Chapter 4

The development of hospital systems in new nations: Central Europe between the Two World Wars[1]

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The study of hospitals has grown substantially in the last twenty years especially in Britain where there has been important work on issues of finance and control, particularly at a local level.[2] As this special issue shows, similar research is now underway in many countries, including France, Germany and Spain where the focus has been on the rise—or not—of a state-supported hospital system funded through compulsory state insurance.[3] Initial research tended to characterise pre-welfare state health provision as limited, disorganised and poorly funded while rarely recognising the significant development taking place.[4] Yet it is apparent that across much of Western Europe hospital provision was growing, with central and local state, philanthropy and the private sector all responsible for increased and improved services.[5] To fund this growth, a complex mixed economy of financial systems developed, including National Insurance, local authority funding, mutual insurance schemes and direct payments.[6] However, in all of these schemes access to hospital treatment was restricted while in terms of coverage the self-employed in business and agriculture were often excluded.[7]

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Although studies of western European health care are growing, there is little published research examining the hospitals of Central Europe—a region dominated by emergent nations attempting to build new health systems from the ruins of Europe's old empires. The nations of central Europe fit uneasily into the traditions of the established nation state, their multinational roots and new nation status offering a very different perspective from which to view the development of their hospital provision.

To date, their hospital historiography has been dominated by a traditional medical history approach focused on individual institutions and specialties, often written by senior medical practitioners working at the hospital or in the area of specialism.[8] There have been important studies on the growth of hospitals in Czechoslovakia by Svobodný and Masova[9] and useful work on Poland,[10] though little critical analysis of the situation in Hungary.[11] The communist era in these countries imposed significant checks on historical method while history of medicine has been largely abandoned as a subject for medical degrees.[12] Much of the health history of the region before the Second World War has focused on racial policy, and especially eugenics, with major contributions from Paul Weindling and Marius Turda.[13] There is a more extensive historiography of the work of international agencies in these nations, with particularly rich research focusing on the Rockefeller Foundation,[14] including studies of support for health institutes, nurse training and the development of health policy generally.[15] However, the Rockefeller Foundation were not interested in the development of hospitals *per se*, although their field officers did amass a great deal of information on the establishment of national services in the 1920s.

Over the course of the interwar period the new nations of Poland and Czechoslovakia and a much-truncated Hungary sought to utilize health care, and especially hospital provision, as evidence of their

progressivism and modernity and as a symbol of nationhood.[16] Yet their intentions were constrained by a complex health inheritance, persistent financial crises and significant health challenges, especially in their poverty stricken eastern regions.

Building on an understanding of the complex demographic, ethnic and economic structures this chapter will utilise case studies of Czechoslovakia, Hungary and Poland to examine the challenges faced by these new nations in delivering a modern health care system. It will explore three key themes: who provided hospitals and how did their scale and scope change over time? How and by whom were hospitals financed and how did this affect access? And did health care feature in the process of nation building? It will show that these three themes were linked as they were pursued by governments with the aim of providing more and better institutions, branded as the work of the new nation and underpinned by a seemingly modern, extensive payment system. Yet despite considerable effort, resource and political will, financial weakness, ethnic conflict and urban-rural divisions limited choices and curtailed the expansion and modernization of the institutional infrastructure.

Access to primary sources varied across the three nations. Both state and local records were extensive for Czechoslovakia, more limited for Hungary and almost non-existent for Poland, where the destruction of Warsaw and other major cities meant few public records survived.[17] The main sources utilised in this text are published reports, such as the *Czechoslovak Health Yearbook*, which provided extensive statistical material on provision and funding structures.[18] Similar, less full, publications exist for Hungary and Poland.[19] In the former case, extensive use has been made of medical and hospital journals for evidence of change at an institutional level and in all cases material has been drawn from insurance data. This has been supplemented by important national data collected by the League of Nations in the

1920s and the International Labour Organisation for the later 1930s. These surveys relied on local contacts well placed within the national health system and included both hospital statistics and information on the operation of insurance schemes.[20]

In a similar vein, the study has drawn on the international publication, *Nosokomeion*, which included a number of articles on general and specific issues concerning hospital services in Poland, Hungary and Czechoslovakia, with Poland receiving the most attention. In addition, particular use has been made of material from the Rockefeller Foundation who worked extensively in Central Europe in the 1920s. The Foundation appointed Selskar Gunn as a resident officer in Poland at the beginning of the decade and he continued to work closely with government health departments until the onset of the Depression saw a shift in RF focus away from Europe to Asia.[21] In addition to a collection of baseline country surveys conducted between 1920 and 1924 and ongoing field officer visits to the region, a number of local reports were produced by teams examining applications for Foundation grants. Together the RF material offers a rich mix of macro level assessment undertaken by policy insiders with considerable knowledge of the country and specific examples of health service provision on the ground.

The first section of this chapter will provide an overview of the health care, and especially hospital, inheritance of these nations at their formation in 1918 set in the context of demographic, ethnic and economic variables. The second will examine developments in the extent and ownership of hospital provision; the third explores the funding landscape, and how this affected access to care while the final section will consider the effect of the multi-ethnic character of these nations on the provision of hospitals and the role of health care in nation building.

The new geography of central Europe

Between 1918 and 1924, following the collapse of the German, Austro-Hungarian and Russian empires, a number of new or much re-drawn nations were created across central Europe.[22] Formed by local politicians and the peace treaties, these countries combined national self-determination with economic and geographical pragmatism, leaving multi-ethnic states to cope with recalcitrant minorities, unsatisfied neighbours, angry separatists and a substantial Jewish minority that the new countries only partially tolerated.[23] In this environment, the body was a key site for the legitimation policies of the new nations with eugenics, racial politics and health care strategies deployed to tie together the disparate national and ethnic groups.[24] In their quest for political legitimacy the governments of the new states directed some of their energies to the creation of modern, efficient and progressive health care provision, often using this to establish a sense of democratic entitlement and national identity.[25] Yet this was a difficult and complex task. Poland and Czechoslovakia inherited multiple hospital systems from their former imperial rulers; Hungary was massively reduced in size and lost many of its leading institutions to the successor states; each new state had large geographical areas with very limited service provision, especially in the eastern lands; and all had to deal with huge financial difficulties, including inflation, currency instability and the effects of the economic depression.[26]

The Polish Republic was created out of lands from each of the former empires including German Silesia and the Polish Corridor, Galicia from Austro-Hungary and both Congress Poland (the central area around Warsaw) and the Pale of Settlement, the predominantly rural area with a largely Jewish population, from Russia.[27] The background for Czechoslovakia was equally complex, with the Czech lands of Bohemia and Moravia in the west seceding from Austria, while Slovakia

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and Ruthenia were Hungarian territories, the latter with a substantial Jewish population.[28] As a result of the Treaty of Trianon (1920), however, Hungary saw its population and landmass reduced by almost 60%, with the large and urbanised region of Transylvania transferred to Romania while substantial territory was ceded to the new states of Yugoslavia and Czechoslovakia.[29]

This complex inheritance was important for a number of reasons. Although Hungary was reduced to a coherent ethnic and linguistic core by the peace settlement, elsewhere ethnic diversity led to problems with delivering a unified, national health system. In Czechoslovakia the Germans continued to maintain and guard their own provision, while in the cities like Prague the main hospitals and the medical schools operated on separate ethnic grounds.[30] In Eastern Poland, the geographical and economic limitations of the dispersed Jewish settlements demanded a different approach to institutional care to that found in the rest of the country.[31] As Table 1 shows, roughly one third of the population of Poland and Czechoslovakia belonged to another ethnic group, with Germans forming a powerful lobby in west Czechoslovakia and Ukrainians and Jews in Eastern Poland. This was particularly apparent in some big cities, with Poles a bare majority of the citizens of Lemberg/Lvov, while Jews numbered around a quarter of the population of Budapest.[32]

Table 4.1: Ethnic Population of Czechoslovakia, Poland and Hungary, percentage distribution, 1921-31

	Czechoslovak	Polish	Hungarian	German	Jewish	Other
Czechoslovakia (1921)	65.3	1.0	5.5	23.3	1.3	3.6
Poland (1931)	-	68.9	-	2.1	10	19
Hungary (1930)	1	-	92	2	5	-

Sources: Heimann, *Czechoslovakia*, 64-5; Prażmowska, *History of Poland*, 102; Molnár, *A Concise History of Hungary*, 268.

The first problem facing these new states was managing the effects of the First World War. In much of the region, especially across Poland, there was considerable war damage compounded by the ongoing disputes with Ukraine and Soviet Russia that lasted until 1922.[33] Millions of people were displaced in this process, some spending up to seven years away from their farms. Large numbers died in the fighting, or as a result of displacement or even of starvation in the famine that swept the region in 1920-21. Epidemic diseases were rampant, especially typhus, typhoid and recurrent fever, the latter proving more life threatening due to inadequate feeding. Around one and a half million houses had been destroyed, farms were in ruins with vegetation across the fields, there were no horses, implements, seed, timber or food and some returnees were reported to be living in the dugouts made by the German army.[34]

Though less extreme, in the Hungarian city of Gyär there were thousands of refugees from Transylvania living in overcrowded barracks while resources were diminished by looting, the occupying Serbian army stealing all of the operating theatre equipment of the small hospital in

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the southern town of Sikles.[35] The borders were officially settled by 1924, but disputes continued to cause instability in the region until 1939.

The economic effects of the treaty settlements hampered the growth of hospital systems. Economically these countries suffered many of the problems of other nations between the wars, but in an aggravated fashion. Both Hungary and Poland were plagued by hyper-inflation until major currency reform in the mid-1920s although the Czechoslovak economy remained stronger than the others and benefitted from a more stable currency.[36] Poland and Czechoslovakia were more economically advanced in the western regions ceded from the German and Austrian empires whose industrial and urban development was more extensive. However, in the eastern areas like Slovakia, Belarus and Subcarpathian Ruthenia (known by the Czechs as Podkarpatská Rus or PKR) subsistence agriculture predominated, there was little urban development and social infrastructure was limited.[37] For Hungary the loss of Transylvania and cities like Bratislava proved particularly problematic as they included many of the country's leading hospitals and medical schools. Moreover, outside of Budapest much of the country was rural, with few towns and a limited organisational base to support an extensive hospital system.[38] The later 1920s saw gradual expansion of public investment across the region, especially on hospitals. Thus, the Czechs focused on 'modernising' the east with public health projects in both Slovakia and PKR. In 1927, the Slovak politician in charge of health secured significant funding from the state insurance scheme surplus for infrastructure development in Ruthenia, including the continued upgrade of the hospital in Mukačevo.[39] However, these nations were badly hit by the depression leading to a significant squeeze on health spending.

All three nations had significant rural populations. In Poland roughly 75% of the population lived in the countryside, for Hungary the proportion was around 67%, while in Czechoslovakia the figure was over 40%.[40] Although there were urban centres in the west, especially in Bohemia

and Polish Silesia, in central and eastern areas there were relatively few large towns and illiteracy was widespread, especially among the older population and women.[41] Transport and communications were weak and in parts of rural Slovakia and Poland the roads were impassable by cars. Moreover, some regions were very poorly integrated into the market. Currency was limited in the east of Poland, many peasants living within a barter economy—indeed there were attempts to allow payment for health services in goods rather than cash.[42] These problems were exacerbated in the early 1930s as the Great Depression forced down world agricultural prices, reducing incomes for farmers, workers and the state. Again, the effects were rather different in Czechoslovakia where both the industrial west and the rural east experienced recession at different points in the cycle and recovered at different rates. In all three countries state and local finances were severely affected, restricting both capital investment and operational income for health provision. However, recovery was driven, at least in part, by war preparation and rearmament and by the changes in relations with Germany after 1933.

There were, moreover, severe public health problems. Infant mortality was well above the western European average and remained stubbornly high throughout the period.[43] The lowest rates were found in Czechoslovakia where a steady decline was noted in the later 1920s to 140/1000 in 1929. However in Hungary the figure remained static at around 180/1000 while for Poland figures were only available for the more prosperous western and southern provinces where in 1926 the rate was 180/1000.[44] Across the region the infrastructure to tackle infant mortality, tuberculosis and contagious diseases was limited despite investment and support from bodies like the Rockefeller Foundation.[45] Mobile infectious disease units were developed for use in remote areas, especially PKR and eastern Poland[46] and across these regions the health centre—with the hospital as support—emerged as the key vehicle for delivering services.[47]

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The new nations inherited a diverse range of health funding systems from the previous imperial regimes. The German, Austrian and Hungary governments had introduced health insurance by 1914, though this was absent from the Russian empire. Polish Silesia benefitted from the highly developed German system, established in the 1880s and offering cover to the region's industrial and white-collar workers. Austria was quick to follow Germany in establishing health insurance and by 1914 it covered a similar range of industrial and transport workers. In each case family members also benefitted. As a result, these two nations led the world in coverage in 1910 with around one third or more of the population insured by the end of the First World War. The new nations were quick to adopt and adapt these schemes, the Poles ambitiously basing their new national coverage on the German model (even if it was a largely unaffordable aspiration). Each nation also inherited the Hungarian system. Claimed to be the oldest in the world (a voluntary initiative was launched in the 1870s) a limited state health insurance scheme was in operation by 1891 covering a similar range of industrial and transport workers along with a wide range of state employees. In Russia, however, no compulsory state health insurance existed, leaving a substantial hole in the health finances of the new Polish state. Although these countries could draw on these existing schemes, significantly none of them included agricultural workers, a prominent part of each workforce.[48]

Hospital numbers

The new states inherited a health infrastructure based on the four different imperial systems. Hungary, Galicia, Slovakia and PKR had the Hungarian system with strong central control of local institutions. Bohemia and Moravia and Silesia had German or Austrian structures with a national insurance system but devolved hospitals. Poland had a complicated mix of all four former regimes and, with some good provision in the former Austrian, German and Hungarian areas although the bulk of the nation was covered by the very limited Russian inheritance with relatively few hospitals and a weak health infrastructure.[49]

Defining a hospital is a challenging exercise, especially in this period of rapid organizational, intellectual and technical change.[50] A basic definition might include any institution that accepts patients for residential treatment with the aim of curing or 'materially relieving' their condition. By 1918 the bulk of general hospitals had provision for surgery and internal medicine while increasing numbers had specialist departments for various parts of the body. They might include isolation facilities for infectious diseases, facilities to treat venereal diseases and in many cases maternity and gynaecology blocks. From the late nineteenth century specific demographic groups also secured specialist institutions, including women and children. But the hospital was also separating out traditional patient groups and developing services beyond the acute sector. Tuberculosis was usually treated separately from other infectious diseases. The elderly, the infirm and the chronically ill—the bulk of patients in the nineteenth century public hospital—were squeezed out, coming to occupy a less medicalised space in the hospice-style accommodation of the municipality.[51] Those with mental illnesses attracted their own, frequently overcrowded and underfunded, establishments. The extent of these divisions differed across Europe and North America and even within countries.[52]

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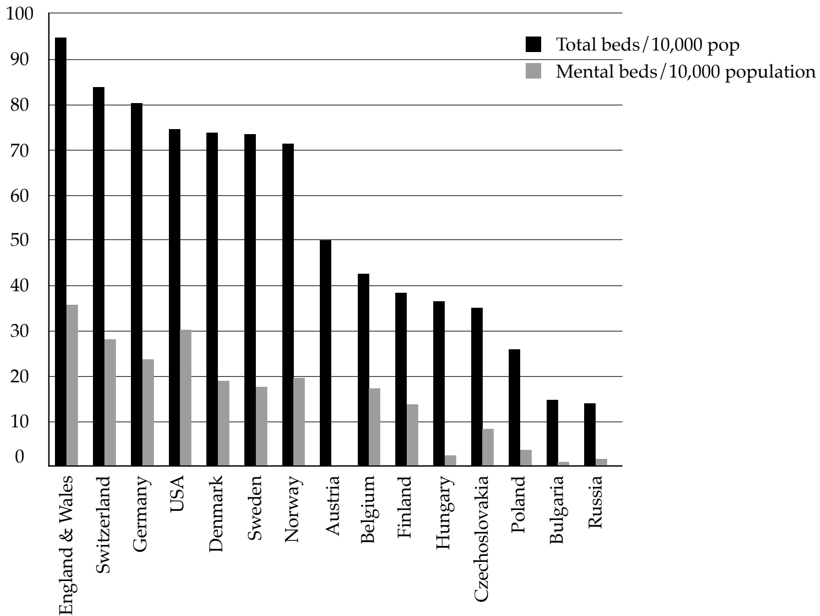
Figure 4.1: Relative Proportion of Provision in Hospitals and Mental Institutions 1931



Source: C. Neville Rolfe, 'Hospital and venereal disease', *Nosokomeion*, 3, 3 (1932), 245. Total beds includes mental health beds.

The available statistics for central Europe, unlike those for the west, rarely distinguished between the curative general and specialist hospital and the care-oriented, chronic institutions associated with the hospice and the poor law.[53] Progress in the visible and politically important general teaching hospitals of urban centres can blind us to the lack of change in county areas administered by cash-strapped local authorities.[54] With these caveats in mind we can see the extent of hospital provision in Europe in 1931 (Fig.1). The northern and western European nations were offering a ratio of approximately 70-80 beds per 10,000 people while the Central European countries provided

roughly half that number. But as can be seen from Table 2, progress was being made to increase capacity: first by building new institutions and, second, by renovating and reorganizing existing hospitals to meet modern demands—although many of these institutions still fitted the older model of mixed acute and chronic care, especially in rural areas.

Table 4.2: Number of Hospitals and Beds in Czechoslovakia, Hungary and Poland, 1918-37

	Czechoslovakia		Hungary*		Poland	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
1918	-	-	429	45,500	322	47,000
1920	163	26,000	183	26,500	-	-
1925	-	-	205	30,000	634	47,000
1930	389	53,500	233	40,000	656	53,000
1935	411	64,000	291	46,500	677	75,000

Sources: István Ágoston, *A kórházi kapacitások és szabályozásuk története*, University of Pécs, 2013, 104; Jiří Říha (ed.), Zdravotnická ročenka Československa, 1928-1940 (Vols. I-XI) (Praha: Piras, 1928-1940); Ministerstwo Opieki Społecznej, *Dwadzieścia lat publicznej służby zdrowia w Polsce odrodzonej, 1918-1938*.
* The figures for Hungary for 1918 show the number of institutions and beds prior to treaty changes.

In the case of Poland the key need was to increase the number and spread of institutions and in this there was success. When the new nation was formed in 1918 the country had just 332 hospitals with around 47,000 beds for a population of approximately 26 million.[55] The number and distribution of institutions improved significantly in

the early 1920s while the mid-1930s saw a new programme of addition and improvement so that the hospital stock had reached almost 700.[56] From this point the number of institutions stabilized but capacity increased significantly while many of the smaller chronic hospitals that had dominated the countryside were upgraded to take more patients and adopt a more curative function.

The Czechoslovak Republic began with an inheritance of 163 hospitals and 26,000 beds in 1923 for a population of 13.4 million, or just over 2/1,000. By 1929, the number of hospitals and beds had almost doubled, while the period 1929-36 saw beds in general hospitals rise by almost a quarter and in all types of institution, including care-focused sick houses, they rose by a third from 70,000 to 93,000.[57]

In 1918 the situation in Hungary was a little better than in Poland in terms of numbers of institutions and beds but as a result of the peace settlement, it lost 57% of its hospitals and 42% of its hospital beds. Yet the nation was able to overcome these problems and by 1935 the number of both had doubled so that there were more beds than in 1915 with a significantly higher ratio of beds to residents than before the War. Part of this transformation was the result of institutions built to replace those lost to neighbouring states, such as the Horthy Miklós Royal State Public Hospital at Debrecen opened in 1931 to serve the city and the new university.[58] In the following ten years over 100 additional establishments were added, restoring provision to above the 1918 level.

Along with deficiencies in the number of institutions these health systems also had to deal with the poor distribution of facilities, the interwar period seeing some progress towards a more uniform allocation. In post-war Poland the existing hospitals were unevenly distributed with virtually none in the north-east area along the Russian border, leading to the erection of 100 temporary hospitals in the region adding thousands of new beds. The average coverage also

improved significantly to one bed per 467 inhabitants overall (just over 2/1,000) by 1938 but this was the national average; enormous regional disparities remained. For example, in the north east there was still only one bed for 1,250 persons and in the district of Postawski only one bed per 5,000 residents. Indeed it was calculated by the Ministry of Public Welfare that to meet the modern standard of three beds per 1,000 residents, beds would need to increase by around 50 per cent.[59] Similar uneven distribution in the quantity and quality of provision wa5s found in Czechoslovakia. For example, in 1920 the Czech lands (Bohemia and Moravia) possessed three quarters of the nation's hospital stock (123/163). Conversely there were just eight institutions in Silesia and four in Ruthenia, and these were all of very poor quality at this time.[60] The 1930s saw significant improvements in peripheral areas like Silesia, as well as attempts to modernize the under-developed region of PKR. Bed numbers in the region increased by 68% while the number of patients treated increased by 175%. However, this did cause problems as the facilities proved unable to keep up with the growth in demand and at Užhorod it was not uncommon for two or more patients to share a bed while others slept on the floor.[61]

As can be seen from Figure 2, new building in Hungary set out to address the poor distribution across the country. In 1923 Selskar Gunn had noted that: 'The total number of beds in the entire country is theoretically sufficient. However, the distribution is not the best, as Eastern Hungary is poorly supplied with hospitals' but by the later 1930s the east had secured a number of prominent new institutions.[62] Yet once again the distribution remained uneven with the central and eastern portions of the country less well served than the west and south. Moreover, the lost institutions were heavily based in Transylvania and included a number of medical schools as well as important hospitals. Replacements had to be established within the truncated Hungary in cities like Pécs (which acquired staff and equipment from

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the university at Bratislava), Szeged and Debrecen[63] supplemented by new hospitals in Budapest, like the Hospital of the National Insurance Institute, opened in 1927 with over 500 beds.

Figure 4.2: Hospitals in Hungary, 1938

Map drawn by Balázs Szélinger.

Hospital Ownership and Management

In each of these three nations there was a mix of providers including central, regional and municipal government, charitable, philanthropic and private sector involvement.[64] Given their origins in the four predecessor systems, both Poland and Czechoslovakia even had more than one type of local provider. Thus hospitals in former Hungarian regions were managed by the higher level county authorities acting as the representatives of the central state, while in

the Austrian areas the main provider was the lower tier city or district council—usually referred to as the municipality. This diversity was demonstrated by the Rockefeller Foundation's agent, Selskar Gunn, who found four main types of ownership in Hungary in 1923: a) state, b) public, c) semi-public, and d) private.

'A: State hospitals were run by central government and included university clinics, midwifery schools etc. The staff were well qualified civil servants. The fees were fixed by the Ministry.

B: Public hospitals were supervised by an Administrative Commission of the County and usually had departments of internal medicine, surgery and venereal diseases as well as accommodation for mental illnesses and infectious diseases. Fees fixed by Ministry of Welfare together with the county council.

C: Semi-public institutions were private hospitals recognized by the Ministry and therefore eligible for payments from public sources for treating the poor. Fees for sick poor set by Ministry in consultation with owners.

D: Private hospitals were subject to the supervision of the Administrative Commission but otherwise independent of the system.'[65]

Within categories C and D were to be found a number of religious institutions including the Brethren of Mercy.

These categories of ownership and responsibility were broadly replicated across the region, as shown by Tables 3 and 4, although in Czechoslovakia the private sector appears to have been weaker. Thus, in 1921, the largest number of hospitals in Hungary were private, including many run by religious houses, but these tended to be small or very small. The county hospitals, operating services for the central state, were the second largest category and they also included the bigger institutions, many with departments of internal medicine, surgery and venereal diseases, as well as accommodation for mental illnesses and infectious diseases. There was a relatively small number

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of medium-sized, semi-public hospitals recognized by the Ministry and therefore eligible for payments from public sources for treating the poor. In terms of specialist facilities, the biggest expansion, in line with developments across Europe, was among obstetrical clinics and hospitals which by 1930 numbered 34 and offered 4,700 beds. Counties were able to extend their hospital provision after 1928 with the assistance of US loans, almost 50 authorities taking advantage of the Speyer loans.[66] Thus, the Miklós Horthy public hospital in Nagykanizsa completed an extension funded by a combination of Ministry of Welfare loans and grants, a subvention from the County of Zala and over 600,000 pengo[67] from the town council thanks to a Speyer loan.[68]

Table 4.3: Hospital beds by type, Czechoslovakia 1921 (n. 163)

	Beds
Urban Hospitals (All)	8,967
District Hospitals (Bohemia)	7,672
State Hospitals (Bohemia, Moravia, Slovakia)	4,127
County Hospitals (Slovakia & Ruthenia)	2,186
Provincial Hospitals (Moravia & Silesia)	1,883
Private Hospitals (Not Ruthenia)	1,176
Total	26,000

Source: Pelc, *Organisation of the Public Health Services in Czechoslovakia*

In both Galician Poland and Slovakia, a similar pattern of provision was evident to that in Hungary of county management and state finance. In Poland the central state had limited input—mostly the infectious disease hospitals they had established in 1918. Generally local municipal control was the norm—although by the later 1920s federations of local authorities were joining together to build institutions of wider significance such as mental illness facilities. As can be seen from Table 4, by 1927 local government was the largest provider, although these were mainly small institutions, social organisations were very significant while the fully private sector was small in terms of beds. The social organisations included social insurance funds and social / congregational bodies, such as charities like the Red Cross, and religious and ethnic communities—Catholic, Jewish and Orthodox.[69] Among social insurance providers was Kasa Chorych, supported by very good hospitals in the west run by Spólka Bracka, the miners' insurance fund. In 1928 they ran eight hospitals, including the substantial, modern facility at Katowice which had undergone a significant extension, increasing capacity to just under 500 beds for internal, surgical, eye and ear patients.[70] The legacy institutions from the German and Austrian empires tended to be of a higher quality than those left by the Russians and Hungarians—although it was noted that the former German institutions were beginning to age by the later 1920s.[71] In the east, conversely, social insurance hospitals were less prominent, Bialystock did not have any kind of insurance institution until 1933.[72] However, there was an attempt in this region to meet need by the creation of health centres, supported by both the Rockefeller Foundation and by levies from the health insurance fund and offering preventive services and some mobile facilities.[73]

In general, the Public Health Department of the Polish Ministry of Welfare favoured a centralized system similar to that operating in Galicia, for it was seen to provide uniformity and financial stability.

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In 1922 they had proposed taking all hospitals under state control and funding them as far as possible from state taxes.[74] However, many localities resisted this, claiming government preferred large, multi-purpose institutions rather than responding to specific local needs. Critiques of the 1928 Hospital Ordnance suggested it failed to support local initiative which had done much to develop hospital provision over the preceding fifteen years preferring urban new builds over improvement and better administration.[75]

Table 4.4: Hospitals in Poland by Provider, 1927 and 1937

Provider	No Institutions		No Beds	
	1927	1937	1927	1937
State	30	72	6,856	11,873
Local Government	343	283	31,433	37,659
Social Welfare Orgs	207	214	17,391	23,469
Private	76	108	1,633	1,971
Total	656	677	57,313	74,972

Source: Ministerstwo Opieki Społecznej, *Dwadzieścia lat publicznej służby zdrowia w Polsce odrodzonej, 1918-1938*

By 1937 there had been significant expansion of bed numbers especially in the facilities run by the state and the social welfare organisations, for example the Polish Red Cross. This was facilitated by increased state planning and a policy of closing hospitals with fewer than ten beds and, where possible, merging institutions to increase efficiency. For example in Suwalki, a town in northern Poland, the Hospital of St. Peter and Paul

and the Jewish Hospital decided to merge since they already shared the same building.[76]

In Czechoslovakia a plan to nationalise the hospitals in 1920 only included a small number of strategic institutions, mainly in Prague leaving Hungarian-style county hospitals to operate in Slovakia and PKR and municipal control in Bohemia and Moravia. Private institutions were uncommon, although works' hospitals were common in the west, especially in the coal mining areas. However, the most famous company institution was the Baťa Health House in Zlín which brought together health and social services on one site. By 1936 it included partnerships with associations like the Red Cross, the Masaryk League for Combatting Tuberculosis, local leagues concerned with the health of young people and mothers and babies, the Health Centre of the Baťa Works and the District Health Insurance fund.[77] The key success of the institution lay in the way it brought these interests together to get the sick worker into the health system at an early point, thus reducing chronic and recurring illness and bringing down costs for the company and insurance fund.[78]

Despite these initiatives, many municipalities only provided simple hospice-style care in their institutions along with some infectious disease beds—though these might not be segregated. Thus, in 1926 in Bendzin, Silesia, the Rockefeller surveyor, Dr George Bevier, visited the hospital which he found to be:

> …an old institution and under the Russian regime was a sort of "poor law hospital". It has been remodelled to some extent, but is not really satisfactory even now. It has an average of 80 to 90 patients per day, supports a small laboratory and an X Ray… There were many old ladies who were apparently chronics and we were told that it was the only place for old people. However, all were bed cases.[79]

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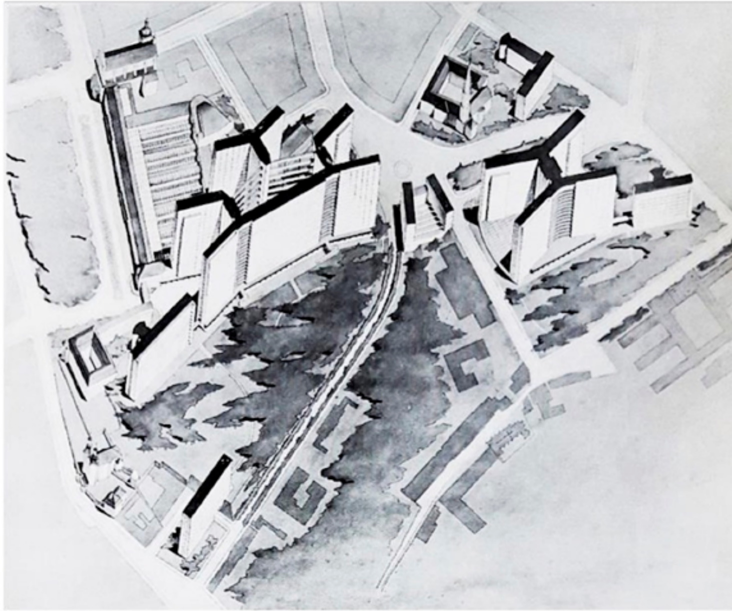
The social care functions of hospitals were very evident in small town Hungary in the early 1930s, the director of a hospital in Miskolc writing that:

> Due to the grave economic situation, disjointed or absent family background, the shortage of food and housing, the hospital today is a shelter for the poor. Especially when the rainy and cold season comes, masses try to get admitted into the hospital… considering the social environment…some 15-20% of the patients treated have no serious illness but we replace their missing home with hospitalisation to give them back the ability to work.[80]

Yet the generally poor quality of much of the provision meant local populations were often sceptical about hospitals, Dr Ryder of Bendzin observing 'that people in this district usually object to going to hospital as they still associate it with dying and prefer to die at home. They have to be educated to go to hospital.'[81]

New-build hospitals were significantly larger, some with more than a thousand beds, and plans were in place for major projects, like that in Prague in the later 1930s. This envisaged creating a new 4,000 bed hospital with 32 clinics spread across two main blocks and a shared central service building, to replace the existing Czech and German university hospitals and medical schools. The new complex, which shared much in common with the project for the Regional Hospital in Lille,[82] envisaged state of the art planning in skyscraper tower blocks connected by bridges. The final 'hospital city' would have a Czech facility with 2,400 beds and twenty-two clinics while the German side would consist of 1,200 beds and ten clinics supported by a substantial shared medical school. The building was not developed but instead a new hospital was created in the suburbs at Motol and began taking patients in 1943.[83]

Figure 4.3: Plan for new Hospital and Medical School, Prague, 1937



Source: J. Havlicek, V. Uklein, B. Albert, 'Study of A Health Centre and University Medical School at Prague', Nosokomeion, IX, 3 (1938), 210. (Reproduced with the permission of the Wellcome Collection)

This new building was underpinned by grandiose planning, including the district plans demanded by the Polish government in 1928 and the proposed Trapl-Albert plan in Czechoslovakia. The latter plan, produced by two medical doctors, Jiří Trapl and Bohuslav Albert, was published in 1933. Drawing on the experience at Zlín and US ideas about hierarchical regionalism, it proposed a merger of smaller uneconomical hospitals with larger provincial ones including the provision of social care and advice all in one institution or at least a set of affiliated institutions run from the centre. It had much in common with the health centre model promoted by Thomas Gruska with its focus on outpatient

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work as the primary function of institutional provision.[84] The plan formed the basis of a hospital bill introduced into the Czechoslovak parliament in 1937 but as a result of the worsening political situation this was shelved and not revived in the changed world of 1945.[85]

In all three countries nursing was in the hands of religious organisations. This was particularly the case in Poland, the most devoutly Roman Catholic of the three nations, but replacing the religious carers was a substantial task. There were few trained lay nurses and training facilities were limited. In 1922, Selskar Gunn found that in Poland nursing was largely 'done by nuns and on account of a strong catholic feeling it is difficult to dislodge them' while the country's leading health reformer, Ludwik Rajchman, thought them the 'most poisonous feature' of the Polish hospital situation.[86] It proved difficult for lay nurses to get training in hospitals dominated by nuns while 'the attitude of the medical profession towards the trained nurses is the same as that found in other continental countries, and it will take time to educate the doctors to the status of the trained nurses.'[87] In the 1920s Rockefeller's Elizabeth Crowell toured central Europe to establish the scale of training facilities—and the problem with untrained nurses—and built lasting networks to establish new schools.[88] However, Crowell and the RF generally favoured the training of public health nurses rather than the bedside staff the hospitals desperately required.[89] Moreover, neither hospitals nor doctors particularly wanted to see the nuns replaced. They were cheap, compliant and dedicated to care—essential for institutions which still dealt largely with the sick, infirm and chronic.[90] Nevertheless, by the late 1930s lay nurses dominated the hospitals of Budapest where the city's eleven public hospitals employed over 1000 nurses only 200 of which came from religious orders.[91]

Overall, the hospital services of these three nations were in the hands of multiple providers, with local authorities at the centre. The role of the central state was limited and outside of the big cities institutional care

was largely in the hands of cash strapped counties and districts who concentrated on meeting the needs of the poorest. Non-state providers played a prominent role in Catholic Poland while employers managed a range of institutions in the industrial west.

Finance

As with provision, a mixed economy of finance existed across central Europe drawing on national insurance schemes, local taxes, state subsidies and private philanthropy as well as obligations imposed by government on employers. As noted, the former German, Austrian and Hungarian areas all inherited national insurance schemes from the former imperial systems but in the Russian territories no state scheme had been instituted before 1914. The benefits from these schemes were generous—certainly in terms of domiciliary and ambulatory services—and included some institutional care. Much of the responsibility for maintaining and treating hospital patients should have fallen to these schemes which were extended during the 1920s. But in each country the proportion of the population covered was low—usually less than 20 per cent. In particular, agricultural workers and peasant proprietors were excluded in all three countries, a major issue when up to three quarters of the population were involved in agriculture.[92] Hospital treatment was seen as expensive—a drain on the insurance funds' reserves—and an uncertain method of treatment. Strict conditions were applied. There was a requirement that institutional treatment would result in a cure, chronic diseases were excluded and benefit was usually time limited to four weeks—while domiciliary treatment could last up to a year. On the other hand, dependents were eligible for hospital treatment in both Hungary and Czechoslovakia.[93]

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The widest scheme was in Czechoslovakia where a programme inherited from Austria was revised and extended on four occasions. It covered all workers with a contract and by 1938 around 3 million workers were included in the scheme, approximately 20% of the population.[94] Contributions were collected from employees and employers in equal proportions and administered by sickness funds overseen by a central social insurance institution and ultimately the Ministry of Social Welfare. The Key benefits were sickness benefit paid for up to a year—including dependents—GP ambulatory and domiciliary care, dentistry, access to a sick fund dispensary and some specialist treatment. Hospital treatment was available on a discretionary basis to cover maintenance and treatment in the lowest class of public hospital ward for up to four weeks. Further treatment beyond four weeks and admission for family members was optional to the fund. Tuberculosis sanatorium treatment could also be recommended where it was felt invalidity might be prevented. All hospital referrals were strictly controlled with GP recommendations approved by the Medical Officer of the Sickness Fund.

> 'The guiding principle laid down by the [Central Social Insurance] Institution make a distinction between cases in which hospital treatment is <u>indispensible</u> and those in which it is indicated by the presence of special conditions; they also enumerate the cases in which hospital treatment is not indicated.'[95]

Patients had to be admitted in the case of acute attacks, infectious diseases and where immediate surgical treatment was required. Ambiguous cases included those where: no specialist was available locally; housing conditions prevented effective treatment at home; the patient was too far from the GP for regular attendance; specialist diagnosis or treatment was required; a 'patient is recalcitrant to medical

or other supervision'. But the GP and the Fund MO also had to ensure that admission was neither 'unduly prolonged' nor ended prematurely, 'negating the effects of treatment'. Exclusions encompassed chronic patients without the prospect of 'substantial improvement'; those who could be treated at home; and 'in particular, patients disabled by an incurable disease'.[96]

The social insurance scheme in Hungary was similar to Czechoslovakia, though it was more restrictive in terms of coverage with the focus on trade and industry, mining and state employees. The self-employed, including peasants, were therefore excluded. Access to benefits was also similar and included dependents who could be eligible for hospital treatment for up to four weeks. As with other schemes the focus was on a GP service closely regulated by the funds with some urban dispensaries, access to specialists including gynaecologists for home births and the whole overseen locally by a District Practitioner. There was significant central state control, with GPs employed on salary and the schemes regulated by statute.

Poland was the most complex as it necessitated the development of a new scheme to cover the whole nation. Although the Austrian system was the preferred model, it proved too expensive to contemplate and instead a watered-down version was rolled out across the nation in 1934. Insurance was compulsory for all wage earners with a contract and for salaried employees up to a certain level. Again, the self-employed, including tenant farmers and peasants, were excluded. Treatment was only available for 26 weeks, while dependents were eligible for just thirteen weeks' cover. In addition to GP, dental and specialist services, funds could grant free maintenance and treatment in the general class ward of a public hospital. As elsewhere, institutional treatment was reserved for those who could not be treated at home, the infectious, those who needed constant observation, and those who would not comply. Unlike the other schemes, there was a

small co-payment element 'intended rather as a means of preventing unnecessary consultations than as a participation of the insured person in the cost of treatment.'[97]

Given the low coverage of the health insurance systems—especially in rural areas—the hospitals remained dependent on traditional sources of income to cover the cost of poor patients, though they were also able to open their doors to paying patients. The poorest patients were charged to the local authorities in Austrian areas or the central state through the counties in Hungarian regions. As in France this proved highly problematic in the era of rampant inflation that undermined the economies of Poland and Hungary until the late 1920s.[98] Municipal allocations—and even insurance payments - were frequently insufficient, either because the flat rate subvention did not cover the cost of patient treatment or because inflation ate into the daily rates paid. Thus, in industrial western Poland in the mid-1920s both midwives and doctors complained that the health insurance fund (the Kasa Chorych) 'pays not only poorly but very slowly'.[99] Even before the depression, Kasa Chorych was failing to meet its obligations, owing the hospitals of Warsaw almost two million zlotys in October 1929.[100] As the depression of the early 1930s peaked across Poland and Hungary, health insurance funds failed to pay to the hospitals and with a rising number of debtors, hospitals had to close wards and limit capacity. In Hungary, this was caused primarily by a shift in the means of paying for municipal patients. Up until 1930 the local authorities had paid a daily treatment rate but after this point a flat rate fee per capita was paid irrespective of the cost of the patient. Hospital managers calculated this was equivalent to a 50% reduction in the tariff while the number of indigent patients increased by around 20% to two thirds of all admissions due to the impact of the depression. One hospital director complained that 'Management by this fixed flat-rate is possible only in one of two ways. First, which the hospital has done, is to reduce the number of

beds according to the state flat-rate; Second is to compromise the level of the treatment. Both of these are anti-social actions' but clearly ones being practiced by managers across the country.[101]

In one Hungarian hospital the number of debtors increased from sixteen in 1929 to 445 in 1936, around half of whom were insured patients and the rest poor patients who were the responsibility of the council.[102] More generally by 1932, Hungarian hospitals were operating at only 78% of capacity and one institution reported that it could only open 200 of its 600 beds due to lack of funds.[103] Although the situation in Czechoslovakia was less serious, the sharp increase in unemployment—to around one third of the insured population in 1933—meant the income of the schemes was substantially reduced. As a result the insured were forced back on to municipal support—also constrained by the depression—or charitable initiatives promoted by the government.[104] For each of these nations, the main weakness in the system was the exclusion of peasants from the insurance scheme. In an echo of the feudal era, it was expected that Hungarian landowners would meet the health costs of their tenants and workers. As the depression put significant downward pressure on agricultural prices and incomes many landowners defaulted on this obligation, forcing their peasantry onto the local state just as income from taxes was falling.

Hospitals set fees based on three classes of patient. In the Hungarian situation, which was similar to that elsewhere, third-class patients paid little or nothing with their costs met equally by the community of residence and the Ministry of Public Welfare (also the case in Slovakia and Polish Galicia). The insured were paid by the insurance fund. First-class patients had a private room, second-class shared two to three bedroom wards. This mix of public and private patients was different to the case in England or France—though similar to the US and Germany—and may have helped to supplement the income of hospitals in the difficult years around 1932 when all institutional funders were struggling.[105] Thus, at

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one small public hospital in north-east Hungary one in six patients paid for their own treatment, mostly in the third-class public wards, while just over ten per cent were covered by the insurance schemes and two thirds by the local state.[106] But there was also concern that potential paying patients were taking advantage of the hospitals to secure free treatment: 'It cannot be the interest of the provider, nor of the doctors, that wealthy patients, misusing the conditions, get beds, food cheaper than hotel prices, and medical care for free, at the public's expense.'[107]

There was also some philanthropic and charitable income within the sector, along with a range of institutions funded partly or wholly by employers and mutual funds. The primary philanthropic providers were religious bodies and ethnic groups who managed much of the chronic care along with services for specific communities. There was also a prominent contribution from the Red Cross. Although the Rockefeller Foundation did not fund hospitals directly it was instrumental in supporting the capital development of services, especially for research and nurse training for example in Prague and Cracow.[108]

Hospitals for a new nation

The countries that emerged from the collapse of the central European empires after 1918 had to build both coherent social, ethnic and political nations and strong states with modern services from their diverse inheritances. For Poland, Czechoslovakia and Hungary this involved the development of social welfare, and particularly health, infrastructure that would distinguish the new nations and build national identity. New hospitals, extended health insurance schemes, and modern social care facilities were created as evidence of the commitment of the new states to their people. In particular, each nation demonstrated a desire

to create a modern, democratic health care system that reflected the power and status of an independent nation, free to make its own choices. This was especially evident in Poland where a myth had developed that the Russians had suppressed their original and well-developed hospital system. Writing in Nosokomeion in the 1930s various Polish authors pointed to the Russian fear of the Polish hospital services that led to them being placed under the dependence of political administrators and to their suppression for 'exclusively political motives'.[109]

Thus these new states attempted to build their identity through their health care policies in a range of areas. Most importantly they sought a uniform and generous health insurance scheme and each attempted to establish this by the 1930s—though often with limited operational effectiveness.[110] They also tried to develop curative hospitals over the caring regimes that dominated in the institutions they had inherited—especially in rural areas. The medical profession attempted to establish themselves as modern and progressive, even ahead of the traditional nations of Europe. In particular through the pages of *Nosokomeion*, they promoted the importance of the health centre model and of hospital led extra-mural services, with a Polish doctor active in public health management stating in 1934 that the 'modern hospital cannot longer be confined to its conventional work; it must dive into the masses and for that purpose it must go beyond its walls.'[111] They also sought to deliver uniform provision across the country both in terms of standard and quality of service and of management and administration. But this proved difficult given the persistence of different administrative systems for the delivery of hospital services in both Czechoslovakia and Poland.

Across the region, we see a focus on the name of the national leader—Masaryk in Czechoslovakia, Horthy in Hungary—and of symbolic national characters, like St Elizabeth. This naming process was particularly applied to new or controversial types of facility, like the Masaryk Homes development in Prague which saw traditional

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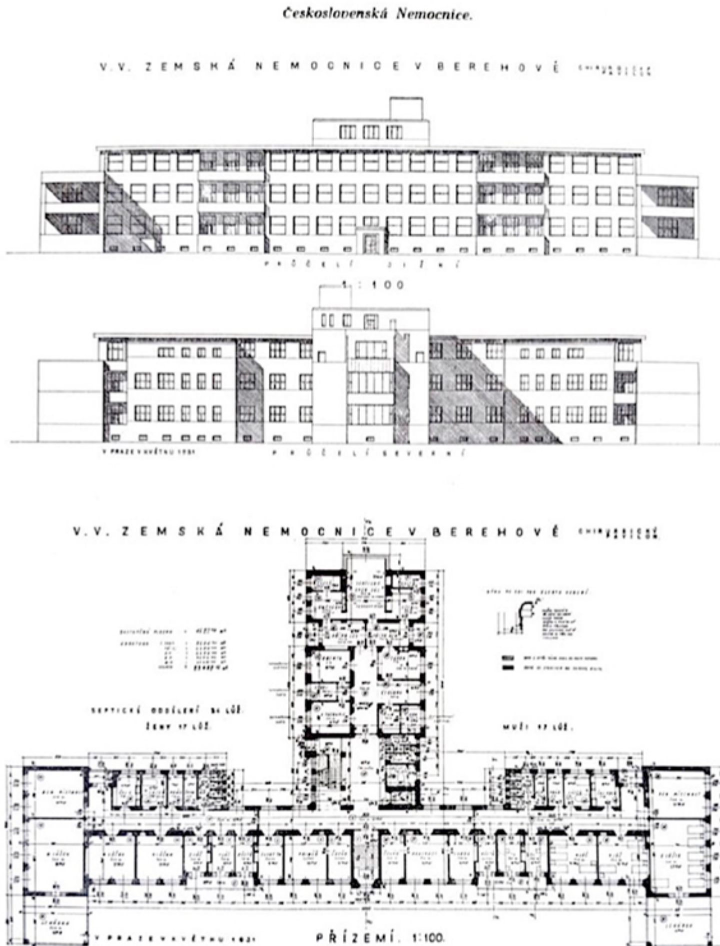
sick houses replaced by new social care facilities.[112] Similarly, in PKR the Czechoslovak state attempted to integrate the new region by improving health facilities—but with a nation building intent. The state had nationalised some of the region's hospitals and focused surpluses from the national insurance scheme on rebuilding projects in the east. Thus, the planned reconstruction of Ruthenia's Berehovo Provincial Hospital included a new maternity unit and a four-storey surgical block for male and female patients. Plans were also in place for three other new pavilions for internal, Ear, Nose and Throat, isolation and VD and skin.[113]

In Hungary, the new medical schools and hospitals were a defiant response to the losses suffered as a result of the treaty of Trianon. In the immediate pre-war period there had been a spate of new public hospitals (seven between 1900-1914) named Erzsébet after the national hero St Elizabeth of Hungary. However, a number of the new hospitals built in the 1920s and 1930s in border areas to replace institutions seceded to neighbours carried highly nationalistic names. The new institution for Bihar county on the Romanian border was named Count István Tisza, the prime minister of Hungary during the First World War who was assassinated at the beginning of the 'Aster Revolution' in October 1918. In Debrecen, where a new medical school was established, the hospital was called the Miklós Horthy Royal State Public Hospital while that in Szikszó took the name Ferenc II Rákóczi after the leader of a failed nationalist uprising of the early eighteenth century. There were at least two other Miklós Horthy hospitals, including an existing institution renamed after 1918.[114]

Further efforts to modernise and nationalise saw attempts to transform hospital personnel, replacing untrained nuns and patient helpers by nursing staff who had completed lengthy, accredited courses. They sought to ease out German, Austrian and Hungarian medical staff (there were still many German doctors in Silesia in the late 1920s),[115] while establishing skill and authority through schemes like the Rockefeller Fellowships and the

Figure 4.4: Plans for Berehovo Provincial Hospital, Ruthenia, 1933



Source: Československá nemocnice, 3,5, 1933, 109 (Reproduced with the permission of the National Library of the Czech Republic)

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establishment of national associations. They drew on western examples, and, where available, western advice and money.[116]

However, ethnic diversity made the creation of a unified health care system nearly impossible. Many cities had two or three large ethnic groups who often set up institutions to provide for their own. Duplication of services remained a severe problem, especially in elite institutions like universities, medical schools and even hospitals. For example, in Czechoslovakia, the German population maintained a prominent role in health provision and as a result both Czech and German speaking doctors were trained and practiced in Prague's main hospital, alternating clinics on a weekly basis. As the Czechs gradually took over Charles University, the Germans formed their own German University and Medical School. Thus when plans were developed for a new hospital in Prague city centre in the late 1930s, two separate buildings were envisaged with a 2,800 bed Czech institution and a 1,200 bed German facility on the same site sharing key services like catering, laundry and laboratories.[117] Jewish populations of the east also established a range of institutions for their own use. In the early 1920s separate nurse training schools existed for Jewish women, Gunn noting that 'in general it may be stated that the mixing of Jewish and gentile pupil nurses in the same school presents great difficulties' and he reported that a separate system for Jewish nurses was planned with schools in Warsaw, Łódź and Wilno where there were large Jewish hospitals to facilitate training.[118] As political tensions mounted at the end of the period the Rockefeller Foundation found that the Germans refused to share a new nurse training institution they were willing to fund and insisted on their own classes in German. They eventually walked out and formed their own school in 1938.[119]

The experience of these three states is paradigmatic of the experience of most of the post-imperial nations of interwar Central and South-East Europe formed by the break-up of the four empires.

These were largely multi-ethnic nations that drew on two or more imperial inheritances. Economically they were rural and as such struggled to raise the levels of finance needed for a modern health care system—a task made more difficult by rampant inflation in the 1920s and by the Great Depression in the early 1930s. But their inheritances also meant they could benefit from the existence of well-established national insurance schemes and a basic hospital infrastructure with professional staff trained mostly in the German/Austrian system. The central states were also determined to modernise and extend the system—with some success. Certainly, by 1938 the number and quality of hospital beds had expanded, with concerted attempts to improve provision in the least developed areas of eastern Poland and Czechoslovakia and in central Hungary. The later 1930s saw each nation, and especially Hungary, launch extensive schemes to extend access to and provision of hospitals, while specialist, and especially maternity services, became more widespread. But delivering this proved to be a significant challenge as economic crisis, political instability and ethnic conflict undermined these schemes, while the rural nature of these countries limited their ability to create a robust health infrastructure. Moreover, the ambition to create unified and universal systems proved very difficult to fulfil, particularly in Czechoslovakia where political and ethnic conflict saw the country become less integrated by the end of the period. The ambition of these countries to create inclusive, modern health care for the new nation foundered on the central state's inability to fund, or create the environment for, a uniform model while the contribution of non-state actors proved patchy and parochial. Yet overall, the interwar period did see these countries improve their hospital services significantly and position health as a major political feature of their political ambitions.

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45. RAC RG6/SG1/395/45/523, Gunn, op. cit. (note 31); RAC RG6/SG1/395/47/528, Gunn, op. cit. (note 31); RAC RG6/SG1/395/49/546, Rose and Gunn, op. cit. (note 31).

46. Václav Veselý, 'Státní epidemické autokolony', Zdravotnická ročenka Československa, IV (1931), 52–53.

47. On Czechoslovakia, Theodor Gruschka, 'The Hospital as a Centre of the Health Work in the District', Nosokomeion, IV,2 (1933), 264-5; on Poland, T. Mogilnicki, 'Le role social du medecin de l'hopital rural', Nosokomeion V,1 (1934), 47–51. See also the health demonstration work in Czechoslovakia in note 39.

48. Tomka, op.cit. (note 11), 128 and 134; Inglot, op.cit. (note 11), ch.2.

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49. For more detail on these different systems see below.

50. See Barry Doyle, 'What's in a Name? What is a Hospital? Part 2' https://healthcarebeforewelfarestates.wordpress.com/2017/08/11/what-is-a-hospital-part-2-whats-in-a-name/ [accessed 13.01.2019]

51. See the discussions of Britain and France in George Weisz, Chronic Disease in the Twentieth Century: A History (Baltimore: Johns Hopkins University Press, 2014).

52. Mental hospitals, infectious diseases and even chronic care are often excluded from the hospital historiography of Britain. See the works in notes 2 and 5 above. John V. Pickstone, Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region (Manchester: Manchester University Press, 1985) is good on provision for all types of physical complaints. For a regional study of mental health provision in the early twentieth century see Alice Brumby, 'From 'Pauper Lunatics' to 'Rate-Aided Patients': Dismantling the Poor Law of Lunacy in Mental Health Care: 1888-1930' (unpublished PhD thesis: University of Huddersfield, 2015).

53. Brian Abel-Smith, The Hospitals, 1800-1948: A Study in Social Administration in England and Wales (London: Publisher missing 1964); Christian Chevandier, L'Hôpital dans la France du XXe Siècle (Paris: Perrin, 2009); Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century, (New York: Basic Books, 1989).

54. This is explored by Lucey, op. cit. (note 24).

55. Witold Przywieczerski, 'Les Hopitaux en Pologne', Nosokomeion, V, 1 (1934), 140-143.

56. Ministerstwo Opieki Społecznej, op. cit. (note 18), 97.

57. Zdravotnická ročenka Československa, op. cit. (note 18).

58. Magyarország gyógyintézeteinek évkönyve, op.cit. (note 18); RAC RG1.1/750C/386/2/22 'Debrecen School of Nursing, 1925-1933, 1936'.

59. Przywieczerski, op. cit. (note 54), 141.

60. Hynek Pelc, Organisation of the Public Health Services in Czechoslovakia (Geneva: League of Nations, 1925). Grombir, op. cit. (note 38)

61. Grombir, op. cit. (note 38).

62. RAC RG6/SG1/395/45/523, Gunn, op. cit. (note 31), 158.

63. Grombir, et al, op. cit. (note 8); RAC RG1.1/750A/386/2/11-12, 'University of Szeged'.

64. For the situation in the US, England and France see Stevens, op. cit. (note 52); Doyle, 'Healthcare', op. cit. (note 5).

65. RAC RG6/SG1/395/45/523, Gunn, op. cit. (note 31), 153.

66. Ibid.; I. Dobrossy, 'Miskolc infrastruktúrájának modernizálása és a Speyer Bank-

kölcsön felhasználása', in A. Herman (ed.) A Hermann Ottó Múzeum Évkönyve. (Miskolc: Herman Ottó Múzeum, 1996), 423-450. The loans from the US Speyer Bank, formed part of a League of Nations sponsored financial restructuring of Hungary in the mid-1920s which focused on lending to improve industrial and state infrastructure. Tamás Magyarics, 'Balancing in Central Europe: Great Britain and Hungary in the 1920s', in Aliaksandr Piahanau (ed.), Great Power Policies towards Central Europe, 1914-1945, (E-IR Publishing) https://www.e-ir.info/2019/03/13/balancing-in-central-europe-great-britain-and-hungary-in-the-1920s/.

67. Following post-war hyper-inflation in Hungary that made the korona effectively worthless, the Pengő was introduced in 1927 as part of the economic restructuring promoted by the League of Nations. It proved relatively successful in stabilising the economy and trade and controlling inflation until the Second World War.

68. Zoltán Takács, 'Horthy Miklós Városi Közhórház, Nagykanizsa', Magyar Kórház, Supplement to Vol. V (1936) 'Register of Hungarian Healthcare Institutions', 247-62. See also Emil Wallner, 'Veszprém megyei város közkórháza', Magyar Kórház, Supplement to Vol. V (1936) 'Register of Hungarian Healthcare Institutions', 263-78 for extensions funded by Speyer loan, 1930-33.

69. Maciek Godycki-Ćwirko, Marek Oleszczyk, and Adam Windak, 'The Development of Primary Health Care in Poland from the 2nd Republic to the Round Table Agreement (1918–1989)', Lekarz rodzinny, XII, 1 (2010), 29-36.

70. S.B Walsh, Handbook of Employees Service Social Insurance Giesche Spółka Akcyjna (P.P. 1928)

71. Ministerstwo Opieki Społecznej, op. cit. (note 18), 96.

72. Magdalena Grassmann, Agnieszka Zemke-Górecka and Kędra Bogusław. 'Szpitalnictwo cywilne w województwie białostockim w II Rzeczpospolitej'Miscellanea Historico-Iuridica, 8 (2009), 141-2.

73. Przywieczerski, op. cit. (note 54), 141; Veselý, op. cit. (note 45).

74. RAC RG6/SG1/395/47/528, Gunn, op. cit. (note 31), 11.

75. Przywieczerski, op. cit. (note 54), 142.

76. Ibid., 136. This contrasts with England and the US where private hospitals resisted merger or closure. Barry M. Doyle 'Competition and Cooperation in Hospital Provision in Middlesbrough, 1918-48', Medical History, 51 (2007), 337-56; Stevens, op. cit. (note 52).

77. Vlad. Uklein, B. Albert, D. Tolar, 'Das Bata-Haus Der Gesundheit in Zlin', Nosokomeion, VII, 2 (1936), 128-39.

78. Uklein, Albert and Tolar, op. cit. (note 77).

79. RAC RG1.1/789J/386/4/50, 'Poland, Health Demonstrations: Bendzin Report, 1926. Memorandum of Visit to Bendzin, Poland, Bevier, November 7-8, 1925', 12-13.

80. Gyula Jäger, 'Szociális takarékosság a racionalizált közkórházban', Magyar Kórház, Supplement to Vol. IV 1 (1935) 'Register of

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Hungarian Healthcare Institutions', 7.

81. RAC RG1.1/789J/386/4/50, 'Poland, Health Demonstrations: Bendzin Report, 1926, op.cit. (note 79), 15.

82. https://bmdoyleblog.wordpress.com/2014/02/06/pie-in-the-sky-paul-nelsons-design-for-the-cite-hospitaliere-de-lille-1932/ [accessed 2.2.2019]; Julie Willis, Philip Goad and Cameron Logan, Architecture and the Modern Hospital: Nosokomeion to Hygeia (London: Routledge, 2019), 188-202.

83. J. Havlicek, V. Uklein, D. Albert, 'Study of A Health Centre and University Medical School at Prague', Nosokomeion, (1938), 202-221; Hlaváčková,Svobodný, Bříza, op. cit. (note 29).

84. See for example, Theodor Gruschka, 'Die Praventiven Aufgaben Des Krankenhauses', Nosokomeion, IV, 1 (1933), 6-13.

85. Masova, op. cit. (note 9).

86. RAC RG6/SG1/395/47/528, Gunn, op. cit. (note 31), 26.

87. RAC RG6/SG1/395/47/528, Gunn, op. cit. (note 31), 28.

88. Elizabeth D. Vickers, 'Frances Elizabeth Crowell and the politics of nursing in Czechoslovakia after the First World War', Nursing History Review, 7, 1 (1999), 67-96.

89. For reports by Frances Crowell on nursing in Poland see the files in RAC RG1.1/789c/386/3/29-32 especially 'Memorandum re: sick nursing and health visiting, 1922' and 'University of Cracow: Public health and bedside nursing'.

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91. Béla Ródé, 'A székesfőváros közkórházainak ideiglenes alkalmazottai', Magyar Kórház, Supplement 11, Vol. VI (1937) 'Register of Hungarian Healthcare Institutions', 207-14.

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93. ILO, op. cit. (note 7); Inglot, op. cit. (note 11).

94. LoN, op. cit. (note 19).

95. ILO, op. cit. (note 7), 156.

96. ILO, op. cit. (note 7), 47-56.

97. ILO, op. cit. (note 7), 234.

98. For the situation in France see Barry M. Doyle 'Contrasting accounting practices in the urban hospitals of England and France, 1890s to1930s', in Hüntelmann and Falk (eds), op. cit. (note 3).

99. RAC RG1.1/789J/386/4/50 Poland Health Demonstrations: Bendzin Report 1926, 11.

100. Zofia Podgórska-Klawe, Szpitale Warszawskie, 1388-1945, (Warsaw: Państwowe Wydawnictwo Naukowe, 1975), 292.

101. Jäger Gyula, 'Borsodvármegye Erzsébet közkórháza, Miskolc', Magyar Kórház, Supplement to Vol. IV (1935) 'Register of Hungarian Healthcare Institutions', 209-222.

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104. Pavel Victor Ovseiko, 'The Politics of Health Care Reform in Central and Eastern Europe: The Case of the Czech Republic', (Unpublished D.Phil. thesis: University of Oxford, 2008), 64-7.

105. George C. Gosling, Payment and Philanthropy in British Healthcare, 1918-48 (Manchester: Manchester University Press, 2017); Olivier Faure and Dominique Dessertine, Les cliniques priveés: Deux siècles de success, (Rennes: Presses Universitaires de Rennes, 2012); Stevens, op. cit. (note 52); Hüntelmann in Hüntelmann and Falk, op. cit. (note 3).

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109. Przywieczerski, op. cit. (note 54); Boleslaw Jakimiak, 'La Legislation Polonaise Concernant les Hospitaux et son Development, Nosokomeion, 2 (1934), 106-119 at 110.

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111. T. Mogilnicki, 'Le role social du medecin de l'hopital rural', Nosokomeion, V, 1 (1934), 47-51.

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113. Svatopluk Veselý, 'Rekonstrukce zemské nemocnice v Berehově', Československá nemocnice, 3,5, 1933, 107-10.

114. Magyarország gyógyintézeteinek évkönyve, op. cit. (note 18).

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