[42] Public health—as the organization of healthcare and hygiene in the societal domain—increasingly became the primary expense and affair of the national government, who deserted its traditional pre-war attitude of healthcare for a more hands-on approach.[43] This chapter will highlight the interrelatedness between governmental practice and public health, as to set the framework for an exploration of the welfare municipality. In the process, it will nuance the welfare state perspective.

In the literature on the Dutch public health system, the Netherlands are often portrayed as a laggard country, adopting welfare state ideas and policies only hesitantly after the Second World War.[44] *Verzuiling* is seen as the primary explanation for this hesitance. Since late nineteenth century, the Netherlands were organized along four societal, ideological 'pillars'—Catholics, Protestants, socialists and liberals—, keeping the country administratively running but making general, national policy difficult. Due to such a pillarized structure, healthcare and public health were deliberately and consciously outsourced from the central government to the private organizations of the four pillars, who managed the main societal structures of public health. Even after the Second World War, the Dutch government was hesitant to embrace public health

[40] Just a little taste of the wide variety of available literature: Claus Offe, *Contradictions of the Welfare State* (London; 1984); Nicolas Barr, *The Economics of the Welfare State* (Oxford; 2020); Gøsta Esping-Andersen, Duncan Gallie, Anton Hemerijck and John Myles, *Why We Need a New Welfare State* (Oxford; 2002); Peter Taylor-Gooby, *New Risks, New Welfare: The Transformation of the European Welfare State* (Oxford; 2004); Richard M. Titmuss, *Essays on 'The Welfare State'* (Bristol; 2019); Asa Briggs, 'The Welfare State in Historical Perspective', *European Journal of Sociology,* vol. 2, no. 2 (1961), 221-258; Elizabeth Wilson, *Women and the Welfare State* (London; 1977); Hans-Werner Sinn, 'A Theory of the Welfare State', *The Scandinavian Journal of Economics*, vol. 97, no. 4 (1995), 495-526.

[41] Analysis of the concept of the welfare state is complex and very diverse. The welfare state is seen to take an essential role in a lot of European modern political history, also related to both socialist, fascist, and democratic or liberal history. See for example: Thomas Humphrey Marshall, 'Citizenship and Social Class', Christopher Pierson, Francis Geoffrey Castles (eds.), *The Welfare State Reader* (Cambridge; 2016); Robert Paxton, 'Vichy Lives... In a Way', *The New York Review of Books*, vol. 60, no. 7 (New York; 2013).

[42] Theda Scokpol, *Protecting Soldiers and Mothers. The political origins of social policy in the United States* (1992).

[43] Michael Moran, 'Understanding the Welfare State. The case of health care', *British Journal of Politics and International Relations*, Vol. 2, No. 2 (2000), 135-160.

[44] Interestingly so, the United States are often seen as a laggard too. In other arenas of twentieth century healthcare, the United States were seen as the Netherlands' foreland. A comparative study between the United States and the Netherlands regarding state intervention in social security and healthcare might uncover some similarities between Dutch and American culture. For existing literature, see: Stefan Couperus, 'The managerial revolution in local government: municipal management and the city manager in the USA and the Netherlands, 1900–1940', *Management & Organizational History*, vol. 9, no. 4 (2014), 336–352.

initiatives, leading to a return to form that had dominated pre-war administration.[45] The Netherlands had been introduced with health policy in the 1941 *Ziekenfondsbesluit* (Sickness Funds Decree) implemented by the German occupier, but remained uninterested in furthering national policy on public health, holding on to the privatized organization it had known in the years before the war.[46] Only in the 1950s did the welfare state emerge, with the Roman-red coalitions of the Willem Drees cabinets. As such, the Netherlands is often seen by historians as a welfare *laggard*, meaning the country was falling behind on welfare developments in other neighboring countries such as England, Germany, France or Belgium.

However, the national state perspective might, for several reasons, not tell the complete story when it comes to explaining the Dutch welfare and public health system of the first half of the twentieth century. Where the national government might not have been able to implement public health policy on the national level, on the municipal level, governments often did take action. Talking about the first half of twentieth-century public welfare development, a different blueprint than that of a lagging state is needed: the *welfare municipality*. Such an approach to Dutch welfare history, and the gap in the literature and historiographical debate it fills, is explored in this chapter, which functions to chart the field of public health and municipal welfare, and to position this thesis.

## ii. WELFARE AND PUBLIC HEALTH HISTORY

The interrelation between public health and welfare history should be elaborated upon more thoroughly, for the two concepts are intricately related. Analysis of the interrelatedness between the concepts provides the necessary framework through which the welfare municipality can be explored as a concept that too builds upon both welfare and public health history. On the one hand, the welfare municipality of the interwar years was part of a longer tradition of municipal welfare interference in the social arena that reached back to the nineteenth century with municipalities taking care of poor relief.[47] On the other hand, the interwar public health initiatives of the municipality specifically were driven by the belief that a broad intervention in society was necessary to reach a long life in good health—the subject of public health history. Municipal intervention in the welfare arena touched on more domains than that of healthcare only, and encompassed housing, labor and morals too. As such, the boundaries between broader welfare initiatives and public health became less clear in the interwar period.

Historically, the broader societal approach to reach the desired long life in good health was present in interwar definitions of public health too.[48] For example in 1920, when the acknowledged bacteriologist Charles Edward Amory Winslow, took public health to mean:

> [...] the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of

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[45] Bertens, *Liberal Solidarity*, 118-120.

[46] Ibidem, 103-106.

[47] See, for example: Marco H. D. van Leeuwen, 'Surviving with a Little Help. The importance of charity to the poor of Amsterdam I800- 50, in a comparative perspective', *Social History*, vol. 18, no. 3 (1993), 319-338.

[48] Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (California; 2011), 9; René Sand, *The Advance to Social Medicine* (London; 1952); George Rosen, *A History of Public Health* (New York; 1958); C.E.A. Winslow, 'The Untilled Fields of Public Health', *Science*, vol. 51, no. 1306 (1920), 23-33.

> medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.[49]

The way Winslow defined public health shows how the broader welfare programs of the interwar municipality were part of public health lexicon.[50] Housing, labor and morals all ensured a standard of living that was adequate for the maintenance of good health. Chapter two tackles the broader welfare programs and its relation to health more thoroughly.

In recent years, historian of medicine Dorothy Porter, in her edited volume *Health Citizenship*, summarized public health as the wide concept of 'collective action in relation to the health of populations'.[51] Porter observed that the historiography of public health is primarily focused on social structures such as class, political organization, institutions, or education, within which people as a collective are part and take action related to the broader societal health of the population at large.[52] In the work Porter acknowledges the ambiguous boundaries between public health history and the broader history of welfare. She makes a case for an understanding of public health as an interplay between collective action, state formation and civilizing process. She writes:

> The history of public health needs also to examine how collective actions which aimed to regulate or improve the health of populations were involved in changing the historical relationship between the civilizing process and state formation.[53]

The triangular notions of *collective action*, *civilizing process* and *state formation* together provide a very useful framework for examining the welfare municipality in Amsterdam. The three notions that Porter brought together will help us shape the necessity of the welfare municipality for Dutch welfare and public health history.

*Collective action* allows for the exploration of a variety of social groups and organizations; not the mere scientific and medical aspects of healthcare, but general societal actors as the main driving force behind public health development.[54] It recognizes bottom-up elements of public health, such as religious charity or worker-organized associations, and their place within a broader organization of society. Moreover, it reveals the public health challenges that are faced from a social perspective, including a society's beliefs, traditions and the choices they make accordingly. It helps in answering what challenges were faced by the municipalities through emphasizing the societal circumstances to which welfare and public health measures were taken.

*The civilizing process* then allows for the examination of 'the social contract of health' and historical development of citizenship, also known as 'health citizenship'.[55] While this touches on individual health care history, it also acknowledges a health history of social control and class

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[49] Winslow, 'The Untilled Fields of Public Health', 30.
[50] Ibidem, 27, 28.
[51] Porter, *Health Citizenship*, 12.
[52] Ibidem, 12; there is historiography on individual health care as antithetical to public health historiography, which focuses on patient autonomy and the individual as seen from a citizen perspective. See for example: Frank Huisman, 'Expertise and trust in Dutch individual health care', Joris Vandendriessche, Evert Peeters, Kaat Wils (eds.), *Scientists' Expertise as Performance. Between State and Society, 1860–1960* (London; 2015).
[53] Porter, *Health Citizenship*, 15.
[54] For a thorough take on the collective action and 'the public in public health', see: Alex Mold, Peder Clark, Gareth Millward & Daisy Payling, Placing the Public in Public Health in Post-War Britain (2019).
[55] Again, see: Porter, *Health Citizenship*. But also: Michael Gard & Carolyn Pluim, *Schools and Public Health. Past, Present, Future* (Lanham; 2014);

emancipation.[56] Citizenship in the late nineteenth century and early twentieth century was often associated with health and hygiene and it therefore deserves a rightful place within public health history.[57] The history of citizenship captures an important aspect of Dutch public health mentality in twentieth-century Amsterdam, as is elaborated upon below. It helps in answering by what idealism welfare and public health measures were taken.

The third, *state formation*, enforces us to think of public health in its relation to the bureaucratic, large-scale organization of healthcare and welfare and the growing expansion of the national state into a position of caregiver. It emphasizes De Swaan's thesis of collectivization and similarly helps us conceptualize the welfare municipality. In this category, the systemic and organizational side of healthcare can be examined, which will help answer *how* welfare and public health challenges were dealt with. Taken together, Porter's triangular notions will be used to extrapolate on the concept of the welfare municipality.

### iii. THE NETHERLANDS: LAGGARD, SONDERWEG, OR SOMETHING ELSE?

"Measured against such indicators as wealth and urbanization, the Netherlands between 1850 and 1890 qualifies as a developed and modernized economy that, according to the modernization tradition in welfare state research, should have developed modern social policies early on. Because it did not, the country can be classified as a welfare state laggard or latecomer."[58]

There is a general idea amongst Dutch historians of the welfare state that the Netherlands should be qualified as a welfare state *laggard* due to its above-average level of wealth but lack of involvement by the government for central social policy in the late nineteenth and early twentieth century. Instead, the liftoff of the Dutch welfare state is seen to have happened only after the Second World War and in the 1950s when mutual political interest between social democrats and Catholics finally broke the status quo of the national political arena and the new, centrally organized system of welfare was hastily implemented.[59] As one of the last countries in Western Europe, the Netherlands finally joined the modern economies, and the first cracks in the pillarized composition of Dutch society became visible. Latecomer and laggard, it is a common notion that the Netherlands would make up for its initial hesitation by skyrocketing on the welfare ladder in the 1970s.[60]

This narrative, however, comes with a few shortcomings that should be addressed. There are several arguments to present that question the 'welfare laggard' narrative and show that such a perspective does not necessarily do justice to Dutch public health and welfare history specifically. If not a laggard, but still highly hesitant on centralized social policy and public healthcare, what would a Dutch *Sonderweg* look like?[61] Did the Netherlands walk its own path?

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[56] The influence of Foucault is apparent.
[57] See the footnote about health and citizenship on page 12.
[58] Kees van Kersbergen, 'Religion and the Welfare State in the Netherlands, Kees van Kersbergen and Philip Manow (eds.), *Religion, Class Coalitions, and Welfare States* (2009), 119.
[59] Van Kersbergen, 'Religion and the Welfare State in the Netherlands', 130; Ton Kappelhof, 'Omdat het Historisch Gegroeid is. De Londense Commissie-Van Rhijn en de ontwikkeling van de sociale verzekeringen in Nederland (1937-1952)', *Tijdschrift voor sociale en economische geschiedenis*, vol. 1, no. 2 (2004), 71-91, p. 88-91; Walter J.M. Kickert, 'Expansion and Diversification of Public Health in Postwar Welfare State. The case of the Netherlands', *Public Administration Review*, vol. 56, no. 1 (1996), 88-94; Wim van Oorschot, 'The Dutch Welfare State. Recent trends and challenges in historical perspective', *European Journal of Social Security*, vol. 8, no. 1 (2006), 57-76.
[60] Van Kersbergen, 'Religion and the Welfare State in the Netherlands', 119, 142.
[61] A *Sonderweg* being the idea of a separate path, a road walked alone.

The Netherlands was traditionally structured with a weak central government. It is therefore that recent literature on the twentieth-century history of public health shows an increasing focus on private organizations and the citizen's individual responsibility on matters such as hygiene and healthcare.[62] Society was divided in the four pillars, and each pillar was responsible for the care of its own group. The central state's role is sometimes seen as that of a financer, but in most of Dutch healthcare history, an aloof partner when it comes to the public organization of healthcare. As such, it is supposed that the origins of the Dutch public health system stemmed primarily from bottom-up organization, typically along privatized lines of pillarized organizations. The national state was in most cases altogether absent and *if* it was part of the public health system, only as a financer. This is taken to be the *Sonderweg* of Dutch public health.

This idea is also prevalent in work by sociologist H. Rigter and historian R.B.M. Rigter on social-democratic policy of public health. In 'Volksgezondheid: een Assepoester in de Nederlandse Politiek', they analyze the political outlook on public health and welfare by social democrats in the twentieth century and show a striking emphasis on private initiative and state absence up until 1966.[63] If there is one political party that should have pursued national policy on public health and welfare early on, they argue, it is the social democrats. And yet the social democrats too appear to be in favor of privatized public health. This shows, Rigter and Rigter believe, that public health in the Netherlands was primarily a responsibility of the citizens itself, or otherwise organized along private lines.[64] No Dutch government actively pursued a nationally organized public health system until years after the Second World War.

Other historians stress a different role for the national state. Historian Roland Bertens, for example, criticizes the narrative of an absent government by stating that the organization of healthcare in the Netherlands did not come about through central state rhetoric, but *did* through practice. The central state may have attempted to change national legislation on public health, but between 1904 and 1939, many proposals of a central organization of healthcare failed, leading Bertens to conclude that the Dutch government was not able to break its pillarized structure just yet.[65] Instead, Bertens maintains that the pre-war era of Dutch healthcare can be described as a time of 'ambivalent governmentality', in which 'nominally "private" initiative increasingly came to be backed by public funds'.[66] However, Bertens says, this should not be taken as a sign of welfare laggardness. By financing private organizations, the history of Dutch healthcare is best understood not as *weak state rhetoric* but as *strong state practice*.[67] The fundamental role as financer of healthcare is clouded by the apparent non-interventionalist approach to public health on the outside. But the financing structure of Dutch public health discharges the Netherlands' apparent laggard position. It was not truly a laggard. In fact, the Dutch government found a way past its own difficult political structure of pillarization.

Where such histories do criticize the *welfare laggard* narrative and take into account the Dutch political, financial landscape, the pillarized structure of politics, the administrational system created by Thorbecke's laws (see below), and the privatized organization of healthcare,

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[62] See for example the very recent works of Martijn van der Meer, *Individualised Public Health. A conceptual history of heredity in the Dutch interwar years* (thesis History and Philosophy of Science; 2020); Roland Bertens, *Liberal Solidarity*.

[63] H. Rigter and R.B.M. Rigter, 'Volksgezondheid: een Assepoester in de Nederlandse Politiek. Een analyse toegespitst op de sociaal-democratie', *Gewina*, vol. 16, no. 1 (2012) 1-17, p. 1.

[64] Ibidem, 'Volksgezondheid: een Assepoester in de Nederlandse Politiek', 1, 2.

[65] Bertens, *Liberal Solidarity*, 284-286.

[66] Ibidem, *Liberal Solidarity*, 286.

[67] Ibidem, *Liberal Solidarity*, 284.

they miss out on the importance of a different governmental structure. The municipal, political circumstances and organization of Dutch cities played a major role in the specific execution of the governmental welfare system on the local level. And in the interwar period, the municipal welfare system increasingly encompassed healthcare too. Capturing the many different domains of the broad municipal welfare system of the Netherlands is therefore a crucial element for understanding the Dutch route to a national welfare system. This route is not so much characterized by a struggling national government, but by a multitude of municipalities that were experimenting individually with public health and welfare creation within their own municipality. Privatized healthcare in Dutch healthcare history is apparent and fascinating but does not in and of itself complete Dutch public health and welfare state history. It does not answer in what way the Netherlands became a welfare state. The welfare municipalities could possibly provide an essential addition to this history.

To capture the mentality and outlook of the municipalities, and the governmental roots of the welfare state, it is best to take a different perspective than that of the central state. Instead, the conceptual proposition of the *welfare municipality* is introduced, to which we will turn now.

### iv. THE WELFARE MUNICIPALITY…

Because the national government was traditionally a rather weak power in the Dutch political landscape, it is all the more interesting to look into the Dutch local, political administration of the early twentieth century. Diving into this history, we find that two societal developments characterized the changing position of the municipality in the early twentieth century: (1) public governance and an expanding set of duties for the municipality, and (2) poor relief, citizenship and *volksverheffing,* the Dutch-specific idealistic notion which roughly translates to mean the emancipation and civilization of the working classes. Bringing those concepts together, the welfare municipality appears.

How did public governance change for the municipality and in what way were its duties expanded? The municipality was an important player in the Dutch administrational landscape, one of the three centerpieces in Thorbecke's constitution, wielding a lot of influence, power and carrying legal responsibility.[68] In fact, by law the municipality was its own administrational body, an independent layer along with the layers of the central government and the province. The rather large degree of independence granted to the municipalities had been implemented in the belief that political affairs could be restricted to one layer of government only, distributing the workload over different governmental layers.[69] By 1851, after four years of reformation since the constitutional foundation of 1848, Thorbecke and his government had anchored the municipal structure of mayor, aldermen and council within the constitution, and in its essence, it still exists today.

However, fast industrialization and rapid urbanization hit the Netherlands in the second half of the nineteenth century, and from that moment, the economic and cultural importance of the Dutch cities steadily began to increase. Several cities became industrial powers bursting at the seams, housing an ever-larger group of people while coping with the side-effects of the new

[68] Raijmakers, *Leidende Motieven bij Decentralisatie*.

[69] This is also called the *subsidiariteitsbeginsel*, or subsidiarity, the idea that political or social issues should be dealt with on the most immediate (organizational) level. Couperus, *De Machinerie van de Stad*, 11-14.

industrial world; a total make-over of what had been the city in the days of Thorbecke.[70] As such, by 1900, a discrepancy began to appear between Thorbecke's three-way administrative division as a legal framework on the one hand, and the practicability of the system in a changed, modernizing society on the other.[71] This discrepancy primarily had to do with the distribution of money, the role of the council, aldermen and mayor, and the expanding public commitments of the municipality. While the municipality was politically and administratively autonomous, financially it was dependent on streams of money from the central government.[72] This created friction.

Since the 1851 municipality law, the financial balance between the central government and local government had been under constant revision to better the financial situation of municipalities. In 1865, municipal value added taxes were abolished, and since 1897, the central government started paying a fixed surtax per citizen to the municipalities.[73] While important for municipalities, this latter change also created a disbalance between municipalities. Some cities attracted a larger group of the industrial working class, increasing expenses for the many public facilities that were needed to further the societal position of this group. Facilities such as bathhouses, libraries, or municipal housing drove the financial burdens of the cities to new heights. All the while smaller municipalities close to cities maintained low taxes, attracting the richer population.[74] What followed was that industrial cities such as Rotterdam or Amsterdam were progressively troubled by financial distress, unable to close the books. As we have already seen with Heijermans, help by the central government was requested to make legal leeway, but the confessional, liberal character of Dutch national politics created an impasse and changes came very slow.

By 1900, there were other problems arising with local governance. In Thorbecke's system, the council held primary power within the municipality. It was a controlling organ, choosing the mayor and aldermen, steering their conduct, and restricting their influence. Moreover, the council was tasked to create council-committees for specific areas of policy such as healthcare or housing.[75] Around the year 1900, however, this was no longer working in practice, as municipal legal responsibility in the public sphere had increased dramatically since 1880, practically shifting the council's role to that of monitoring body primarily. The municipal responsibility for public facilities had become more and more complex, making it difficult for the council to keep a clear and knowledgeable overview of what was happening in the modern Dutch cities. Instead,

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[70] Historian Auke van der Woud has built an impressive series of books on the changing world of the Netherlands in the nineteenth and early twentieth century. See, for example: Auke van der Woud, *Een Nieuwe Wereld. Het ontstaan van het moderne Nederland* (Amsterdam; 2006); Auke van der Woud, *Koninkrijk vol Sloppen. Achterbuurten en vuil in de negentiende eeuw* (Amsterdam; 2010); Auke van der Woud, *De Nieuwe Mens. De culturele revolutie in Nederland rond 1900* (Amsterdam; 2015); Auke van der Woud, *Het Landschap, de Mensen. Nederland, 1850-1940* (Amsterdam; 2020).

[71] Ido de Haan and Henk te Velde, 'Vormen van politiek. Veranderingen van de openbaarheid in Nederland 1848-1900', *BMGN,* vol. 111, no. 2 (1996), 167-200; Koos Bosma, 'Town and regional planning in the Netherlands 1920–1945', *Planning Perspectives*, vol. 5, no. 2 (1990), 125-147; Oscar Gaspari, 'Cities against States? Hopes, dreams and shortcomings of the European municipal movement, 1900-1960', *Contemporary European History*, vol. 11, no. 4 (2002), 597-621.

[72] Marjolein 't Hart, Joost Jonker and Jan Luiten van Zanden (eds.), *A Financial History of the Netherlands* (Cambridge; 1997), 85.

[73] Henk van der Velden, *Financiële Toegankelijkheid tot Gezondheidszorg in Nederland, 1850-1941. Medische armenzorg, ziekenfondsen en de verenigingen voor ziekenhuisverpleging op nationaal en lokaal niveau (Schiedam, Roordahuizum en Amsterdam)* (Rotterdam; 1993), 93; Couperus, *De Machinerie van de Stad*, 13-18.

[74] Van der Velden, *Financiële Toegankelijkheid*, 93, 94.

[75] Van der Velden, *Financiële Toegankelijkheid*, 93; Couperus, *De Machinerie van de Stad*, 13-18.

the influence of daily governance by the municipal board of mayor and aldermen increased, and their agendas grew independent from the council due to the complexity and quantity of work.[76] The council was practically outplayed by the changing society.

It is a just question to ask why the Dutch municipalities continued the creation of public facilities if the costs were so high, as it complicated their relationship with the central government and changed the administrative practice of local governance dramatically. The answers to that question involve much of the reasoning behind this thesis. It comes down to two things. On the one hand the municipalities of industrial cities had no choice but to take action. Without the local state to step in, society would become unmanageable and illegible, obstructed by the many stacking hygienical, moral and economic problems that came in the wake of industrialization.[77] There were simply too many side-effects of modernization that needed to be tackled and this did not happen by itself. On the other hand—and this is most interesting for our argument—several influential voices increasingly demanded emancipation of the working classes by creating a variety of welfare services. These were middle class voices primarily.[78] The negative side-effects of industrialized society became so visible that the new middle classes were confronted with the reality of the working class. Moreover, for the middle class—benefiting most from industrialization and modernization—the misery of the working class hit a very specific moral and political dimension: citizenship and *volksverheffing*. How did the idealism behind the emancipation of the working classes impact the position of the municipality?

For example, within British historiography of the early twentieth century, the notion of 'urban governance' is used to analyze the city-specific culture of local administration and healthcare.[79] Within that concept, a whole variety of perspectives on governance is captured. Not only city councils, their aldermen and mayors are considered, but also the interaction between local elites and societal organizations, or between experts and civil servants.[80] This view of the municipality as a self-contained and autonomous entity within a larger country highlights interactions between historical actors and their belief systems, giving a more thorough look into their identity and beliefs as citizens of a city.

In his article 'Putting the City Back into Citizenship', historian Tom Hulme argues for a renewed conceptualization of early twentieth century citizenship as primarily expressed through the city. The perspective that citizenship and national identity are indivisible, he writes, should more actively be challenged by historians, for the national perspective only partly captures a person's identity. It is instead within the city-boundaries that citizenship in the 1920s and 1930s is best understood, as the rights and responsibilities of citizenship were received and enacted within the city.[81] Local governance was 'the guardian of the life and health of individuals and communities'.[82] Many cities had their own understanding and education of civics and the local culture and history behind citizenship. Hulme writes:

[76] Couperus, *De Machinerie van de Stad*, 63-100.
[77] On governmental legibility of society, see: James C. Scott, *Seeing Like A State. How certain schemes to improve the human condition have failed* (London; 1998).
[78] Christianne Smit, *De Volksverheffers. Sociaal hervormers in Nederland en de wereld, 1870-1914* (Hilversum; 2015), 7-19.
[79] See for example: Marjaana Niemi, *Public Health and Municipal Policy Making. Britain and Sweden, 1900-1940* (Farnhem; 2007).
[80] Couperus, *De Machinerie van de Stad*, 4, 5.
[81] Hulme, 'Putting the City Back into Citizenship', 26-51.
[82] Ibidem, 26.

"Civic education was arguably only the most obvious expression of the idealist understanding of the relationship between the local state and the citizen. These principles were also present in a variety of movements and events common to the inter-war period that remain under-researched; civic weeks, local health and education weeks, and the social management of municipal housing. [...] It remains clear, at the least, that the local was the prism through which many inter-war educators thought about the notion of citizenship [...]."[83]

While presenting a case of British citizenship, important parallels with the Netherlands can be drawn. Dutch and English comprehensions of the city, its culture, and its governance was aligned in a number of ways. Floor Wibaut already called the municipality the 'center where the whole life of the modern human being is reflected and forced into activity'.[84] Couperus shows us that for the Thorbecke critics of the early twentieth century, the English model of municipal governance offered a solution to the Dutch legal and practical discrepancy. In England, the constitution offered room for city-specific needs and cultures, making it flexible and pragmatic to a changing society. Especially the English arrangement of *committees*—non-aligned governmental boards that had clear and specialized tasks to very specific societal problems—inspired Dutch jurists to propose a different approach to the Dutch municipality.[85] Jurist W.F.M. Schutte, for example, saw the English structure as superior to the other alternative for the Dutch municipality, the German municipal structure, which was based on a centralized, authoritarian, expert oriented governance.[86] The democratic, elastic and decentralized character of the English system, Schutte believed, fit the Dutch culture perfectly. It catered to the city-specific needs, culture, and citizenship.[87]

Not surprisingly, Hulme mentions local healthcare weeks and social management of municipal housing as expressions of local citizenship. These events and practices of health were deeply embodied within the notion of citizenship, and also present in larger narratives of the emancipation of the working classes.[88] In the Netherlands, a similar understanding of citizenship and the municipality existed.[89]

In addition to citizenship, the Dutch-specific concept of *volksverheffing* was equally important. This starts by understanding Dutch citizenship and the emancipation of the working classes in the second half of the nineteenth century, when privately organized corporations and well-to-do individuals took responsibility over the social, moral and hygienical wellbeing of their fellow citizens.[90] It would be from a similar idealism and practice that the welfare municipality emerged.

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[83] Ibidem, 35.
[84] See: F.M. Wibaut, 'Internationale gemeentepolitiek', 494.
[85] Couperus, *De Machinerie van de Stad*, 43-47.
[86] Ibidem, 38-43.
[87] Ibidem, 47.
[88] Porter, *Health Citizenship*, 221-246.
[89] Shane Ewen and Stefan Couperus, 'Whose "Urban Internationale"? Intermunicipalism in Europe, c.1924-36. The value of a decentred interpretive approach to transnational urban history', Nicolas Kenny and Rebecca Madgin (eds.), *Cities Beyond Borders. Comparative and transnational approaches to urban history* (London; 2015), 149-172.
[90] Ido de Haan, 'Vigorous, Pure and Vulnerable: Child Health and Citizenship in the Netherlands Since the End of the Nineteenth Century', Marijke Gijswijt-Hofstra and Hilary Marland (eds.), *Cultures of Child Health in Britain and the Netherlands in the Twentieth Century* (Leiden; 2003); Ali de Regt, *Arbeidersgezinnen en Beschavingsarbeid*. *Ontwikkelingen in Nederland 1870-1940* (Amsterdam; 1984).

Dutch historian Christianne Smit, in her book *De Volksverheffers*, researched the societal role of Dutch social reformists between the years 1870 and 1914. Before the governments stepped in, Smit writes, well-to-do citizens from the new middle classes started to address social problems within cities and actively pursued a higher social and hygienic standard of the population by organizing courses and lectures, establishing societies, and publishing art and literature on topics regarding citizenship.[91] Their goal was to promote citizenship to the lower classes by educating those classes and addressing their potential. Some of these middle-class citizens organized themselves in religious, charitable circles, but their focus remained rather individualistic in their approach to citizenship. The bottom line of Smit's argument, then, is that before 1900, most charity and emancipatory work was done by middle class individuals, who sought to convey their citizenship-spirit to working class individuals.[92] Their own personal understanding of citizenship, captured in their ideas on discipline, desired morals and work ethic, had increased their societal position and prosperity. In the modern Dutch society, they believed, an individualistic approach of addressing personal responsibility was the key to the emancipation of the working classes as well.[93] On the side, this also meant that those individuals the philanthropists did not deem fit for emancipation, such as *paupers* who were in a constant struggle to survive, were excluded from this great strive for emancipation. Paupers were often blamed for being too lazy or even genetically inferior.[94] They lacked the discipline and work ethic that was central to the belief-system of those citizenship-educators. Such ideas of citizenship still held strong in the interwar society, but the means to achieve such civilization had shifted from individual initiatives to the municipality.

At the end of the nineteenth century, the government still played a marginal role in the public health field. The driving mentality of these middle-class individuals to change the situation of the working class and educate them in culture and citizenship had yet to find a strong political facet. Rather, these were individuals working for the betterment of other individuals, mainly operating from the liberal belief of individual responsibility.[95] Top-down governmental policy fit no such story. In those years, the only municipal initiatives in the public healthcare field were focused on taking care of the most helpless groups of people, those who fell outside of philanthropic and religious caritas. The care for the just mentioned paupers or mentally ill, for example, was already organized by the municipality as it fell under the broad notion of poor relief, which was traditionally the domain of the municipality.[96] In providing this poor relief, however, the origins of the welfare municipality can be found.

This trend of minimal municipal healthcare initiatives started to shift as industrialization and urbanization changed the social dynamics in the cities. At the end of the nineteenth century, medical relief became a primary responsibility of the municipality.[97] It is telling that in their approach to the problem, local citizenship and *volksverheffing* remained the central notion of their philosophy. This suggests that the great Dutch narrative of *volksverheffing* was being

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[91] Smit, *De Volksverheffers*, 8.
[92] Ibidem, 8.
[93] Ibidem, 7-8.
[94] Harry Lintsen, Frank Veraart, Jan-Pieter Smits and John Grin (eds.), *Well-being, Sustainability and Social Development. The Netherlands 1850–2050* (Cham; 2018), 83-92.
[95] Jeroen J. H. Dekker, 'Transforming the Nation and the Child: Philanthropy in the Netherlands, Belgium, France and England, c.1780–c.1850', Hugh Cunningham and Joanna Innes (eds.), *Charity, Philanthropy and Reform. From the 1690s to 1850* (London; 1998).
[96] Henk van der Velden, 'The Dutch Health Services before Compulsory Health Insurance, 1900-1941', *The Society for the Social History of Medicine*, Vol. 9, No. 1 (1996), 49-68, p.53.
[97] Ibidem, 54.

translated to a larger scale, a continuation and extension of individual relief initiatives of the late nineteenth century.

What had changed in the municipalities between 1870, when only philanthropists and religious organizations pursued a better, healthier life for working class individuals based on the principles of citizenship, and 1900, when the municipal councils started to create the first municipal, public relief services, open and in service of the total population? In essence, what had changed was a shift in the mentality of society. A shift, which was being translated to the political landscape. Where in 1870 it was believed that citizens had to take their personal well-being into their own hands, and caritas was organized as to empower the individual to do so, in 1900, responsibility was carefully taken out of their hands and put in the hands of the municipality. Municipal hands now slowly began to carry its citizens, first as the backbone of privatized care, but drawing a larger part of public healthcare to itself every year. A huge shift was occurring: the *welfare municipality* was coming into existence, decades before the national welfare state would emerge.

The welfare municipality did not emerge overnight. The collectivization of public healthcare was an important step, as exemplified by the creation of two municipal medical and health services.[98] From 1890 onwards, Dutch society, and its economy in tow, was ready for the municipality to step in. Municipalities increasingly started to pressure the national government to change laws that gave them more legal leeway for social relief. Even though the central governments were still mainly liberal and, as a consequence, non-interventionist, a few law-changes greatly changed the way municipalities could act within their own cities and expand the social relief systems. In 1901, laws on housing and public health passed parliament. In 1912, a new poor law followed, and in 1913, several smaller social security laws were also accepted by parliament.[99]

This opened up legal space for the municipalities to act within. The real acceleration of municipal welfare could then finally begin in earnest, and municipal relief boomed during and after the First World War. Even though the Netherlands did not participate in this war, it was significantly impacted by it. More and more, the municipality complemented privatized organizations and religious charities, who often turned out to be too precariously organized in times of great societal distress.[100] The municipality became the main authority that managed the socio-economic situation of the cities. One municipality did so on a larger scale than any other, and that was Amsterdam.

### v. ... OF AMSTERDAM

In the city of Amsterdam a combination of *volksverheffing* and the growing municipal responsibility in the public sphere changed the dynamics of municipal administration and governance.[101]

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[98] See chapter two for an analysis of the creation of these municipal services.

[99] These are, in chronological order: the *Woningwet* (1901), the *Gezondheidswet* (1901), the *Nieuwe Armenwet* (1912), the *Radenwet* (1913), the *Invaliditeitswet* (1913) and the *Ziektewet* (1913). For a beautiful article on the consultation of the Council of State on these laws, see: http://resources.huygens.knaw.nl/socialezekerheid/nadere_toegangen/html_bestanden/RaadvanState, consulted on June 6th 2021.

[100] Couperus, *De Machinerie van de Stad,* 1.

[101] Remieg Aerts and Piet de Rooy (eds.), *Geschiedenis van Amsterdam, III, Hoofdstad in Aanbouw 1813-1900* (Amsterdam; 2006).

Nineteenth-century Amsterdam had known its various philanthropists who had invested time, money and influence in the first efforts of a public welfare system. Samuel Sarphati, a physician, was among the first to engage in creating a public health structure for the city. In 1847, he started to collect human waste and garbage for processing outside the city, making it so that waste was no longer dumped in the same canals where the people would get their drinking water. And a few years later, in 1855, he would open a bread factory that would sell to the working classes at a low price.[102] Sarphati's projects are even considered to have contributed to the general rise of life expectancy in Amsterdam.[103] Aside from having an eye for the hygienical and health situation of Amsterdam's poorest citizens, he would also attempt to develop a greater sense of local citizenship to the people. In 1864, the *Paleis voor Volksvlijt* (Palace of Popular Diligence) opened, a place for huge exhibitions open for the people, inspired by the famous Great Exhibition. It was planned to be the new cultural and societal center of Amsterdam, and was supposed to be of great importance in Europe. The exhibition hall would put Amsterdam back on the map as a city of high culture and inspire Amsterdam citizens to develop a greater sense of what it meant to be a citizen of Amsterdam. The municipality was yet to be interested.[104]

Another example is the influential character Aletta Jacobs, a philanthropist and doctor from Groningen who spent most of her working years in Amsterdam. Primarily known for her feminist work and ideals, and also as being the first woman to enjoy higher education as a student of medicine, she had strong beliefs on topics of emancipation of the working classes as well. From 1879 on, Jacobs worked as a general practitioner in Amsterdam, where she gave free advice to working class women on contraceptives and instructed the general population on matters of hygiene, while also giving lectures.[105] There were plenty of moments, she described in her memoirs, when patients were too weak to come for consultancy, and she would visit them in their homes. In her memoirs, Jacobs proclaims 'Such misery I encountered there!'[106]

This firsthand experience characterized the philanthropic individuals of the late nineteenth century.[107] They encountered the hardship of the working classes by walking through the same streets. The daily miserable circumstances of Amsterdam's working classes was something that concerned them and about which they felt strongly. Smit has outlined how philanthropic idealism was characterized by the search for a new social communication between society's classes, attempting to create more coherency in the changing working relations in the ever-expanding city.[108] As such, the citizenship of Sarphati, Jacobs, Ligthart or Suringar became connected with their mission in the city.[109] It laid the roots for the emerging welfare municipality.

It would be a matter of time before such philanthropists started to organize themselves politically. They simply could not do it by themselves. For the changes they envisioned, a broader movement was necessary. As such, the radical corners of this well-to-do liberal middle class

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[102] J.Z. Baruch, 'Dr. Samual Sarphati, Medicus en Planoloog, (1813-1866)', *Historia* (1967) 79, 80.
[103] Henny van der Kooy and Justus de Leeuwe, *Samuel Sarphati 1813-1866. Een biografie* (Amsterdam; 2001).
[104] Baruch, 'Dr. Samual Sarphati, Medicus en Planoloog, 80, 81.
[105] Smit, *De Volksverheffers,* 19-21.
[106] Aletta Jacobs, *Herinneringen van Dr. Aletta H. Jacobs* (Amsterdam; 1924)*,* 77. This is a translation of the following: 'Wat een ellende heb ik daar aanschouwd!'
[107] For an excellent work on the Dutch hygienical movement in the nineteenth century, see: Eddy S. Houwaart, *De Hygienisten. Artsen, staat en volksgezondheid in Nederland, 1840-1890* (Maastricht; 1991).
[108] Smit, *De Volksverheffers,* 387.
[109] For literature on Ligthart and Suringar, see: Sjoerd Karsten, *Op het breukvlak van opvoeding en politiek***.** *Een studie naar socialistische volksonderwijzers rond de eeuwwisseling* (Amsterdam; 1986); Jo Egging, *Willem Hendrik Suringar (1790-1872). Een 'filantroop' in Nederland en Europa* (Nijmegen; 2019).

started to politically organize themselves by increasingly identifying with reformist and socialist ideology. They anticipated the creation of a social welfare system that was funded or even executed by the government. Some would organize themselves in the *Radicale Bond* (Radical League) in 1892, springing from the Amsterdam electoral division who broke with the *Liberale Unie* (Liberal Union).[110] Others would radicalize differently, proclaiming a stronger socialist agenda, leading to the political establishing of the Social Democratic Worker's Party in 1894.[111] Henri Polak, Pieter Lodewijk Tak, Monne de Miranda and Floor Wibaut would become familiar SDAP-faces in those years, all residing in Amsterdam. Moreover, the SDAP specifically had very distinct visions on municipal governance and the creation of a municipal welfare system, a consequence of the fast-changing dynamics within municipal administration.

In 1899, the party released a document called the *municipal program*.[112] In the document the social democratic party demanded more legal leeway for municipal governance, proposing ten changes in municipal governance, ranging from greater legal margins for poor relief and examination of provisions, to public health, education, the creation of a system of municipal public officials, and housing.[113] Where the central government's legal structure was not adequate enough for such municipal concerns, the SDAP argued, the municipal councils had the 'duty and responsibility to insist for improvement of those laws'.[114] The SDAP even organized courses for their members on the specific workings of the political arena.[115]

While Utrecht was the first city to house a social democrat in the municipal council in 1899, it was Amsterdam that would house the largest number of social-democratic councilmembers and aldermen in the first half of the twentieth century.[116] In 1903, Henri Polak would enter the Amsterdam municipal council as the first SDAP-member and many others would soon follow.[117] Quickly, social-democratic individuals would not only be members of the council, but also started to obtain positions within the Amsterdam administration as aldermen or directors of municipal services (see chapter two). Prominent people like Treub, Tak, Wibaut or De Miranda would leave their mark on Amsterdam municipal governance since the 1910s.[118] They were a driven bunch, changing the way local governance of the city council was functioning.[119] They introduced what would historically become known as *wethouderssocialisme*

[110] For a thorough and extensive work on this history, see: Meine Henk Klijnsma, *Om de Democratie. De geschiedenis van de Vrijzinnig-Democratische Bond, 1901-1946* (Amsterdam; 2007).
[111] Henny Buiting, *Richtingenstrijd in de SDAP. Het ontstaan van de Sociaal-Democratische Partij in Nederland* (Amsterdam; 1989).
[112] *Gemeenteprogram SDAP* (1899).
[113] Ibidem.
[114] The Dutch phrasing is very telling: "Overwegende, dat, waar maatregelen, wenschelijk in het belang der gemeente, mochten indruischen tegen de rijkswetten, regelende de verhouding tusschen Rijk en Gemeente, de gemeenteraden de taak en de bevoegdheid hebben om op verbetering dezer wetten aan te dringen, stelt de S. D. A. P. op het gebied der gemeente-politiek de volgende eischen ongeacht de belemmeringen, door de rijkswetgeving aan de vervulling in den weg gelegd [...].", *Gemeenteprogram SDAP* (1899).
[115] Couperus, *De Machinerie van de Stad*, 148.
[116] The first Dutch social-democratic councilor was Jan Oudegeest, a labor union leader for the Dutch railways. See: https://socialhistory.org/bwsa/biografie/oudegeest, consulted online on June 5th 2021.
[117] Jos Perry, 'Socialisme en Gemeenten', Marnix Krop, Martin Ros, Saskia Stuiveling en Bart Tromp (eds.), *Het Negende Jaarboek van het Democratisch Socialisme* (Amsterdam; 1988), 23.
[118] For literature on the interplay between the mayor and the social democrats, see: Harm Haal, *Het Hoofd van de Stad. Amsterdam en zijn burgemeester tijdens het interbellum* (Amsterdam; 2008).
[119] Couperus, *De Machinerie van de Stad*, 144-148.

(aldermen socialism), a concept regarding the many social-democratic aldermen in the local political arena.[120]

The SDAP aldermen changed the dynamics of the council. The somewhat unruly social democrats greatly emphasized the need for municipal interventions in society. Especially from the start of the First World War—when 42% of the 1913 votes of the local elections in Amsterdam had gone to the SDAP—the municipality started to intervene in society.[121] The municipality became an employer, a *collective institution*, where municipal services offered a large quantity of people a steady income.[122] In the 1920s, the municipality would even become Amsterdam's greatest employer, having more than 20.000 people in employment.[123] By doing so, it mimicked companies like Philips and organizations like Patrimonium.[124]

The municipality as an employer, the SDAP believed, was to hit two birds with one stone.[125] On the one hand, it created labor and jobs that would help citizens obtain a steady, reliable source of income. And on the other, the municipal organizations that offered such labor increased the quality of the city itself by providing services in the public sphere. The municipality started to mingle in a wide variety of societal projects such as municipal housing—Berlage's *Plan Zuid* as its most famous example—, soup kitchens for the poor, and the so called '*waterbeschaving',* the building of bathhouses and washing locations in every neighborhood, meant to increase the hygienical wellbeing of all Amsterdam citizens.[126] All such projects were initiated by SDAP aldermen. Finance, housing, provisions, municipal employment: from 1914 on these portfolios were controlled by the SDAP.[127]

What differentiated these SDAP councilors from their fellow philanthropists a few decades before? Their concerns were the same: the social emancipation of the working classes in a fast-changing society. What was different was their philosophical outlook on municipal governance. Their beliefs of citizenship and *volksverheffing* had merged with the legal and financial possibilities municipal governance had to offer. It was the municipality that had become the guardian of life and health, and it was the municipality that provided the foundation of a long life in good health for all its citizens. That amounts to the welfare municipality.

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[120] The focus of the social democrats on the municipality and aldermen can also be related to 'Troelstra's Error' in 1917, the social-democratic leader who proclaimed a working-class coup after the defeat of Germany on November 11th, 1917. His coup failed, however, and in the process the social democrats were pushed to the sidelines in the national arena until the end of the 1930s. The focus on the municipality by the social democrats, then, was a necessary endeavor because the party had no national power. See, for example: Boterman, *Tussen Utopie en Crisis*, 40, 41.
[121] Couperus, *De Machinerie van de Stad*, 145.
[122] Ibidem, 145.
[123] Ibidem, 145.
[124] Wouter P. Beekers and Rolf E. van der Woude, *Niet bij Steen Alleen. Patrimonium Amsterdam. Van sociale vereniging tot sociale onderneming, 1876-2003* (Hilversum; 2008); Annemieke van Drenth, *De zorg om het Philipsmeisje. Fabrieksmeisjes in de elektrotechnische industrie in Eindhoven, 1900-1960* (Zutphen, 1991).
[125] *Gemeenteprogram SDAP* (1919).
[126] Martijn de Jong, 'De Amsterdamse 'waterbeschaving': baden, zwemmen en wassen', *Stichting Historische Interieurs in Amsterdam* (2016), consulted online on March 19th 2021, https://www.historischeinterieursamsterdam.nl/blog/de-amsterdamse-waterbeschaving-baden-zwemmen-en-wassen/.
[127] Couperus, *De Machinerie van de Stad*, 149.

### vi. CONCLUSION

The Netherlands might in fact have not been a welfare laggard. Instead, the municipalities stepped into the welfare gap, which was translated to the central state only in the 1950s. In this chapter, the notion of the welfare municipality had been introduced along with public health and local administration historiography. By combining local identity with citizenship and citizenship with health and hygiene histories, an attempt is made to produce a strong foundation on which histories of the welfare municipality can be written. The Dutch municipality, and Amsterdam specifically, became the strongest proclaimer and pursuer of a healthy society in the late 1910s, both by propagating such a mentality and by actively building upon it. The municipality of the interwar years had become the so called 'guardian of life and health', not only providing a basic public sphere but also vigorously attempting to arrange municipal relief organizations and institutions that supported citizens in all aspects of life.

By now having conceptualized the welfare municipality and grounding it in historiography, through the lens of the welfare municipality, chapter two is dedicated to Louis Heijermans, director of the Amsterdam Municipal Medical & Health Service between 1919 and 1937. This organization became the spindle in Amsterdam's public health service but extended even further by tapping into the domain of public housing and labor. It was Heijermans' belief that the working classes should be educated in their day-to-day living in order to achieve the highest level of societal hygiene. He did so by founding public, municipal organizations that guided this part of the population towards adequate citizenry. By what philosophy did Heijermans work? What were his beliefs? And how did that translate to practice? As we will see, the municipality was the center of his thought processes.

# CHAPTER TWO
## The Welfare Municipality: between idealism and practice

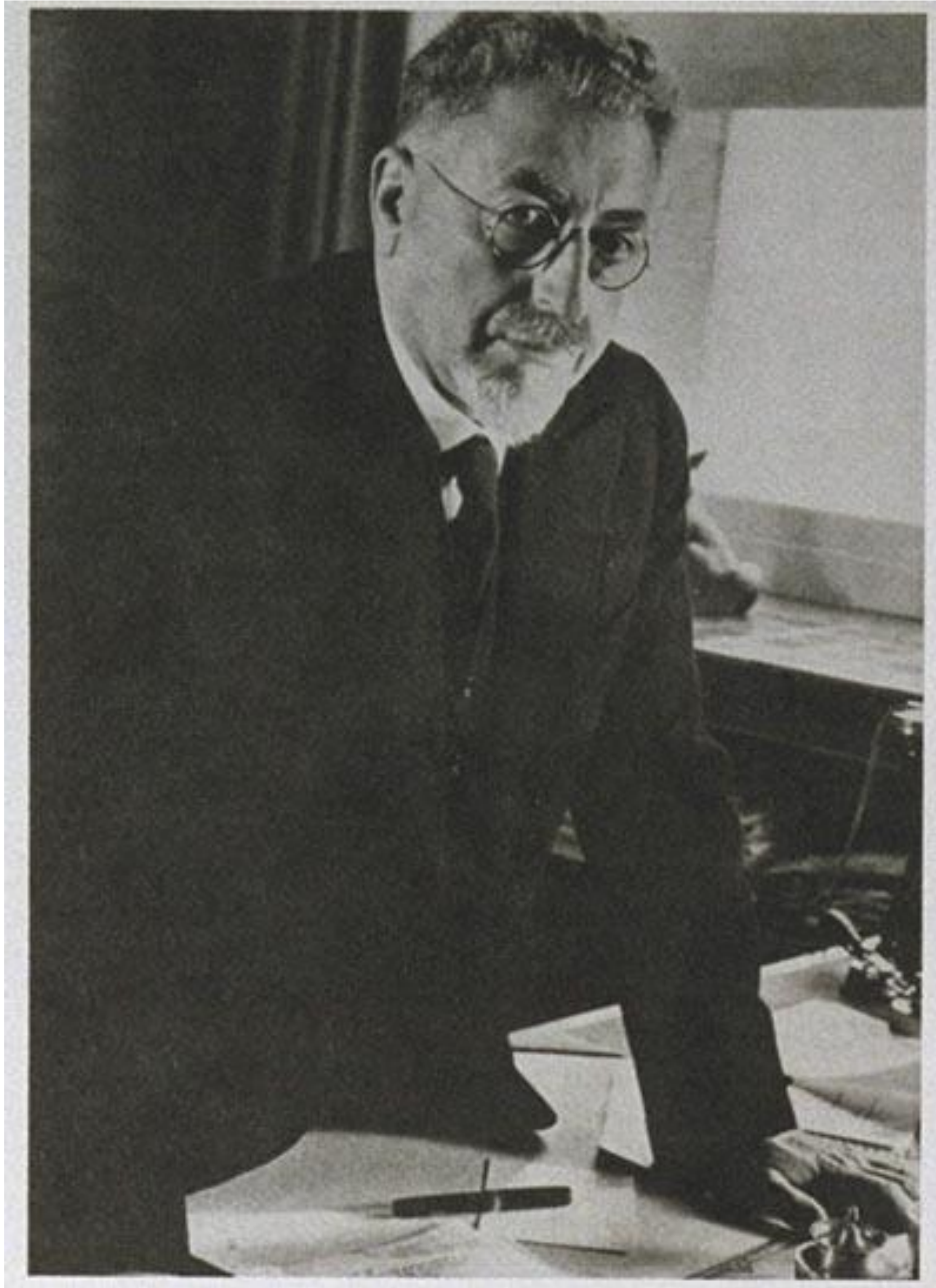

*Figure 3. Louis Heijermans, director of the Amsterdam Municipal Medical & Health Service*

SYNOPSIS

This chapter highlights Louis Heijermans, director of the Amsterdam Municipal Medical and Health Service in the interwar years. A vigorous character, his work as a director was defined by his strong socio-hygienical beliefs, shaping the institute to become the cornerstone of the municipal welfare system of Amsterdam.

## i. AN INTRODUCTION: WHEN IN DOUBT, LOOK FOR THE MUNICIPALITY

It is a curious perception to see Louis Heijermans, director of the Amsterdam Municipal Health Service between 1919 and 1937, being relatively absent in Dutch welfare history. Apart from Han Israëls' and Annet Mooij's book on the general history of the Amsterdam GG&GD and a postdoctoral thesis by Dick Spreeuwers on his role in the creation of occupational medicine, no academic works are dedicated to the man himself, his life, work and beliefs.[128] He is mentioned only sometimes on the sidelines in the interwar history of Amsterdam. But in his time, Heijermans must have been a familiar face as the director of a municipal service that helped thousands of people.

Heijermans' historiographical absence is compensated by the many contemporary documents written by Heijermans himself; his own written reports, books and scientific treatises—of which there are many. These documents are highly valuable, for they allow for an analysis of the impact of his work in the creation of a welfare municipality in Amsterdam in the 1920s and 1930s. In this chapter these documents are analyzed extensively. By doing so, the chapter describes how in the interwar welfare municipality of Amsterdam, welfare domains such as housing, labor, nutrition, and morals all were seen by Heijermans as areas related to public health. And the municipal organizations had a central position in executing this responsibility.

A few crucial moments and decisions in Amsterdam's welfare politics, and Heijermans central position in those moments, will be highlighted in this chapter. The attention will be focused on an in-depth analysis of the idealism that drove Heijermans and the specific role he attributed to the municipality to reach the desired long life in good health for every citizen. The concept of social hygiene will be crucial in understanding Heijermans' visions of municipal intervention. This will provide a frame of reference when analyzing the position of the Municipal Medical and Health Service.

## ii. THE BREADTH OF THE WELFARE MUNICIPALITY

Municipal interference in the public sphere and organization of social life is not a phenomenon that came out of nowhere in the interwar years. Underneath the surface, the municipality was increasingly appropriating such initiatives for a long time, if only on a small scale and in a limited variety of domains.[129] The organization of poor relief, for example, exemplifies a municipal role before the creation of the broader welfare municipality.

However, increasingly, other domains were added to the portfolio of the municipality, centering around the idea that the municipality was responsible for its citizens. If the municipality was the guardian of life and health, it also had to act accordingly. Life and health became central notions around which municipal practice was organized. It is Louis Heijermans who symbolizes this idea, as we have already seen at the end of the introduction, where Heijermans' publication of *Gemeentelijke Gezondheidszorg* was introduced. That manual for a municipal healthcare system captured the different societal and social facets of a long life in good health, further capturing the

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[128] Han Israëls and Annet Mooij, *Aan de Achtergracht. Honderd jaar GG&GD Amsterdam (*Bert Bakker, 2001); Dick Spreeuwers, 'Louis Heijermans (1873-1938) en de opkomst van de arbeids- en bedrijfsgeneeskunde', *Nederlands Tijdschrift Geneeskunde,* vol. 132, no. 30 (1988), 1403-1406.

[129] The primary nineteenth-century public interference of the municipality was the domain of poor relief. However, the municipality was also involved in the creation of an infrastructure of public health. See, for example: Rineke van Daalen, 'Openbare Hygiëne en Privé-problemen. Het ontstaan van de Amsterdamse gezondheidszorg', *Amsterdams Sociologisch Tijdschrift,* vol. 9, no. 4 (1983), 568-605.

scope and the breadth of what Heijermans believed the municipality should entail. Heijermans wrote:

> The principles for a long life in good health can be summarized in a few lines: good housing, correct nutrition, healthy labor, and hygiene of body and morals. [130]

How do these principles—*good housing*, *correct nutrition*, *healthy labor*, and *hygiene of body and morals*—portray the breadth of municipal welfare practices?

*Figure 4 - Amsterdam, a picture taken by George Hendrik Breitner between 1894 and 1898. The poorest classes often lived in so called* 'kelderwoningen'*, small rooms at or below canal level.*

As the above principles suggest, public health and healthcare were not the only municipal practices portraying the welfare municipality in the interwar years. Moreover, from the late 1910s the scope of municipal responsibility was expanded to a broader set of societal dimensions. The principles above help highlighting this expanding scope.

The first and foremost principle to come under the expanding scope of the municipality was that of facilitating good housing. In the early twentieth century, the municipality of Amsterdam became increasingly invested in providing residency for the working classes.[131] Since the rapid industrialization at the end of the nineteenth century, daily living conditions for the working class were in decline rather than prospering. The city was bulging with people and there was no room to house them all. Consequently, the poorest of the working class often had no choice

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[130] Heijermans, *Gemeentelijke Gezondheidszorg*, 9. This is a translation of the following: 'De voorschriften om lang in goede gezondheid te leven kunnen samengevat worden in enkele regels:
goede woning, juiste voeding, gezonde arbeid, reinheid van lichaam en zeden.'

[131] See, for example: Vladimir V. Stissi, *Amsterdam, het Mekka van de Volkshuisvesting. Sociale woningbouw 1909-1942* (Amsterdam; 2007); Wouter Pieter Beekers, *Het Bewoonbare Land. Geschiedenis van de volkshuisvestingsbeweging in Nederland* (Nijmegen; 2012).

other than accepting so called *kelderwoningen*—small, damp rooms at or below canal level (see figure 4).[132] Up until a change of law in 1901, when the municipality became responsible for housing citizens when private initiative was lacking, the municipality had remained uninvolved in the creation of housing.[133] However, in the first years of this new law, the municipality only supervised the creation of housing and did not yet initiate the building of public housing itself.

In 1915, this started to change, when, under the portfolio of SDAP-councilor Floor Wibaut, the Amsterdam municipality commenced the building of public housing, residences built by the municipality specifically meant to house the large number of working-class families.[134] An often-heard slogan of that time was *Wie Bouwt? Wibaut!* ('Who Builds? Wibaut!'), referring to the great changes visible in the Amsterdam streets, where old slums were put down and whole new neighborhoods emerged for the working classes.[135] Between 1921 and 1926, 39.000 houses were built in Amsterdam alone, mostly for the working classes, who could now be placed in residences with separate living-, sleeping- and kitchen quarters.[136]

The house became the center of the civilizing process that substantiated this new municipal responsibility. Building public housing, however, was only part of the job. In the spirit of *volksverheffing*, every detail in a working-class residence had to be correct and create the right incentive for proper citizenship and hygiene. Bedrooms had to be separated from the kitchen, and a cut-off chamber for sanitaire was of the most importance.[137] The architect had a large responsibility. Heijermans writes:

> Considering this subject [working class housing, ps] it is of importance, that the hygienical issues are of a primary concern — the architect, the engineer, is the expert on the technical work, and must realize the hygienical demands which the principles of health, the physiology, and the knowledge of causes of disease, have brought forward.[138]

The Amsterdam School of architecture, for example, had specific ideas about the interior of its housing.[139] The largest of the school's projects were municipal instructions for the creation of public housing, such as the famous but only partially executed *Plan Zuid* of architect Hendrik Petrus Berlage.[140]

Another important facet of civilizing the working class was improving the labor situation. Louis Heijermans. In 1908, for example, he wrote a study on occupational hygiene and diseases, introduced by Municipal Medical Service director Saltet, which quickly became a standard in the

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[132] Nicolaas Tetterode, *De Onbewoonbare Kelderwoningen te Amsterdam* (Amsterdam; 1893).
[133] Böhl, *Wibaut de Machtige*, 215, 216.
[134] In 1915, the municipal service for municipal housing under the directorship of Arie Keppler was created too.
[135] Not so easily translated to English, meaning something as 'Who Builds? Wibaut!". See also: Andere Tijden, *Wie Bouwt? Wibaut!*, direction by Erik Willems, no. 266 (26 september 2009), https://www.anderetijden.nl/aflevering/266/Wie-bouwt-Wibaut, consulted on June 6th 2021.
[136] Böhl, *Wibaut de Machtige,* 301.
[137] Nancy Strieber, *Housing Design and Society in Amsterdam. Reconfiguring urban order and identity, 1900-1920* (Chicago; 1998).
[138] Heijermans, *Gemeentelijke Gezondheidszorg*, 45. This is a translation of the following: 'Bij de behandeling van dit onderwerp is het de bedoeling, de hygiënische vraagstukken op den voorgrond te plaatsen — de architect, de ingenieur, is de deskundige op technisch gebied, die de hygiënische verlangens moet verwezenlijken, welke de gezondheidsleer, de physiologie, de kennis der ziekteoorzaken naar voren hebben gebracht.'
[139] Nancy Strieber, *Housing Design and Society in Amsterdam,* 259-268.
[140] Ibidem*,* 259-268.

field and placed Heijermans in the spotlights.[141] Such a study on the working conditions of the working classes had been absent in the socio-medical studies of that time.

Good health and hygiene were, in the eyes in Heijermans, primarily a day-to-day practice, something that required daily attention and was centered around routines within the house.[142] The woman of the house, as such, had a very important societal role to play as a housewife. Heijermans and many of his contemporaries believed that a stable and functioning family provided the basis of both good citizenship and a healthy life, whilst a disfunctioning family was the root of social and hygienical problems.[143]

The requirements for a long life in good health also influenced the way Heijermans thought about emancipating the working classes. Social hygiene—the capacity to relate oneself to the needs and desired ways of society—was an important aspect of that emancipation of the working classes, something that the lower classes had to be taught and educated in. In it, the idea of a malleable society can be found. Consequently, when social and hygienical problems occurred in a family of the working class, first and foremost the day-to-day tasks of the housewife were examined. Municipal house supervisors roamed Amsterdam streets like Zeeburgerdorp, a street that functioned as a residential school for dislocated and disfunctioning families, to check up on the families. From 1926 on, families living there were put under supervision by the municipality and were advised and directed in day-to-day living (see chapter three).[144]

This group of people—who lacked the capacity to maintain a proper and functioning household—were considered *onmaatschappelijken* (unsocietal people), a group consisting of the disabled, mentally ill, homeless and criminals. Consequently, they were often considered to be a problem of society at large. And as was the case with Zeeburgerdorp, Heijermans saw the municipality as the main institution for taking care of these people, trying to at least teach them the basics of a good and healthy life. However, those individuals could be steered in the right direction with a strong, fatherly pedagogical and civic approach towards the working classes, as most cases of unsocial behavior were from this group of economically and civically disadvantaged population. As Heijermans saw it:

> A part of the proletarian must be *taught* to live. Someone who has never eaten with knife and fork, does not understand, that the "civilized" looks to the dripping, greasy fingers with a certain disgust. But the principles — of personal health — can only be followed, when the means to it are present: when the tableware is missing, the table cannot be set; and only when it is present, it can be educated, how fork and knife must be held and used. Such a manner applies to the entirety of the house — and similarly to nutrition.[145]

In a sense, the municipality stepped in to provide that tableware to that 'part of the proletariat', the unsocietal population.

[141] Louis Heijermans, *Handleiding tot de Kennis der Beroepsziekten* (Rotterdam; 1908).
[142] Heijermans, *Gemeentelijke Gezondheidszorg*, 9.
[143] Ali de Regt, 'Ontoelaatbare Gezinnen: over het ontstaan van onmaatschappelijkheid', *Amsterdams Sociologisch Tijdschrift,* vol. 7, no. 4 (1981), 391-432.
[144] Ibidem, 391-432.
[145] Heijermans, *Gemeentelijke Gezondheidszorg*, 9. This is a translation of the following: 'Men moet een deel van het proletariaat *leeren* te leven. Wie nooit met mes en vork gegeten heeft, begrijpt niet, dat de „beschaafde" met eenigen afschuw naar de van vet druipende vingers kijkt. De voorschriften — van de persoonlijke gezondheidszorg — kunnen echter pas opgevolgd worden, wanneer de middelen daartoe aanwezig zijn: ontbreekt het servies, dan kan de tafel niet gedekt worden; en eerst indien het aanwezig is, kan geleerd worden, hoe vork en mes moeten worden vastgehouden en gebruikt. Zoo gaat het over de geheele lijn met de woning — zoo gaat het met de voeding.'

In 1923, Heijermans published an article in the Dutch *Tijdschrift voor Sociale Hygiëne*, a scientific magazine on the social aspects of medicine. In the article, titled 'De Opleiding der Sociale Verpleegsters', he advocates for a national training program for nurses specifically trained in matters of social hygiene. He writes:

> The development of social hygiene and social medicine, the more profound supervision of public health, the growth of municipal health services, the want for confessional and disinterested district nursing, the progressively applied program of preventive medicine: infant care, action against venereal diseases and tuberculosis — the therapy and prophylaxis *en masse* outside of hospital and institutional confines, have an increasingly urgent necessity for a social-hygienical nursing staff, who for the sake of brevity I will call: social nurses.[146]

Heijermans advocated for such 'social nurses' because the world of medicine was changing. Around 1900, more and more of the medical and hygienical focus, especially that of the municipality, was directed at the preventive aspects of health.[147] No longer was it centered around the hospitals or private clinics of doctors only; preventive medicine was seen as a societal project and its goal was to raise a higher standard of general hygiene for the entire society, preventing contagious diseases such as tuberculosis and limiting poor diseases. That asked of those directly involved, Heijermans believed, a new type of interaction with patients: a socially educated nurse, who next to medical training also had knowledge of social interaction, daily hygiene and a technical awareness of social concepts. Often this was the territory of the woman, who was believed to have a natural gravitation towards such social dynamics.[148]

The metaphors of tableware, forks and knives, and education touched on what Heijermans considered the essential beginning of good life: housing. The house functioned as the basis of good hygiene and citizenship. And as the municipality became increasingly invested in providing for that good life and health, the municipality had an important responsibility in creating the houses where such citizenship could be nurtured. Heijermans' vision for elevating the working class from their less than desirable houses was well articulated in his 1929 manual:

> A housing policy, which aims to fulfill the socio-hygienical desiderata, must pursue as ultimate goal the transplantation of the socio-retarded part of the population to better and ampler residences. One cannot nearly come to think to teach to the lower classes concepts of self-esteem, cleanliness, childcare, in short the most elementary of concepts of civics and hygiene, if no start is made with housing in houses, where it is possible to put this to practice.[149]

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[146] Louis Heijermans, 'De opleiding der sociale verpleegsters', *Tijdschrift voor Sociale Hygiëne,* vol. 25 (1923), 204. This is a translation of the following: 'Het opkomen der sociale hygiëne en sociale geneeskunde, het diepergaand toezicht op de volksgezondheid, de groei van gemeentelijke geneeskundige diensten, de behoefte aan confessioneele en neutrale wijkverpleging, de steeds meer toegepaste preventieve geneeskunde: zuigelingenzorg, bestrijding van geslachtsziekten en tuberculose — de therapie en prophylaxis en masse buiten de ziekenhuizen en gestichten hebben steeds dringender doen gevoelen de noodzakelijkheid van sociaalhygiënisch gevormde verpleegkrachten, die ik kortshalve wil noemen: sociale zusters.'

[147] Van Daalen, 'Openbare Hygiëne en Privé-problemen', 579, 580.

[148] Berteke Waaldijk, 'Personeel van Sociale Instituties. Over het verband tussen vrouwenbeweging en maatschappelijk werk', *Low Countries Historical Review,* vol. 130, no. 2 (2015), 44-69; Ali de Regt, 'Woningopzichteressen: een mislukt professionaliseringsproces', *Amsterdams Sociologisch Tijdschrift*, vol. 6, no. 3 (1979), 418-448.

[149] Heijermans, *Gemeentelijke Gezondheidszorg,* 57, 58. This is a translation of the following: 'Een woningpolitiek, welke er op uit is de sociaalhygiënische desiderata te vervullen, zal als einddoel moeten najagen, het sociaal-achterlijke deel der bevolking over te planten in betere en ruimere woningen. Er valt bijkans niet aan te denken, aan de onderste lagen begrippen van eigenwaarde, zindelijkheid, kinderverzorging, kortom de meest elementaire begrippen van beschaving en gezondheidsleer, bij te

Heijermans was not alone in believing that an overarching municipality could provide the foundation for a long life in good health. Directors and aldermen from Amsterdam's different services and municipal departments lived by similar philosophies, the likes of famous aldermen Floor Wibaut and Monne de Miranda. Or municipal director of the Public Housing Service Arie Keppler, who built a working municipal service from the ground-up, despite being rather infamous for his stubbornness and whimsicality. Floor Wibaut wrote in the *Haagsch Maandblad* that the municipality had become the 'center where the entirety of life for the modern person comes to expression and efficacy'.[150] In that center, he presented municipal housing in the Amsterdam municipality as the 'red experimental garden'.[151] There, Heijermans' socio-hygienical desiderata could be fulfilled.

How did that philosophy of a providing municipality translate to practice for Heijermans? Economically, the municipality became an employer, providing in the creation of labor, one of the building blocks for a long life in good health. For Heijermans, the municipal services had to take the lead in creating a space where social hygiene could grow. Right from the start of his directorship in 1919, he started by hiring more employees into his municipal service. By 1919, 200 employees worked for the Amsterdam Municipal Health Service. A few years later this was increased to over 500.[152] The municipality had become an important employer for the city in general, and the municipal health service followed in that direction too.[153] This was done, mainly, by taking over private organizations and creating new municipal institutions, all in line with the SDAP municipal program that was newly published in 1919.[154] Municipal collectivization of private organizations and creating new, collective institutions was an important development in the creation of a welfare system. Heijermans' service would play a pivotal role by merging with the Municipal Health Service, as is further explicated below.

The municipality was seen as the guardian of that life and health, where the modern person came into existence. That mentality was expressed by several of Amsterdam's aldermen and municipal directors, and Heijermans was one of the vocal ones, publishing treatise after treatise about public health and the municipality. Citizenship and identity, morals and health, sufficient labor and nutrition, all were seen to come from the organizational center of the municipality. As a mentality and as a vision for society, the welfare state existed long before it actually came to practice. But aside from being great visionaries, Heijermans, De Miranda, Wibaut, Keppler, Saltet and others all put their vision of the municipality into the work they did.

### iii. THE ORIGINS OF THE MUNICIPAL MEDICAL & HEALTH SERVICE

Having now described the welfare municipality in its full breadth, it is useful to fixate on a specific element of this municipal system: the Amsterdam Municipal Medical and Health Service. How did the service become such an important player in Amsterdam? Where nineteenth-century medical experts had been highly independent actors within society, having their own clinics, treating the

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brengen, als niet begonnen wordt met de huisvesting in woningen, waar het mogelijk is deze in practijk te brengen.'

[150] Floor Wibaut, 'Internationale Gemeentepolitiek, *Haagsch Maandblad*, vol. 11 (1929), 484-495, p.494.

[151] Böhl, *Wibaut de Machtige*, 301.

[152] Israëls, Mooij, *Aan de Achtergracht*, 97.

[153] See chapter one on the *collective institution* of Amsterdam. At its height in the 1920s, the municipality had over 20.000 people in employment.

[154] *Gemeenteprogram SDAP* (1919).

poorest patients from philanthropic ideals and at their own preferred time, rate and expenses, the municipal government of larger cities started to appropriate the decision-making processes behind poor relief and public health. The 1901 establishment of the Amsterdam municipal *Geneeskundige Dienst* (medical service, *GD*) was a scandalous and turbulent happening in the city, the first of a series of crucial moments in Amsterdam's municipal welfare history that are highlighted in this chapter.[155]

The creation of the Amsterdam *GD* was the first time that a local government broke with the privatized, scientific monopoly by the medical experts. These medical experts had operated essentially freely since the 1865 law by Thorbecke, and the later law of 1878, that had secured the position of the medical profession as sole providers of healthcare by limiting the exercising of medicine to trained physicians only, those who were officially taught in medicine and pharmacy at universities.[156] The law by Thorbecke is commonly seen by historians as a focal point in a large process of professionalization of medicine at the end of the nineteenth century.[157] It put the academically trained physician right in the middle of the profession and was similarly designed to push out quacks, as such aimed to increase the quality of the medical profession and medical service.[158] In that process, however, the physicians started to wield much professional power, and they were apprehensive when municipalities entered the scene to adopt a significant part of their work in poor relief. The medical community felt threatened.

The *GD* was born out of a struggle—a struggle between the Amsterdam municipality and the medical elite of the city. The tensions were highest in the area of poor relief, where the municipality acquired a seat at the table. In 1900, radical liberal alderman of poor relief Carel Victor Gerritsen announced that the municipality would appoint an inspector who would oversee the medical poor relief in the city in order to get an overview of the quality and capacity of outdoor relief.[159] Physicians reacted furiously, for it meant an infringement of their sole right of treatment. Moreover, they feared it was but the first step in a larger appropriation by the municipality, an institution they believed should remain aloof in such matters. Their fear was justified. Historian Henk van der Velden, researching Dutch health services preceding the Second World War, writes that 'the transfer of medical relief preceded the transfer of other relief services by decades and, by the turn of the century, outdoor medical relief had become accepted as the responsibility of municipal authorities'.[160] On the 1st of January 1901, Menno Huizinga was appointed director of the newly founded Municipal Medical Service by the Amsterdam council and aldermen, even though many private physicians had objected.[161] The municipality had taken a major step in appropriating medical care for Amsterdam's poorest citizens.

It would not be long, however, before the municipality and the Amsterdam physicians would bury their hatches and find common ground. In 1902, after a two-year tug of war, it was decided that 36 physicians would be selected as civil servants to provide medical relief to the poor. Their work was based on a successful model that had already been implemented in

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155 Israëls, Mooij, *Aan de Achtergracht*, 42-46.
156 Frank Huisman, 'De Medische Professie', Harry F.P. Hillen, Eddy S. Houwaart and Frank G. Huisman (eds.), *Medische geschiedenis. Ziekte, kennis, dokter en patiënt, gezondheidszorg en maatschappij* (Houten; 2018); Frank Huisman, 'Farmacie, Apothekers en de Geest van Thorbecke. Farmaceutische disciplinevorming aan het eind van de negentiende eeuw, *Gewina,* vol. 19, no. 4 (1996), 280-295.
157 For a general history on the professionalization of scientific medicine, see, for example: William F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge; 1994).
158 Frank Huisman, 'Farmacie, Apothekers en de Geest van Thorbecke', 286-288.
159 Israëls, Mooij, *Aan de Achtergracht*, 50.
160 Van der Velden, 'The Dutch Health Services', 54.
161 Israëls, Mooij, *Aan de Achtergracht*, 53.

Groningen, where a small group of physicians had come under full payment by the municipality and whose main job was to provide medical relief to Groningen's poorest citizens.[162] In 1903, a careful start was made in expanding the service in Amsterdam.

At the same time, however, the *GD* had a counterpart in the in 1893 founded *Gemeentelijke Gezondheidsdienst* (Municipal Health Service, *GG*). Public hygiene, the monitoring and supervision of food supplies, a service for disinfection of infectious diseases, among other such assignments, were provided by the municipality in this service. In 1893, physician Rudolph Hendrik Saltet was appointed director by the council and aldermen. It was his job to make sure that the food that entered the Amsterdam market was of good quality, that infectious diseases that plagued the city were diminished or kept at a minimum, and to subsequently disinfect residences and ships that had housed such diseases. The service even had its own scientific laboratory to support them in their job, for example chemically verifying the quality of milk and checking on bacteria.[163] A few years before the municipality entered the medical arena, hygiene in general had already been on the agenda.

While these two services were largely operating independently from each other, their importance as operators of health and welfare municipal services was significant. They were the first branches of the municipal welfare system of Amsterdam. It shows how the municipality gradually infiltrated and centralized the field of public health, founding municipal services next to privatized organizations and collectivizing them along the way. Particularly, a switch in mentality had occurred around 1900: private organizations or philanthropic individuals were no longer deemed to be the reliable ground on which poor relief and public health could be built. While still having an essential role to play in the execution of a welfare program, philanthropists and private organizations were slowly pushed to the sidelines. It was now the municipality that centered itself at the heart of the operation, for where a private organization was receptive to changes in management or purpose, the municipality was deemed invariable and had access to the means.

While gradually developing in the following years, an acceleration in the creation of Amsterdam's municipal welfare would not commence until the late 1910s, when Louis Heijermans took office as director of the *GD*. Quickly, he started to include other forms of relief to his service. As exemplified by his work, most notably the manual *Gemeentelijke Gezondheidszorg* for municipalities published in 1929 after a decade of firsthand experience in Amsterdam. In it, his views on the role of the municipality in providing a broad basis of life and health are undeniable:

> In the social arena, the government must take on those provisions that are of general significance to the wellbeing of the population, that are of considerable public importance and cannot be dependent on the judgement and understanding of private individuals.[164]

Under the directorship of Heijermans, the Amsterdam Municipal Medical Service grew to be a primary socio-medical institute for Amsterdam citizens. A giant step was made in 1923, when the two main municipal public health services, the Municipal Medical Service and the Municipal

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[162] Ibidem. This is fairly interesting and needs further exploration. What is the exact meaning of Groningen in early municipal public health intervention?

[163] Ibidem, 27-38.

[164] Heijermans, *Gemeentelijke Gezondheidszorg*, 25. The quote is a translation of the following: 'Op sociaal terrein zal de overheid op zich moeten nemen voorzieningen van algemeene beteekenis voor het welzijn van de bevolking, voorzieningen, die men niet kan laten afhangen van de inzichten van particulieren, waarmede te groote algemeene belangen gemoeid zijn'.

Health Service, merged and formed one organization. The boundaries between these services had been vague since the foundation of the *GD* decades earlier, but with the directorship of Heijermans at the *GD*, who expanded on the duties and tasks of his service, the two became almost indistinguishable. The merger was a logical step in Heijermans' vision of municipal healthcare. By expanding his service, the totality of that municipal responsibility over the lives of Amsterdam's citizens was better covered. After the merging, he remained director of what was now coined the Municipal Medical & Health Service.

The new service now comprised a whole range of social and medical relief services, ranging from medical school supervision to laboratory research on contagious diseases to polyclinics for poor diseases to infant care to the inspection of food wares.[165] The thread through all these organizations was Heijermans belief in preventive medicine and social hygiene. In that idea, all of the municipality's relief services fit. Curative medicine was slowly pushed to the sidelines, where that had been the basis of the medical service before he became director.[166] How can Heijermans' directorship be characterized within the broader development of the municipality as a whole? Answering this question requires a look into the changing position of the municipal directorship in the 1910s and 1920s.

### iv. A NEW DIRECTOR TAKES THE WHEEL

A short look into Louis Heijermans' biographical profile substantiates the reasons behind his later work for the municipality. Heijermans had been working at the Amsterdam Medical Service since 1903, when he was appointed as one of the 36 municipal physicians that came to be working under Menno Huizinga. Born on the 22nd of December 1873 in Rotterdam, of a family of eleven children and a father working as a journalist for the *Nieuwe Rotterdamsche Courant* (*NRC*), Heijermans must have been quick to learn the problems that are innate to large families. Social-democratic ideals began to characterize his thinking and that of his brothers and sisters. Aside from Louis himself, three of his siblings would become rather famous socialist promoters: his brother Herman Heijermans, a playwright who joined the SDAP in 1897 and was one of the founders of the socialist newspaper *Het Volk*; his sister Ida Heijermans, a pedagogist with strong feminist and social-democratic ideas about family-life and upbringing; and sister Marie Heijermans, a visual artist who painted the lives of the poor and provided art for the magazines of the SDAP, which she had joined in 1898.[167]

Louis Heijermans himself would follow a slightly different course. Having first completed the *Hogere Burgerschool* (Higher Civic School), he would continue to study medicine at the University of Amsterdam, where he graduated in 1899. By then, he too had become a fervent social democrat, living together with his brother Herman, which gave rise to a mentality that would also translate to his work as a physician for the Amsterdam municipality.

Heijermans' socially critical upbringing paved the way to his belief that a higher societal standard of hygiene could be achieved via 'social hygiene', the essential element in emancipating and educating the working classes. His 1908 study on occupational hygiene and diseases is a telling study, focusing on industrial workers and the dangers they had to cope with in the factories. In his view, *volksverheffing* and medicine were interrelated given one tries to

[165] Israëls, Mooij, *Aan de Achtergracht*, 109-115.
[166] Spreeuwers, 'Louis Heijermans (1873-1938) en de opkomst van de arbeids- en bedrijfsgeneeskunde', 1405.
[167] For biographical information on Louis Heijermans and his siblings, see the biographical dictionary of Dutch socialism and the labor movement (in Dutch): https://socialhistory.org/bwsa/.

understand the harmful factors of industrial society on the health and general wellbeing of workers specifically and citizens in general. The goal of his work, above all, was to raise social hygiene awareness in doctors, engineers, workers, and factory employees, and consequently he lobbied for a technical and scientific labor inspection that would sporadically check up on factories.[168]

As Christianne Smit has already shown, by the start of the First World War, social reformists had changed greatly in mentality and tactics. Where in the 1870s and 1880s this group of rich middle-class thinkers had focused on their personal, financial means and own projects, the problems of the working masses simply could not be tackled by individuals alone. Emancipation and education of the working classes in the twentieth century developed differently, as something that could be forced upon the people or otherwise encouraged.[169] A new, larger means to emancipation and civilization was found: the political arena; the ways of the government. Smit rightly emphasizes the fact that, generally speaking, no socialist utopia was envisioned by these reformists. Instead, society according to liberal-socialist ideals was characterized by social progress, improvement and development, stimulating health and self-help, two important features of Dutch citizenship.[170] By the start of the First World War, the government became the great facilitator of this social progress and, according to Smit, the 'responsibility of the "salutary progress of humanity" was henceforth carried by emancipators and policymakers alike'.[171] Heijermans was one of this new generation. When his directorship started in 1919, he not only became the new director of the municipal service, he was a new kind of director.

As we have seen in chapter one, the Dutch central government in the 1910s was hesitant or otherwise unable to provide for the radical public health reformation resulting from the pillarized power balance and political status quo of that moment. The political parties in power were mainly confessionalist or classical-liberal and less eager to create legal space for governmental social reform. Rather, they emphasized the individual responsibility and private initiative that had characterized their public health relief for the past decades. Thorbecke's spirit and citizenship still ruled the conference rooms of the Dutch parliament, all while the industrial, bursting cities increasingly cried for change. Something was to happen. More radical reformists, then, focused their work and attention on the municipalities, where the pillarized balance was often more fluctuant and moldable.

In Amsterdam, the city's governance and administration were under constant legal and philosophical discussion. Aldermen with specific tasks were alleged to have too much power or were being hijacked by socialist persona's, while social democrats themselves pleaded for the further legal expansion of the position of the aldermen. The board, classically appointed to govern the city, was no longer able to administrate the municipality, but timebound to inspecting and monitoring municipal policy only. And the municipal directors had become free and independent individuals who led their municipals services for years, operating outside of the political day to day debates, which some saw as a good and others as a bad thing.[172]

When Heijermans was appointed director, Amsterdam was in the midst of *wethouderssocialisme*, an era where socialist aldermen vigorously pushed their agendas and

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[168] Spreeuwers, 'Louis Heijermans (1873-1938) en de opkomst van de arbeids- en bedrijfsgeneeskunde', 1404.
[169] Smit, *De Volksverheffers*, 385.
[170] Ibidem, 385, 386.
[171] Ibidem, 386, translated from Dutch: 'de verantwoordelijkheid van de 'zegenrijke vooruitgang der menschheid' werd voortaan gedragen door volksverheffers en beleidsmakers samen'.
[172] See my account in chapter one, or: Couperus, *De Machinerie van de Stad*.

forced other political parties to take new positions on matters of social relief. A focal point of that social-democratic municipal program was the creation, and takeover, of companies and institutions by the municipality.[173] In municipal hands, those institutions provided the basic necessities of life, such as public housing and provisions, and guarantee the possibility of work.[174] As such, healthcare and hygiene too were central elements of the social-democratic philosophy of the time. Good health provided the fertile soil within which other necessities could thrive. And because of that, it was something that had to be guarded and provided by the municipality.

The municipal institutions and companies that sprouted as a consequence of such politics, were plentiful. All quickly became managed by autonomous directors, something historian Stefan Couperus called the 'kingdoms within the municipality'.[175] Where did the executive tasks of the municipal directors end and political responsibility and leadership of the aldermen begin? The problem was, once again, one of the legal backbone of local administration. Until the eventual breakthrough in 1929's Civil Servant Law, the role of the directors was not anchored within Thorbecke's municipal legislation, but had grown in practice over a period of decades. In Amsterdam, municipal directors were nominated by the mayor and aldermen, after which the municipal board appointed the new director.[176] Once in place, these directors often stayed in function for a long time, sometimes for decades, working on fulfilling their own vision of the institution they were responsible for. They became a new governing elite. Where politicians left the stage after a few years, municipal directors were there for the long run.[177]

Heijermans was one of them, ultimately working at the municipal health service for 34 years, of which 18 years he served as a director that took the idea of a responsible and providing municipality very seriously. Right from the get-go, he wanted to make the Municipal Medical and Health Service the spindle to which all of Amsterdam's healthcare was necessarily turned. His municipal service formed the center.

## v. THE LIMITS OF A DREAM?

Heijermans' influence reached much further than his own medical service. Historian Piet de Rooy writes that Heijermans became head of a municipal commission in 1926, publishing a report on unemployment rates in Amsterdam.[178] An increasing group of workers, the commission feared, were becoming permanently unemployed, and the longer their unemployment lasted, the harder it would become for them to find work again.[179] Concluding that the unemployment rates amounted to 6,2% of the total labor force of Amsterdam, the commission warned:

> [...] in the long run the dangers cannot be shun, of degradation of the physicality and morality of the unemployed, who, due to limited rotation of labor, lose the adequacy for work and work skills; of a weaning of work discipline; of impoverishment of families and consequently the demoralization of a part

[173]*Gemeenteprogram SDAP* (1899); *Gemeenteprogram SDAP* (1919).
[174] Israëls, Mooij, *Aan de Achtergracht*, 93.
[175] Couperus, *Machinerie van de Stad,* 154.
[176] Ibidem*,* 158.
[177] Ibidem, 159.
[178] Piet de Rooy, *Werklozenzorg en Werkloosheidsbestrijding, 1917-1940. Landelijk en Amsterdams beleid* (Amsterdam; 1979), 44.
[179] Ibidem*,* 44.

of the Amsterdam labor force, because relief can never be as high in that it can sufficiently stop the effects of long lasting unemployment.[180]

That demoralization was a danger not only to the individual's health. A whole group of unemployed workers threatened the health of the society too. De Rooy writes that 'the unemployed of the second half of the 1920s were not appreciated as valuable members of society'.[181] They endangered society by being morally inferior.

Municipal relief provided help for some through municipal work programs, but the threat of a growing number of permanently unemployed citizens was a serious danger to what Heijermans and his contemporaries wanted to create. They were a financial burden to the municipality, but a moral one too. Such dilemmas touched on the fine line that municipal emancipators were walking. The goal was to emancipate and civilize the lower classes and improve the level of social hygiene in society. But some might not be able to achieve such degrees of basic citizenry. To those, such as the permanently unemployed, the municipality believed they had no further role to play other than maintaining them. Heijerman's commission on employment rates came to similar conclusions.[182] The permanently unemployed formed a liability and there were limits to what the municipality was willing to do within their financial means. Chapter three further explores this theme.

### vi. CONCLUSION

Under the directorship of Heijermans, the Municipal Medical and Health Service grew to be the spindle in the municipal welfare program.

But even before 1919, the municipality was starting to transmit public health services for the poorest of Amsterdam's citizens from private organizations to the municipality. The creation of two services at the end of the nineteenth and early twentieth century, the Municipal Health Service (1893) and the Municipal Medical Service (1901), were amongst the first. Later this would extend to become a complete system of several interconnected municipal health services, culminating in the 1923 merger of what would become the Municipal Medical and Health Service. From the get-go, municipal services were concentrated on preventive measures, both as a financial incentive and as a philosophy. Via consultation bureaus, thorough education of, and supervision over, daily life and hygiene, providing municipal housing, becoming the largest employer of the city, and propagating such citizenship, the Amsterdam municipality drew a wide variety of relief services to itself.

This brings us back to Abram de Swaan's thesis on the welfare state as a gradual process of collectivization. The Amsterdam municipality in the interwar years seems to fit this story. Most telling is the philosophy that influential people like Heijermans lived by. Social hygiene and prevention are key words when trying to understand the reasons behind their success. The 1930s, however, would be very different from the 1920s. The world was changing rapidly,

[180] As taken from De Rooy, *Werklozenzorg en Werkloosheidsbestrijding,* 44, 45. This is a translation of the following: 'Op den duur kan eechter het gevaar niet uitblijven, van aantasting van het physiek en de moraliteit der werkloozen wegens het door te weinig rouleering bij den arbeid inboeten aan arbeidsgeschiktheid en verliezen der arbeidsvaardigheid, van ontwennen aan arbeidsdiscipline, van verpauperiseering der gezinnen en dientengevolge demoralisatie van een deel der Amsterdamsche arbeidsbevolking, omdat een steunregeling nooit hoog genoeg kan zijn, om deze gevolgen eener langdurige werkloosheid voldoende te keeren.'

[181] Ibidem*,* 63.

[182] Ibidem*,* 49.

politically, economically and ideologically. Above all, the impact of the economic crisis limited the financial means of the municipalities even more and forced municipal directors and aldermen to consider cuts on their relief services. There were limits to the dream.

# CHAPTER THREE
Social psychiatry within the Amsterdam welfare system

*Figure 5. Zeeburgerdorp, 1927. A picture of overseer madam Schuurman with four children of Zeeburgerdorp's inhabitants.*

SYNOPSIS

Social psychiatry emerged in the 1920s but would skyrocket in the 1930s as the Amsterdam municipality attempted to more effectively evaluate the admission of mental patients into psychiatric hospitals. In order for social psychiatry to work, it depended on a system of municipal organizations, and as such, provides the perfect case study for the concept of the welfare municipality.

## i. AN INTRODUCTION: A NEED FOR PREVENTION

Now that a framework for the welfare municipality has been constructed in chapter one, and it has been argued in chapter two that Heijermans' Municipal Medical & Health Service could be characterized as the symbolization of Amsterdam's welfare municipality, it is interesting to evaluate how the welfare municipality worked in a very specific branch of the system. In this chapter, a study on the pre- and aftercare of psychiatric patients and the emergence of a social psychiatric practice is given. As will be shown, such a system of pre- and aftercare organizations, being part of Heijermans' service, depended on a wide variety of other municipal services in its execution. Specifically, this chapter highlights the emergence of social psychiatry in Amsterdam in the 1920s and 1930s—a psychiatric practice that centered the psychiatric patient as a member of society, and interpreted the patient and his troubles as an interplay between society and the specific individualized illness.[183]

Municipal financial distress proved to be the accelerating force that grounded the practice of social psychiatry in Amsterdam. Ultimately, social psychiatry's emergence as a municipal practice can be traced back to the municipal struggle of keeping relief programs running when expenses reached a critical mass, forcing reformists such as Heijermans to define the boundaries of the welfare municipality.[184] Moreover, the Amsterdam municipality paid for the admission of Amsterdam's psychiatric patients in the provincial hospitals far away from the city such as Santpoort, which cost the municipality a lot of money.[185] That financial responsibility functioned as the right incentive for the municipal interference. Prevention, then, became the new municipal goal. If psychiatric admissions could be prevented by municipal interference, the high expenses could be avoided in the long run.[186] The municipality thus had both a moral and financial incentive.

As we have seen in previous chapters, collectivization of public services and an emancipatory idealism of *volksverheffing* within Amsterdam's government were characteristics of the welfare municipality. The belief that ultimately, the municipality had the best credentials to provide a societal welfare system was present in the thinking of Heijermans and his contemporaries. Social psychiatry provides the perfect case study to illustrate this. In Amsterdam, municipal pre- and aftercare services for the mentally ill were set up in an attempt to reduce the high admission rates of Amsterdam's citizens in mental hospitals, and depended upon a municipal system where the mentally ill could be supported in the different facets of citizenship and day-to-day hygiene.

This chapter is grown from the same soil as chapter two. Heijermans' four requirements for a long life in good health—good housing, nutrition, labor, and hygiene—will form the basis of this analysis of social psychiatry in the interwar era. How were these requirements present in social psychiatric idealism? Subsequently, the chapter is divided by the dichotomy of two decades and two directors. Firstly, Frederik Salomon Meijers, director of the Department for Mental and Nervous Diseases between 1916 and 1933, is introduced. His work and ideology characterize the

[183] Frederik Salomon Meijers, *Inleiding tot de Sociale Psychiatrie* (1947), 8, 9.

[184] In the 1930s, the Netherlands was hit especially hard by the economic crisis. In historiography, this era has down in history as the Austerity Years (*Zuinige Jaren*). See, for example: Jan L. van Zanden, *The Economic History of The Netherlands 1914-1995. A small open economy in the 'long' twentieth century* (London; 1998); Erik Nijhof and Peter Schrage, 'Van Bondslokaal tot Steunloket. De vakbeweging als sociaal vangnet tijdens de economische crisis in Nederland (1929-1935)', *Sociologisch Tijdschrift*, vol. 11, no. 2 (1984), 260-285.

[185] See: Joost Vijselaar (ed.), *Gesticht in de Duinen. De geschiedenis van de provinciale psychiatrische ziekenhuizen van Noord-Holland van 1849 tot 1994* (Hilversum; 1997).

[186] Louis Heijermans, *De Zorg voor onze Gezondheid in het Dagelijksch Leven* (Amsterdam; 1931), 137, 138.

emergence of social psychiatry in the 1920s. It was by his efforts that the practice of social psychiatry found such fertile ground in the Amsterdam municipal welfare climate in the first place. Meijers' views are analyzed, as are the first steps social psychiatry made within the municipal system, Heijermans' committee on psychiatric patients, ending with the retirement of Meijers in 1933. By what beliefs and methods did he shape Amsterdam's pre- and aftercare services?

Secondly, the 1930s are taken as the important second decade of early social psychiatry. The foundation laid by Meijers was further expanded upon by his successor, Arie Querido, who took a more thorough hands-on approach towards the pre- and aftercare services of the municipality than his predecessor—as he was specifically hired to do so by the municipality. While Querido's pioneering role should be nuanced in favor of Meijers, Querido's directorship still holds a crucial position in the development of social psychiatry. A deep study of the practical execution of social psychiatry within a system of municipal welfare is then given to wrap it all together.

## ii. MEIJERS AND THE BEGINNING OF SOCIAL PSYCHIATRY

In 1947, Frederik Salomon Meijers, a psychiatrist who had been working for the Amsterdam municipality since 1916, published an introduction to social psychiatry. It would be one of the first Dutch theoretical pieces on the subject. With academic nuance and phrasing, he writes:

> Social psychiatry is that aspect of the pathology of mental life, in which the human society and the psychopathology meet. It comprises issues of general and individual character. Social psychiatry has the task to fix those problems, that come forth from the interaction between society and the mentally ill. It is confronted with questions of the possible influence which society has in the emerging and shape of a mental abnormality. [...] In general it is her principle, or the leading motive of her acting, that the mentally ill is not seen as a clinical object, less so as a laboratory object, but as a member of society.[187]

After the Second World War, social psychiatry quickly became an academic branch within the broader psychiatric discipline.[188] Social psychiatry, however, was not born out of academia, but out of practice. Practice preluded academia. In Amsterdam, this started in the early 1920s. The definition of social psychiatry that Meijers gave above, then, was the result of almost thirty years of practice. A practice, moreover, that was characterized by his experience within the municipality of Amsterdam.

Meijers had been active in the Amsterdam municipal medical scene since 1897, when he was appointed as a subsidiary physician for the municipality.[189] Also connected to the academic hospital of the University of Amsterdam, from 1905 onwards, he would be chief of the department

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[187] Frederik Salomon Meijers, *Inleiding tot de Sociale Psychiatrie* (1947), 8, 9. This is a translation of the following: 'Sociale psychiatrie is dat deel der ziekteleer van het geestesleven, waarin de menschelijke samenleving en de psychopathologie elkaar ontmoeten. Zij omvat vraagstukken van algemeen en van individueel karakter. De sociale psychiatrie heeft tot taak, die problemen op te lossen, welke uit een wisselwerking van de samenleving en de geesteszieken voortkomen. Zij wordt voor vragen gesteld, die den mogelijken invloed betreffen, welke de samenleving bij het ontstaan en den vorm van de psychische afwijking heeft. [...] In het algemeen is haar stelregel, anders gezegd het leidende motief van haar handelen, den geesteszieke niet als een klinisch object, nog veel minder als een laboratoriumobject te zien, maar als een lid van de samenleving.'

[188] Gemma Blok, 'Geschiedenis van de na-oorlogse psychiatrie', *Gewina,* vol. 20, no. 4 (1997), 337-343;

[189] Jacomien Gijzeman and Joost Vijselaar, 'Reclasseerder van het geestelyk onvolwaardige boevenpak' (unpublished manuscript), 4.

for psychiatric patients at the newly founded *Wilhelmina-gasthuis* (Wilhelmina-hospital), the *Paviljoen III*.[190] In 1916, however, Meijers was offered a new job at the Amsterdam municipality. He was to become the municipal advisor for the Municipal Medical Service on matters of psychiatry and neurology.[191] Having accepted it, in 1917 he would become active in the creation of a municipal consultation bureau for mental health issues, called the *Consultatiebureau voor Geesteszieken* (Consultation Bureau for the Mentally Ill), the first to be founded in the Netherlands.[192] Only two years later, his duties were expanded by adding the municipal care for the wide-ranging group of *onmaatschappelijken* to his portfolio, a collection of the disabled, mentally ill and people with labor incapacity, but also for example criminal offenders who were qualified for probation.[193] This group fell outside of normal healthcare programs, and, being a section of poor relief, was a primary municipal responsibility. This characteristic mixture of tasks turned out to be the real start of a pre- and aftercare system for Amsterdam's psychiatric patients.

*Figure 6. Frederik Salomon Meijers (1868-1953).*

Meijers' office at the Department for Mental and Nervous Disorders created a space where psychiatric patients could turn after dismissal from a mental hospital or in order to avoid admission to such institutions and remain on their feet. The service quickly became overrun with

[190] Arie Querido, 'In memoriam Dr. F. S. Meijers', *Nederlands Tijdschrift voor Geneeskunde*, vol. 97, nr. 4 (1953), 2879.
[191] Gijzeman and Vijselaar, 'Reclasseerder van het geestelyk onvolwaardige boevenpak', 4.
[192] Ibidem, 4.
[193] Ibidem, 4; Querido, 'In memoriam Dr. F. S. Meijers', 2879.

requests, apparently addressing a need that was strongly felt. In 1919 alone, 3335 people visited the service, and Meijers had the task of determining whether the problems of each patient warranted admission.[194] While Meijers still deemed admission unavoidable in most cases, when in doubt, the apparatus of pre- and aftercare would come into motion.[195]

Just as Louis Heijermans believed that an education in the basics of a long life in good health was the key to teach citizenship to the working classes, Meijers would be one of the first in the Netherlands to stress a re-educative treatment of psychiatric patients and other socially unfit persons.[196] Re-education, for example, was a central aspect in the probation of criminals, and Meijers believed that such support in daily life was much more effective than punishment: intervene in the patient's direct milieu, for that environment had a direct influence on the patient's experience of the world.[197] Meijers too touched on that very specific Dutch phenomenon of *volksverheffing*, emphasizing self-help, hygiene, and morals while also feeling a responsibility towards the needy to teach them in such matters. It would be an essential aspect of his views on psychiatric patients and the guiding principle of his municipal service.

For some patients, then, admission to a mental hospital was unnecessary. Special attention was often given to underaged patients coming from families considered socially problematic. These patients, Meijers believed, deserved the support and guidance that was often missing in their families.[198] The root of those cases was often not the mental illness of the patient, but the harmful combination of poor upbringing, unfavorable societal chances, and personal behavioral problems. Other (private) organizations were included in the solution, in cooperation with Meijers' bureau. The *Observatiehuis voor Jongens* (Observational House for Boys) was one of such organizations, where difficult boys were sent and observed for a certain amount of time.[199] Here they were taught in correct behavior and hygiene of body and morals. Some could function well within society if they could only be steered in the right direction, Meijers often concluded. For those, admission into a mental hospital could often be avoided.[200]

Meijers' *Consultatiebureau voor Geesteszieken* grew to be the spindle around which mental healthcare in the municipality was organized. There were daily consultation hours, and Meijers and the two nurses working in the department paid visits to the patients and their relatives.[201] It was the essence of pre- and aftercare. It was so successful that in 1924 Meijers initiated the creation of a new foundation together with psychiatrist C.T. Kortenhorst, called the *Centrale Vereeniging ter Behartiging van de Maatschappelijke Belangen van Zenuw- en Zielszieken* (Central Association for the Advocacy of the Societal Interests of the Nervous and Mentally Ill). In a few years, the foundation would achieve the creation of sixteen consultation bureaus across the Netherlands, based on the Amsterdam model.[202] Moreover, the foundation gave lectures and offered courses for district nurses, training them in recognizing the early stages of psychiatric

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[194] Gemma Blok, *Achter de Voordeur*. *Sociale Psychiatrie vanuit de GGD Amsterdam in de twintigste eeuw* (Amsterdam; 2014), 15.
[195] Ibidem, 15.
[196] Gijzeman and Vijselaar, 'Reclasseerder van het geestelyk onvolwaardige boevenpak', 9-11.
[197] Ibidem, 7, 8.
[198] Blok, *Achter de Voordeur*, 15.
[199] For a very thorough account of this observational house, see: Irene van der Linde, *Stoute Jongens: van Boefjes tot Pupillen. Een geschiedenis van het observatiehuis van de vereniging "Hulp voor Onbehuisden" 1914-1970* (Amsterdam; 1993).
[200] Gemma Blok, *Achter de Voordeur*, 15.
[201] Gerard Joseph Antonius Maria Brouns, *Sociaalpsychiatrische Verpleegkunde: de ontwikkeling van een verpleegkundig specialisme in het domein van de Nederlandse sociale psychiatrie* (Maastricht; 2010), 36.
[202] Gijzeman and Vijselaar, 'Reclasseerder van het geestelyk onvolwaardige boevenpak', 5.

illness and acting accordingly by socially supporting the families when the illness was recognized.[203]

The Amsterdam model of consultation bureaus provided in a need that was yet to be filled in other places in the Netherlands. In other Dutch cities, then, similar initiatives were quickly developed. In Rotterdam, for example, psychiatrist J.H. Pameijer set up an outdoor psychiatric service specialized in the pre- and aftercare of patients from the Maasoord hospital in 1926.[204] Here too, dismissed psychiatric patients were visited in their homes and invited to a weekly consultation hour. Two years later, in 1928, psychiatrist Henk Jelgersma—nephew of the Leiden professor of psychiatry Gerbrandus Jelgersma—opened a consultation bureau in Leiden which, in 1929, would be officially transformed to become the pre- and aftercare service of the municipal Endegeest hospital.[205] In Leiden, expert visitation in the home of the patient became the core of the pre-care service and the estimation whether admission was necessary or not.

Meanwhile, Meijers started to realize that the existence of sufficient income and labor often made the difference in deciding whether a patient could remain in society or not. Most patients on the brink of a mental breakdown were primarily suffering from extreme impoverishment.[206] The fact that a financial injection made the difference between admission or not becomes less strange when you realize that 80% of the patients Meijers treated were people from the lowest classes of society.[207] There were two things his consultation bureau did in such cases. Sometimes, a one-time financial injection would suffice. Later, psychiatrist Arie Querido would describe cases where mental breakdowns would be avoided by giving the patient and relatives 20 guilders in order to pay the rent.[208] Meijers' association would finance such one-time solutions for a total of 6.000 guilders in 1939 alone.[209] A second possible action the bureau could initiate was a more essential one, creating or finding workspaces for those patients 'who have given up the struggle for existence against their more advanced competitors in the free market'.[210]

Just as with Meijers' focus on re-education, the existence of sufficient labor touches on Heijerman's requirements for a long life in good health. Labor was one of those requirements. Patients were often excluded or outcompeted in the free market, which increased the chances of a setback as financial difficulties worsened the precarious situation of patients.[211] Pre- and aftercare services were increasingly jumping in to provide and create work that was suitable for ex-patients. In a 1938 national report by Josephus Jitta on the aberrant labor force of the Netherlands, special attention was given to the way municipalities and psychiatric services provided labor possibilities for the mentally ill.[212] Often, patients were working at the institute they were recently discharged from, employed in gardening, or otherwise working on the grounds of the mental hospitals. The municipalities too started to hire these ex-patients for the

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[203] Brouns, *Sociaalpsychiatrische Verpleegkunde*, 36.
[204] Ibidem, 36.
[205] Ibidem, 37.
[206] Blok, *Achter de Voordeur*, 16.
[207] Ibidem, 19.
[208] Arie Querido, *Doorgaand Verkeer. Autobiografische fragmenten* (Lochem; 1980).
[209] Blok, *Achter de Voordeur,* 16.
[210] Frederik Salomon Meijers, *De Voor- en Nazorg van Geestelijk Hulpbehoevenden* (Amsterdam; 1939), 11. This is a translation of the following: 'Zoo schiep zij o.a. arbeidsmogelijkheden voor hen, die op de vrije arbeidsmarkt den strijd om het bestaan tegen hun volwaardige concurrenten moesten opgeven.'
[211] Ibidem, 11.
[212] Not surprisingly, Louis Heijermans was part of this committee: Staatscommissie Jitta, *Verslag Staatscommissie inzake Onvolwaardige Arbeidskrachten* (Den Haag; 1938), 11-18.

maintenance of public parks, lawns and the city's greens.[213] Whatever the work, labor was a fundamental prerequisite for remaining in society and thus a central part of pre- and aftercare treatment.[214]

The Pre- and aftercare services, however, came with quite high expenses, as supporting the totality of a life came with high costs. Still, the expenditures by the bureaus and the municipalities were considered to be favorable both financially for governments while also benefiting the patients by providing work and preventing admission. In 1939, looking back and celebrating a fifteen-year anniversary of the association, Meijers highlighted the benefits of his pre- and aftercare service for both the government and the patients:

> History learns that in recent years, the governmental interest in both Aftercare and Pre-care have become lively because in it the possibility for a reduction in expenditure is seen, which comfort especially the province and the municipality who provide in the treatment of the impecunious mentally ill. There is a hope, that a well-organized Pre- and Aftercare Service can become the institution that prevents admission in such mental hospitals and shortens the length of treatment. The benefits, then, are twofold, of a material nature, primarily for the community, and in addition of a moral and humane character, for the individual and no less for his environment.[215]

Indeed, the governmental interest came mostly from the possibility of a reduction in expenditure. Near the end of the 1920s the costs of treatment were again rising, and a committee was put together to analyze the high cost of Amsterdam's psychiatric patients.[216] Why was it so high compared to other Dutch cities? And what to do about it? Heijermans and Meijers were part of this committee, Meijers being the most directly responsible in the municipal services. In 1931 it was decided by the committee that the already existing pre- and aftercare services had to be expanded even further in order to deal with the high admission rates and limit the municipal expenses. In order to work more efficiently, the municipal services had to play an even larger role. While this boosted the position and importance of the pre- and aftercare services, the initial organization of such services was already present. In the 1920s, Meijers had been initiating such services and treatments. The consultation bureaus that sprouted up in the Netherlands after the establishment of Meijers' association, and the work he did as a director of the Amsterdam department for mental health both function as examples for such a claim. Upon his death in 1953, he was called the Dutch pioneer of social psychiatry.[217]

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[213] Ibidem, 254, 255.

[214] Moreover, in 1927, the *Vereeniging Arbeidszorg voor Onvolwaardigen* (AVO) was established to advocate for the societal position of citizens with labor disabilities. The mentally ill were considered to belong to this group too. See: H.J.E. Hermans and S.H. Schmidt, 'Een Blinde Fietsenmaker in het Stedelijk. Tentoonstelling en congres "Arbeid voor Onvolwaardigen" in 1928', *Gewina*, vol. 25, no. 4 (2002), 226-240.

[215] Meijers, *De Voor- en Nazorg van Geestelijk Hulpbehoevenden*, 13. This is a translation of the following: 'De geschiedenis leert, dat de laatste jaren de belangstelling bij de Overheid zoowel voor de Nazorg als voor de Voorzorg levendig is geworden, omdat men daarin een mogelijkheid van besparing ziet der uitgaven, welke speciaal provincie en gemeente zich getroosten voor de verpleging van onvermogende geesteszieken. Men hoopt in een goed georganiseerde Voor- en Nazorg-Dienst een instelling te vinden, die opname in bedoelde inrichtingen kan voorkomen en een verplegingsduur kan bekorten. De voordeelen zijn dus tweeledig, van materieelen aard, overwegend voor de gemeenschap en daarnaast van moreel en humaan karakter, voor het individu en niet minder voor diens omgeving.'

[216] This committee was led by Heijermans: Commissie Heijermans, *Rapport der Commissie van Onderzoek in zake de Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten vanwege de Gemeente Amsterdam* (Amsterdam; 1931).

[217] Arie Querido, 'In memoriam Dr. F. S. Meijers', 2879-2880.

Still, the committee marked a fundamental moment in the development of early social psychiatry and deserves some additional attention.

### iii. HEIJERMANS' COMMITTEE

In 1927, Heijermans gathered a small team of medical experts and psychiatrists to investigate the high number of admissions of Amsterdam citizens in psychiatric hospitals. The Amsterdam municipality, responsible for this group and paying for their treatment, was concerned about the high rates of admission, mainly for the high expenditure. Amsterdam peaked well above other Dutch cities, and the committee that Heijermans put together wanted to know what reasons lay behind the high admission rates and what to do about it. They were called the *Commissie van Onderzoek in zake de Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten* (Committee of Research regarding the Treatment and Care of Mentally Ill, the Insane and Socially Unfit).[218]

The creation of the committee is interesting, for it shows two distinct aspects of Amsterdam's municipal welfare system in the late 1920s and early 1930s: (1) the concerns over the ever-increasing expenditure on social relief by the municipality, and (2) the further centralization and creation of municipal social relief in order to avert those high expenditures. In that mixture, Heijermans' municipal philosophy is again captured. In the end, Heijermans' belief was that prevention by municipal means would have the biggest impact, not only on the budget of the municipality, but on the citizen's wellbeing and chances in society too. Managing expenditure and increasing a patients' chances in society could go hand in hand.

In 1927, the committee went on an investigative trip to Frankfurt.[219] That Germany was the destination should not come as a surprise. Social psychiatry, as a concept, was first used by the German psychiatrist Illberg in 1904, who took it to mean the protection of public mental health.[220] It would, however, be a few years before social psychiatry started to emerge as a practice. The war was a breaking point. During the First World War, German municipalities founded so called *Fürsorgestellen*, pre-care organizations that tracked citizens with mental and societal difficulties, and provided specialized support in order to prevent unnecessary admission into mental hospitals.[221] In Frankfurt, where psychiatrist Julius Raecke was director, the municipal service was said to have prevented a total of 10% of this group of citizens from admission into a mental institution.[222] Their preventive techniques were of the kind that Heijermans was searching for in the social nurse: often patients were visited in their homes, checking up on their mental health, discussing their problems and day to day experiences, and looking for solutions.[223] The service in Frankfurt specifically took their task to be a broad range of social support: 'Labor, consultation of the help-seeking afflicted and their relatives, procurement of sleeping residences and labor possibilities, and distribution of relief'.[224]

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[218] Commissie Heijermans, *De Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten.*
[219] Ibidem, 177, 178.
[220] Brouns, *Sociaalpsychiatrische verpleegkunde,* 30.
[221] Ibidem, 29.
[222] Commissie Heijermans, *De Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten,* 177.
[223] Brouns, *Sociaalpsychiatrische verpleegkunde*, 29.
[224] Julius Raecke, 'Moderne Irrenfürsorge und soziale Psychiatrie', *Westdeutsche Ärzte-Zeitung,* vol. 12 (1921), 48. This is a translation of the following: 'Arbeit, Beratung der hilfesuchenden Kranken und Angehörigen, Beschaffung von Schlafstellen und Arbeitsgelegenheit, Verteilung von Unterstützungen.'

Consequently, the tasks of the pre- and aftercare service in Frankfurt were much broader than just providing medical care to patients suffering from mental illness. In order to keep that as much patients as possible within society, normal life had to be maintained as much as possible, ranging from housing to providing labor or giving consultation on day-to-day dealings with mental issues.[225] All were equally important if one tried to keep the patient within society. Via re-education and hygiene, and in providing for basic daily needs, the essentials for a healthy life within society were captured and unnecessary admission could be prevented. Visiting the Frankfurter services must have been a very formative experience for Heijermans and his committee.

Moreover, it shows that the reasoning behind creating a sufficient pre- and aftercare was not just a financial one. It was in the interest of patients and society too. Rejoining 'free society', with all its demands and expectations, was not so easy a thing to do and patients would quickly fall into old patterns when left without help. Heijermans' committee writes:

> In recent years the belief has become stronger, that these patients [the mentally ill, ps] cannot be left to their own devices after their dismissal from psychiatric hospitals and other sanitaria. For many the transition to free society is too difficult, which has as a consequence, that they are again qualified for admission after only a short amount of time.[226]

Readmission was to be avoided, for else an endless loop between admission and discharge would only worsen the situation of the mentally ill patient and cost the Amsterdam municipality a lot of money in the process.

In 1931, the committee finished its research and published their work. The conclusion of their research, much aligned with their Frankfurtian precursors, was clear:

> Concerning aftercare, the committee agrees that a central, municipal structure must be organized as a part of the Municipal Medical and Health Service, which should look for cooperation with other institutions that are active in this field. It would be organizationally incorrect and ineffective, when several institutes, where Amsterdam patients are treated, would all organize individual out-of-doors services where their patients, after release from the institute, are protected and provided in the difficult battle to maintain within society or to start a new living within it. Would one not head towards centralization, then a chaotic situation would emerge.[227]

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[225] Julius Raecke, 'Die Frankfurter Fürsorgestelle für Gemüts- und Nervenkranke, *Psychiatrisch Neurologisch Wochenschrift*, vol. 27, no. 47 (1925).

[226] Commissie Heijermans, *De Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten*, 57. This is a translation of the following: 'Steeds sterker komt men in de laatste jaren tot de overtuiging, dat deze patiënten na hun ontslag uit gestichten en andere inrichtingen niet aan hun lot kunnen worden overgelaten. Voor velen hunner is de overgang naar de vrije maatschappij te moeilijk, hetgeen tot gevolg heeft, dat zij vaak reeds na korten tijd weder voor opneming in aanmerking moeten komen.'

[227] Ibidem, 137. This is a translation of the following: 'Wat de nazorg aangaat, is de commissie van meening, dat hiervoor een centraal orgaan van gemeentewege moet worden georganiseerd en wel als onderdeel van den Gemeentelijken Geneeskundigen en Gezondheidsdienst, hetwelk samenwerking zou moeten zoeken met andere instellingen, welke op dit gebied werkzaam zijn. Het zou toch organisatorisch onjuist en ondoelmatig zijn, dat de verschillende inrichtingen, waarin Amsterdamsche patiënten worden verpleegd, ieder een eigen buitendienst zouden organiseeren om hun Amsterdamsche patiënten na het ontslag uit het gesticht te beschermen en te steunen bij den moeilijken strijd om zich in de maatschappij te handhaven of een nieuw bestaan te verwerven. Zou men niet op centralisatie aansturen, dan zou een chaotische toestand ontstaan.'

The committee was not afraid of proposing for extended centralization of the aftercare of psychiatric patients. Heijermans managed to propose for the expansion of his service as a means to better manage the financial costs of his relief system. Just as was decided in Frankfurt, the municipality was thought to have the best credentials, the best efficacy, and the best organization potential. In the eyes of Heijermans, the philosophy of the welfare municipality was exactly that: the creation of a central municipal service in order to avoid chaos.

The direct consequence of the report by Heijermans and his committee was the hiring of psychiatrist Arie Querido and the expansion of the municipal *Afdeeling Geestes- en Zenuwzieken* (Department for Mental and Nervous Disorders), a subdepartment under the Municipal Medical and Health Service that was led by Meijers since 1919.[228] In the following years, the department would function as the central municipal organ of pre- and aftercare for the mentally ill. Prevention was the starting point of every first case.

### iv. ARIE QUERIDO ENTERS THE SCENE

The report of Heijermans' committee did not just focus on aftercare and support of discharged psychiatric patients but also increasingly focused on pre-care and prevention. A description of an extended municipal role in this aspect of psychiatric care was one of the main conclusions and recommendations of the report:

> The assessment of the necessity of admission should be on the shoulders of a well-equipped, central, municipal and medical organ, that can measure the decency of the measures to take, has an overview of the available treatment and that is the spindle in the [...] organization of pre- and aftercare. This supervision and the corresponding distribution must be lead as good and expertly as possible. Therefore, it is necessary that the director of this important department of the Municipal Medical and Health Service should be entrusted to a psychiatrically and socially schooled leader, who is a full civil servant.[229]

Not long thereafter, on the 1st of June 1931, Arie Querido would be appointed as the new director of the municipal subdepartment for Pre- and Aftercare for Psychiatric Illnesses under Meijers. Querido, completing his medical exams in 1926, had proven himself worthy of the job.[230] In his studies he had gone to the United States to study under physiologist Walter B. Cannon, who was developing a thesis on bodily homeostasis.[231] Querido expanded on this idea of an internal balance within the individual and a constantly changing environment to coincide and interrelate with societal processes.[232] Back in the Netherlands, it was at Endegeest under Henk Jelgersma,

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[228] Blok, *Achter de Voordeur*, 11, 13.

[229] Commissie Heijermans, *De Verpleging en Verzorging van Zenuwzieken, Krankzinnigen en Maatschappelijk Ongeschikten,* 74. This is a translation of the following: 'De beoordeling van de noodzakelijkheid der opneming behoort te berusten bij een goed geoutilleerd centraal gemeentelijk medisch orgaan, dat de juistheid kan afmeten van de te nemen maatregelen, een overzicht heeft van de beschikbare verpleeggelegenheid en dat mede de spil moet zijn van de straks te bespreken organisatie van voor- en nazorg. Maar dan moet deze controle en de daarmede samenhangende distributie ook zoo goed en deskundig mogelijk geleid worden. Daarvoor is noodig de leiding van deze belangrijke afdeeling van den Gemeentelijken Geneeskundigen en Gezondheidsdienst op te dragen aan een psychiatrisch en sociaal geschoold leider, die vol-ambtenaar is.'

[230] Jaap van der Stel, 'Arie Querido (1901-1983), pleitbezorger van de sociale dimensie', Berteke Waaldijk, Jaap van der Stel and Geert van der Laan (eds.), *Honderd jaar sociale arbeid. Portretten en praktijken uit de geschiedenis van het maatschappelijk werk* (Assen; 1999).

[231] Walter B. Cannon, 'Organization for Physiological Homeostasis', *Physiological Reviews*, vol. 9, no. 3 (1929), 399-431.

[232] Van der Stel, 'Arie Querido (1901-1983), pleitbezorger van de sociale dimensie'.

where Querido worked as the second physician between 1927 and 1931, that he witnessed the creation of the pre- and aftercare services firsthand.[233] These two experiences, his internship in the United States and the job at Endegeest put him in the spotlights of Heijermans and the Amsterdam municipality. And those experiences, theoretically learning under Cannon and witnessing the practical functioning of a pre- and aftercare system in Leiden, must have greatly influenced his later work and ideas.

How can we characterize Querido's years at the municipal service? In 1933, Meijers retired, and Querido took over the directorship and responsibility for mental patients and other *onmaatschappelijken* under the care of the municipality. He would continue the work of Meijers, leading the service to even greater importance. Where Meijers had focused on the creation of labor and the possibility of reeducation, and as such the aftercare service, Querido's directorship would be increasingly characterized by a focus on prevention and mental hygiene, and thus more on the pre-care services.[234] Where Meijers was specifically invested in the re-education of the individual mentally ill, Querido took that idea and extended it to the whole family. The family unit became the primary means through which hospital admission could be evaluated and possibly avoided.[235]

*Figure 7. Arie Querido in 1930 and 1931.*

In 1935, Querido published, on instruction of Heijermans, a family guide for approaching family members who were suffering from mental illness. It was part of a series that Heijermans had initiated for the *Arbeiderspers* (Workers' Press), giving practical advice on medical and

[233] Querido, *Doorgaand Verkeer,* 77-84.

[234] As he was specifically hired to keep psychiatric patients out of the hospital.

[235] Hans Blom, 'Een Harmonisch Gezin en Individuele Ontplooiing. Enkele beschouwingen over veranderende opvattingen over de vrouw in Nederland sinds de jaren dertig, *BMGN*, vol. 108, no. 1 (1993), 28-50;

hygienical issues.[236] Specifically focusing on the situation at home, Querido highlights the importance of family members for combating mental illness. Mental illness, he writes, is a process where someone falls short in the 'mental and social contact with his fellow creatures, [...] and retreats into himself'.[237] Psychiatric issues as Querido understood them, were very social in nature. It was a process of isolation.[238] It is within the individual failing to relate to the 'mental unity' of a community or society that mental illness arises.[239]

The solution Querido presented primarily lay in the unit of the family and their ability to assess the mental issues of family members prematurely and taking sufficient action when things were starting to become serious. Children suffering from imbecility, for example, should as soon as possible be brought into contact with special education services. Here, they would be supported in finding a job that was suitable for their disabilities.[240] But in the concluding words, after 50 pages of practical advice, Querido advises not to ignore expert guidance:

> For the association with mentally ill, patience, dedication, interaction, in one word: love, is indispensable. However, as important is the insight and understanding, that can only be given by expert consultation.[241]

For that consultation, his municipal service was available.

Two years later, in 1937, a national conference was organized by the *Vereeniging voor Psychische Hygiëne* (Association for Mental Hygiene). In the committee organizing the conference, both Meijers and Querido were members. The theme was the family. The reason for putting the family in the center of psychiatric issues and practice, is the fact that within the family unit, all aspects of a life in good health should be present. Housing, nutrition, labor, hygiene and morals all focus around, and have influence on, the family. The committee writes:

> The committee shares the belief [...] that it has once again become clear that antisociality as a phenomenon, even if it occurs predominantly in one of a few family members, characterizes the whole complexity of the family and is not restricted to individuals, but stretched over whole families.[242]

How did such treatment of antisociality within families play out in practice? How could the family as a unit be educated in socially preferred and acceptable behavior? Querido's ideas of the family are perfectly captured by looking into an Amsterdam case study, to which we will turn now.

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[236] Arie Querido, *De Omgang met Geesteszieken in het Gezin* (Amsterdam; 1935). This was part of a book-series edited by Louis Heijermans, called the *Practische Gids voor Medische en Hygienische Vraagstukken*. Other parts are: Hendrik Peeters, *Besmettelijke Ziekten* (Amsterdam; 1935); John Salomson, *Levenstijdperken der Vrouw* (Amsterdam; 1936); Neeltje Louwrina Wibaut-Isebree Moens, *Schadelijke Dieren in Huis* (Amsterdam; 1936); Benedictus Herschel Sajet, *Wenken bij Ziekten* (Amsterdam; 1936); Liesbeth LeCoultre-Mulder, *De Huid en Haar Verzorging* (Amsterdam; 1936).
[237] Querido, *Geesteszieken in het Gezin*, 7, 8.
[238] Ibidem, 7.
[239] Ibidem, 8.
[240] Ibidem, 16.
[241] Ibidem, 56. This is a translation of the following: 'Voor de omgang met geestelijk abnormalen is geduld, toewijding, tegemoetkoming, in één woord: liefde, onontbeerlijk, echter even nodig is inzicht en begrip, die slechts door deskundige voorlichting gegeven kunnen worden.'
[242] Commissie Moltzer, *Rapport betreffende een enquête in zake het onmaatschappelijke gezin* (Amsterdam; 1937), 42. This is a translation of the following: 'Zij is van oordeel (en ziehier het resultaat van het ingestelde onderzoek) dat nog eens duidelijk is gebleken, dat de onmaatschappelijkheid als verschijnsel, al spreekt zij zich overwegend uit bij een of meer leden van het gezin, het geheele gezinscomplex kenmerkt en zich niet beperkt tot individuen, maar zich uitstrekt over geheele gezinnen.'

### v. SOCIAL PSYCHIATRY IN A MUNICIPAL WELFARE SYSTEM

As we have seen, Heijermans' requirements for a long life in good health were present in Meijers and Querido too. The practice of social psychiatry was strongly connected to the general philosophy of the Municipal Medical and Health Service. But in order to tie together social psychiatric practice with the hypothesis of the welfare municipality, it is good to study an Amsterdam-specific case that allows for analysis of the overarching research question. A case that presents this has already seen light in this thesis: that of Zeeburgerdorp, a semi-closed community where socially problematic or unfit families forcefully lived together in a single street under the supervision of municipal officials.[243] In Zeeburgerdorp, people were assisted in maintaining their daily housekeeping, finance, hygiene and socially correct behavior. In a way, Zeeburgerdorp was the convergence of all of Heijermans' requirements for a long life in good health, but focused specifically on people who could not achieve that life by themselves. The people in Zeeburgerdorp were dependent on the municipality to provide for them in those requirements.

In 1933, Arie Querido published a report on Zeeburgerdorp. In the report, Querido analyzes the families living there and presents the reader with a list of different degrees and categories of 'social failure', relating these labels to the mental health issues of family members and the consequences of those social failures for their relatives.[244] The goal of his study was to find out why some people were victim of what he called 'societal shipwreck', and others not, and what the chances of recidivism were for the families living in Zeeburgerdorp.[245]

The people living in Zeeburgerdorp all suffered from a multiple societal problems, ranging from serious poverty and child neglect to alcoholism or severe mental issues that were considered dangerous for the children, such as parents with psychopathic conditions.[246] Most families had financial problems resulting in external conflicts with houseowners, neighbors or the municipality, and internal conflicts between the different members of the family. To the supervisors of Zeeburgerdorp and similarly to Querido, however, almost all problems had their solutions. Social education was a primary way to tackle such problems. Social education had the goal to reach a sufficient level of social hygiene, a pedagogical principle that Querido applied in the philosophy of the social psychiatry he practiced. On Zeeburgerdorp, he wrote: '[...] the solution [to their social failure, ps] is sought in providing a socio-pedagogical orientation for treatment: the families are offered an opportunity to learn good housekeeping and so fulfill their duties towards houseowners and neighbors.'[247]

Querido presents three categories of socially problematic families: (1) the *voorwaardelijk maatschappelijken* (conditionally sociable family), whose fall from grace had purely external causes and was not a fault of their own. Their societal problems were corrigible with the helping hand of the municipality, who provided consultation on labor and housing in the short term and

[243] Arie Querido, *Het Zeeburgerdorp. Een sociaal-psychiatrische studie* (Amsterdam; 1933), 7-10.
[244] Ibidem, 10.
[245] Ibidem, 10.
[246] Ibidem, 22-29. Regarding alcoholism, eugenics and other unsociable features, see, for example: Oosterhuis, 'Mental Health as Civic Virtue'; Jan Noordman, 'Eugenics and the Mental Health Movement in the Netherlands 1930–1960', Hans van den Brekel and Fred Deven (eds.), *Population and Family in the Low Countries* (1994), 107-123.
[247] Querido, *Het Zeeburgerdorp*, 8. This is a translation of the following: 'Getracht de oplossing in sociaal-paedagogische richting te zoeken; de gezinnen in quaestie moesten in de gelegenheid worden gesteld, te leeren, hun woning goed te gebruiken en aan hun verplichtingen jegens eigenaar en medebewoners te voldoen.'

prepared them for reentrance in free society in the long term.[248] Then there was the (2) *voorwaardelijk onmaatschappelijken* (conditionally unsociable family), whose societal difficulties were due to social unfitness of individual members, but who, with the right supervision and help of third parties such as the municipality, could potentially still function within society. Their success in free society, however, was dependent on the success of education and the teaching of citizenship, hygiene and morals.[249] Lastly, Querido describes a group he calls the (3) *onvoorwaardelijk onmaatschappelijken* (unconditionally unsociable family), a group that under no circumstances would be able to function in society due to 'inherent disorganization'.[250] This group also encompased the permanently unemployed—whom we have seen in chapter two—and those who did not qualify for education. However, they still had to be maintained in society somewhere. Zeeburgerdorp was the place for them. Interestingly, Querido takes the family unit—and not its individual members—as the basis of his research, placing families within one of the presented categories, along with suggestions of appropriate social treatment and the expectation of improvement.

The neighborhood of Zeeburgerdorp itself—one straight street of 180 meters long and 10 meters wide—housed 56 families, had an office occupied by the overseer who visited the families on a daily or weekly basis, some sanitarian facilities, a gathering house and a small sandbox for children (see figure 8). Moreover, a day-care for babies and children was present. This was supervised by an overseer, who made sure the families lived together in an orderly fashion, that no violence occurred between or within families, and that the families took good care of their children by sending them off to school, dressing them correctly and feeding them well, all the while teaching them proper societal manners and hygiene.[251] In serious situations, the police or the municipal service of Heijermans was called upon to deescalate a quarrel.[252]

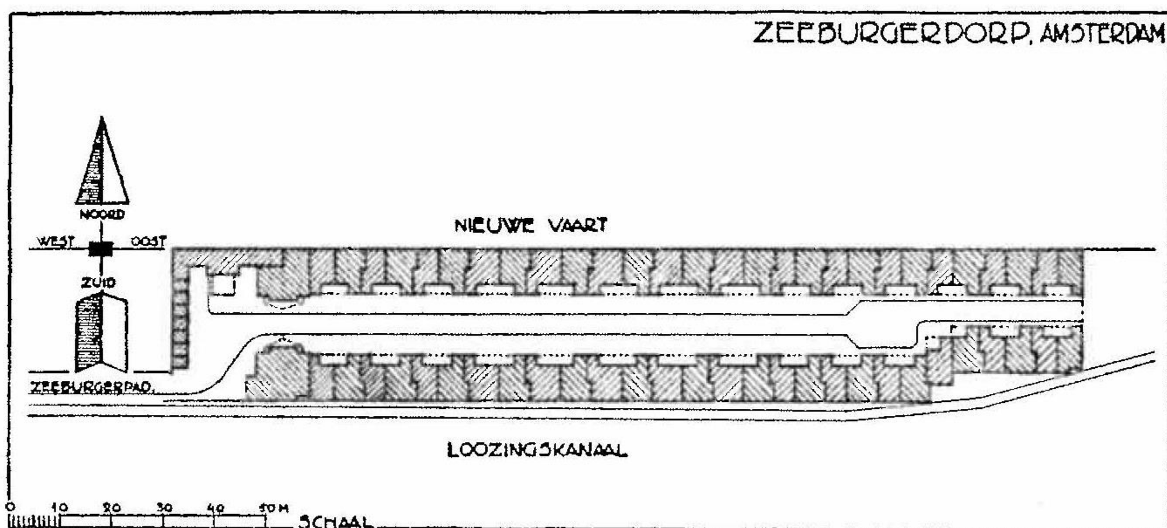


*Figure 8. Zeeburgerdorp in Amsterdam, 1933. The entrance at the very left housed the overseer, the small square blocks six sanitary facilities, adjoined by a gathering house. 56 families lived in a long, straight street that was easily supervised.*

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[248] Ibidem, 22-25.
[249] Ibidem, 25-31.
[250] Ibidem, 21, 22, 31-36.
[251] De Regt, 'Ontoelaatbare Gezinnen: over het ontstaan van onmaatschappelijkheid'.
[252] Querido, *Het Zeeburgerdorp*, 12.

The aims of Zeeburgerdorp can be considered as being twofold: it was a 'pedagogical facility', where psychiatrists and social workers tried to strengthen the societal position of the families living there via social education, social hygiene and the requirements for good health; but secondly, it also provided accommodation to families who otherwise would not have been able to find residency at all due to the social and mental issues of family members.[253] It thus had a role in facilitating a form of social housing as well.

From the municipal perspective, then, Zeeburgerdorp was a sanitarium where the totality of modern life's requirements could be taught. All of Heijermans' requirements for a long life in good health can be found in the practice and philosophy of Zeeburgerdorp. Here, housing was provided, but the families were also taught to live in them, focusing on good hygiene, receiving help in finding a job and keeping it, and battling societal diseases such as alcohol addiction. The ultimate goal was to better the societal position of troubled families, an intention that also had the aim to improve society as a whole. The municipality actively tried to organize the totality of life and did so because it felt responsible for the wellbeing of its citizens.

Zeeburgerdorp was not the only municipal initiative in Amsterdam that made efforts for families that had to be reeducated and lacked good housing or were homeless altogether.[254] Similarly, private organizations made such attempts in a similar way. Increasingly, the municipality started to tie these organizations to their own policy and execution of welfare.

In 1904, for example, an association was established in Amsterdam, the *Hulp voor Onbehuisden* (Aid for the Unoccupied, *HvO*), where homeless individuals or families could be temporarily accommodated and where food was handed out.[255] The association has a history that is characterized by what historian D.P. Rigter called the 'change that had occurred in the twentieth-century attitude of the government in relation to private initiative'.[256] The association itself was not a municipal service, although neutral in ideology, but over the years the Amsterdam municipality started to interfere with the association increasingly. Since the First World War, the municipality subsidized the association and in 1932 it was decided that two municipal delegates would join the HvO to better regulate the expenses of the association. It should come as no surprise that Louis Heijermans was one of them.[257] The relationship between the association and the municipality, however, would soon come under pressure, as the financial crisis in the Netherlands forced the municipality to consider more cuts on the already grim financial situation of the association.[258] Again, as had happened with the subsidizing of the unemployed, the municipality hit a barrier in the 1930s. Within the limits of that time, subsidizing private organizations would come under the most pressure, and the *HvO* suffered, having to cut short on their operation.[259] However, municipal organizations, the municipal government believed, were considered to have the best credentials when a decision had to be made as to whom to finance. Municipal organizations were reliable. Private organizations were not. Zeebugerdorp could thus maintain its facilities.[260]

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[253] Ibidem, 9.
[254] Asterdorp is another such pedagogical facility of the municipal, see: Stefan Steinmetz, *Asterdorp. Een Amsterdamse geschiedenis van verheffing en vernedering* (Amsterdam; 2016).
[255] Danièle P. Rigter, *Een Dringende Noodzakelijkheid. Geschiedenis van de vereniging "Hulp voor Onbehuisden", 1904-1945* (Amsterdam; 1990), 17, 18.
[256] Ibidem, 7.
[257] Ibidem, 83.
[258] Ibidem, 80-87.
[259] Ibidem, 80-87.
[260] The German occupier would close the facility in 1944.

Ultimately, decisions such as these had a large impact on the societal position of the municipal government in providing social relief. The municipality became the primary provider of welfare services and did so by appropriating already existing private organizations. As such, the creation of the welfare municipality came at the expense of private initiative, for in the end, the municipality considered itself to know best the needs of its citizens and was the only one that had the financial means to build an encompassing welfare system.

## vi. CONCLUSION

Taking stock before reaching the final conclusion of this thesis, we have seen that the emergence of Amsterdam's social psychiatric services was largely dependent on the ideological basis of the welfare municipality and the presence of the Amsterdam Municipal Medical and Health Service. As such, the emergence of social psychiatry also captures the philosophy of the welfare municipality. Taking a mental illness to mean an increasingly worsening isolation from those around you, the essence of a long life in good health was to have the possibility to develop within the boundaries of society. Good housing, labor, nutrition and morals were essential in keeping good mental hygiene, and as such, the municipality's pre- and aftercare services for psychiatric patients focused on these aspects.

In some cases, Meijers and Querido found, admission into a mental hospital was not necessary. For them, the municipality provided in a multitude of solutions, ranging from re-educative measures, such as Zeeburgerdorp, to providing mental patients with (municipal) labor, or simply by solving direct financial distress. While these people were still patients, and seen as such, admission could sometimes be avoided. While municipal financial distress should be seen as the primary catalyst of the emergence of such pre- and aftercare services, the ideal of the welfare municipality functioned as its philosophical basis. The municipality was responsible for the general wellbeing of its citizens and sometimes was so at the expense of private initiatives. The financial situation of the municipalities only made things more urgent. If the municipality did not centralize social relief, it was believed, chaos would ensue.

# CONCLUSION
## Looking back on a concept

*Figure 9. Street culture in the Jordaan neighborhood, 1922.*

SYNOPSIS

In this concluding chapter, an overview of the welfare municipality is provided, along with suggestions for further research. In answering the research question, it is concluded that the Amsterdam municipality in the interwar years could very well be defined as a welfare municipality, opening the doors to new ways of approaching this era.

## i. AN ADDITIVE BY LOUIS HEIJERMANS

Dutch citizenship has always been characterized by self-help. *Je eigen boontjes doppen* is still a proverb that many will know and strive for. It is a fascinating part of Dutch culture and identity. When the social question became imminent and action unavoidable in the second half of the nineteenth century, it was believed that via discipline, self-restraint and hard work the ideals of the newly risen middle classes could be achieved by everybody. However, as the day-to-day living situations in large cities like Amsterdam quickly worsened near the end of the nineteenth century, and the working classes prospects of general wellbeing were dwindling, the focus changed. A small encouragement was sometimes very efficient, if not to say fundamental, to the chances of a laborer. They could be taught the fundamentals of hygiene if they were only handed the soap. They could be taught the etiquettes of dining if they were only handed the knife and fork.

Louis Heijermans, an essential figure in these efforts, lived by that philosophy. In his magnum opus, the *Gemeentelijke Gezondheidszorg* on municipal healthcare, he clearly stated his beliefs on the public basis of society:

> Albeit the significance of individual care cannot be underestimated, it is elementary, that such practice can only be realized when the tools to it are present. [...] It is the community which must come to the assistance in the provision of good housing, water supplies, sewerage, urban planning, street construction, a hospital system, street-cleansing, bathhouses and swimming locations, supervision on the quality of food, security against contagious diseases, funeral arrangement, the protection of labor for man, woman and child, etc.[261]

In the early twentieth century, it was the Amsterdam municipality that became the primary organizer of the city's community provisions. It is by the totality of services and provisions that Heijermans mentions above that the municipality started to provide a collective system of safety nets that we have come to understand as the Amsterdam welfare municipality.

## ii. THE WELFARE MUNICIPALITY

In this thesis, the notion of the welfare municipality has been introduced, a notion that was at the center of the Amsterdam Municipal Medical and Health Service and the emergence of social psychiatric practice in Amsterdam.

Taking De Swaan's three dimensions of *collectivization* for the welfare state and applying it to the municipality, we can now answer the research question stated in the introduction. *To what extent can the Amsterdam municipality of the 1920s and 1930s be regarded as a welfare municipality?* De Swaan's three dimensions of *collectivization* were (1) an increase in scale that would include more and more citizens; (2) an increase in the collective character of arrangements dependent not on individual contribution, but mutual contribution and regulation; and (3) an increasingly central position of a public body executing that collective arrangement.[262] It should also be understood as a gradual process. Can these dimensions be positively answered for the Amsterdam municipality in the interwar years?

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[261] Heijermans, *Gemeentelijke Gezondheidszorg*, 10. This is a translation of the following: 'Ofschoon dus de beteekenis van de individueele zorg niet onderschat mag worden, is toch het primaire, dat van hare toepassing eerst sprake kan zijn, indien de hulpmiddelen ter beschikking staan. […] Het is de gemeenschap, welke te hulp moet komen in de zorg voor goede woningen, watervoorziening, rioleering, stedenbouw, stratenaanleg, ziekenhuiswezen, straatreiniging, badhuizen en zweminrichtingen, toezicht op zuiverheid van voedsel, afweer van besmettelijke ziekten, begrafeniswezen, bescherming van den arbeid van man, vrouw en kind, enz.'

[262] De Swaan, *Zorg en de Staat*, 19.

Examining the first dimension—the increase in scale—to what extent did the Amsterdam municipality increase the scale of its welfare services to encompass more citizens? As we have seen, the Amsterdam municipality in the interwar years became responsible for an increasingly large group of citizens. Where first and foremost, in the nineteenth century, the municipality provided in poor relief for only the neediest citizens, in the early twentieth century, under the influence of a fast-changing society, the group of citizens depending on the municipality started to increase in size. Now the municipality had a societal function for the whole of the community. Moreover, however, the ideological basis of the municipality had changed: the municipality considered itself responsible for providing a long life in good health. The municipality was the guardian of life and health. As such, we can conclude that under the wings of the municipality, the welfare services increased in scale.

Secondly, was the creation of welfare by the Amsterdam municipality characterized by a collective character of arrangements and less so by individual contribution? This is probably the most ambiguous question to answer. No compulsory health insurance existed before the German occupation, for example. The creation of the welfare municipality did not specifically exist by grace of mutual contribution or the equalization of all citizens. That being said, by 1930, almost all of Amsterdam's population had access to basic medical care and health services, and accessibility to consultation bureaus on upbringing, labor and housing. By doing so, the municipality focused on a broad accessibility of these services for a general population and that was not dependent on the individual's contribution or background necessarily. However, in most cases, the arrangements were focused on the working classes and general support was provided only by virtue of what the individual could give back for the help he received.

The third and final aspect of De Swaan's collectivization-thesis—the increase of public bodies executing public services—can be answered positively. If this thesis has shown anything, as I hope it did, it is that the Amsterdam municipality was increasingly seen as the best organizing body in providing public services. The municipal organization was not subject to inconsistency, but rather believed to be consistent over a larger period of time. As we have seen with much of the reasoning of Louis Heijermans and his contemporaries, the municipality was at the central of their interpretation of society. In the interwar years, municipal organizations grew to hold a substantial place in public services, and the municipality became the largest employer of the city.

On the basis of these three dimensions of *collectivization* as prerequisites for the creation of a welfare society, the Amsterdam municipality of the interwar years perfectly fits within De Swaan's understanding of an emerging welfare state. In fact, the Amsterdam municipality of the interwar period seems to have anticipated the emergence of the Dutch welfare state in the 1950s. As has been a crucial part of this thesis, the mindset of *responsibility of care* was an essential element in the creation of the welfare municipality. Often, financial decisions and the sheer need of a city to take action were only an aspect of the reasoning behind the creation of a municipal welfare system. The municipality considered itself responsible for the general wellbeing of its citizens, as was very much characterized by a developing and evolving idea of *volksverheffing*. Without the helping hand of the municipality, the working classes were doomed to stay in the damp and moist canal-level apartments, literally living at the lowest level of society. And the municipality took that responsibility very seriously.

### iii. FURTHER RESEARCH: EXPANDING A CONCEPT

This thesis was of an explorative nature. Introducing a new concept, it has attempted to shift the focus of historiographical writing. Consequently, a lot remains to be done. This thesis mainly

focused on the *breadth* of the municipality, trying to capture the multitudinous ways the municipality stepped into the day-to-day lives of its citizens, providing and supporting them in the basis of all aspects of life, ranging from health and hygiene, housing and nutrition, to labor, education and morals. The goal of this thesis, in that sense, was to capture a philosophy and a mindset. By what ideas and beliefs did the historical actors give meaning to their work?

On the contrary, this thesis was much less dedicated to the *depth* of the welfare municipality. Where the multitudinous ways of the municipality were discussed, little attention was given to the details of the welfare municipality. How did it work in practice? By what means did the municipality consolidate its services? In what ways were private organizations involved with the municipal organization of welfare? How did the municipality engage politics at the national level? A large gap in understanding the municipality in the interwar years remains to be filled there. The concept of the welfare municipality thus needs expanding. A few suggestions for further research.

It has already come to pass a few times in this thesis but has consequently been kept in the sidelines for similar reasons, namely what the boundaries and limits of the welfare municipality were. Where did municipal responsibility stop? Where did historical actors draw the line? And for what reasons? The Great Depression swept over the world in the early 1930s, and it is commonly known that the Netherlands were hit hard and long, suffering from economic recession until the end of the 1930s. It would be interesting to research what impact this had on municipal initiatives.

A second suggestion for further research on the welfare municipality is the influence of political color and the subsequent pillarized composition of the municipality. Where this thesis focused its attention on the social democrats and ascribing to their philosophy much of the origins of the welfare municipality, it is unthinkable that other political beliefs, such as the confessionalist parties, were altogether ignorant of the municipality. Special attention should be given to the Catholics, as it would be the combination of Catholics and social democrats that extended the welfare municipality to become the welfare state in the 1950s.

A third suggestion regards the welfare municipality of other Dutch cities. This thesis has been solely focused on Amsterdam, being the largest city in the Netherlands. But how can we characterize the municipal organization of welfare in cities such as Rotterdam, Utrecht, Groningen or Eindhoven? Was Amsterdam alone in its endeavors? Heijermans' manual for the organization of municipal healthcare suggests otherwise. It might be interesting to explore if the welfare municipality as a concept for the interwar period can be attributed to the Netherlands as a whole.

A final suggestion regards research on municipal citizenship and the notion of an emancipating working class. Where the interwar years are characterized very much by the idea of *volksverheffing*, after the Second World War and with the emergence of the welfare state, this idealism starts to dwindle.[263] The state retreated as a civic reeducator and emancipator. Why did this happen? There is a lot to be said for simply attributing this to the death of a generation, a generation that witnessed the complete change of a society in its lifetime and whose idealism was based on the chaotic and sometimes inhumane development of life in the modern world.[264]

[263] For developing a thorough idea on why *volksverheffing* as an ideal disappeared after the Second World War, a good start can be made by reading: Harry Oosterhuis, 'Self-Development and Civic Virtue: Mental Health and Citizenship in the Netherlands (1945–2005)', *Osiris*, vol. 22, no. 1 (2007); Oosterhuis, 'Mental Health as Civic Virtue'.
[264] For such a 'death of a generation' narrative, see: Stefan Zweig, *Die Welt von Gestern* (1942).

### iv. A FINAL STATEMENT BY LOUIS HEIJERMANS

History repeats itself, in a way, even if we would rather say it did not. The proof lies in the past, in the actions and words of people long gone. In a time when the conflict between the Dutch municipalities and central government over the financial responsibility of youth care reaches a decisive moment, it is sometimes wise to look back and ask: has it always been like this? The answer is: yes. Louis Heijermans will show us as much. A final statement from his side:

> *The costs precede the benefits.* It is worrisome to see that this is not appreciated in this country. Regarding the district healthcare services, the minister of Finance has declared, that the state and the municipality cannot carry the expenses which are involved with it, being 4 or 5 million guilders. [...] But that couple of million for a war against disease, on a total budget of 612 million, can surely be found with some goodwill. Spending no money on the fight against, for example, venereal diseases, means a future tenfold expense for the treatment of patients whose illness is caused by syphilis germs. This is just a single example where numerous could be mentioned. If we do not look beyond what is right in front of us, and only notice the direct expenses, then we in the Netherlands will only keep agonizing ourselves over our highly inadequate fight against disease.[265]

[265] Heijermans, *De Zorg voor onze Gezondheid in het Dagelijksch Leven*, 137, 138. This is a translation of the following: '*De cost gaat voor de baet uit*. Het is benauwend om te zien, dat dit hier te lande niet wordt ingezien. Voor de instelling van distriktsgezondheidsdiensten, verklaart de minister van financiën, dat hier te lande staat en gemeenten de uitgaven, die hiermedegepaard gaan, zijnde 4 a 5 millioen gulden [...], niet kunnen dragen. [...] Die paar millioen op een budget van 612 millioen zijn voor oorlog tegen ziekte met goede wil toch zeker wel te vinden. [...] Geen geld uitgeven voor de bestrijding van geslachtsziekten, beteekent later tienvoudige uitgaven voor de verpleging van lijders wier ziekte door de syphiliskiemen worden veroorzaakt. Dit is maar een enkel voorbeeld, een duidelijk, er kunnen er talrijke andere genoemd worden. Als men niet verder ziet dan zijn neus lang is, alleen kijkt naar de direkte uitgaven, dan blijven wij in Nederland tobben met onze hoogst gebrekkige bestrijding van ziekten.'

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