

Essay Review

Public Health in Norway 1603–2003

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Det offentlige helsevesen i Norge 1603–2003. Vol. 1: Ansvar for undersåttenes helse 1603–1850, by **Ole Georg Moseng**; *Vol. 2: Folkets helse—landets styrke 1850–2003*, by **Aina Schiøtz**, co-author **Maren Skaret**, Oslo, Universitetsforlaget, 2003, vol. 1, pp. 367, illus., kr 349 (83-15-00348-6), vol. 2, pp. 640, illus., kr 449 (82-15-00349-4) (hardback 2 vol. set 82-15-00340-8).

During the first years of the seventeenth century many parts of the kingdom of Denmark-Norway were ravaged by the plague. The Crown's responses to these epidemics can be interpreted as the incipient germination of public health policy in the two countries. Quarantine was adopted as a general means to protect society at large, not just the royal court, against the spread of disease. And the activities of trained medical personnel received official promotion. For example, in July 1603 a royal patent awarded the Danish-born physician Villads Nielsen a lifelong annual income from the public purse to provide medical services to the inhabitants of Bergen, the largest town in Norway at the time. Here it must be remembered that until 1814 Norway was a dependent province in the state of Denmark-Norway and ruled by the Danish monarch in Copenhagen. None the less, the royal award to Nielsen was subsequently used to justify the official celebration of 400 years of public health services in Norway in 2003. The timing of the jubilee was propitious. In 2003 the country's infant mortality was one of the lowest in the world, its life expectancy one of the highest. Its expenditure on health care in relation

to national product was also one of the world's highest, and a former prime minister, Gro Harlem Brundtland, was installed as Secretary-General of the World Health Organization (WHO). The quarter-century of state engagement in public health was a substantial affair with exhibitions, lecture series, and conferences organized throughout the country. Many of these activities were short-lived, but there were also lasting spin-offs. Parliament funded the establishment of a national museum for health and medicine as a permanent centre of information and public learning.¹ Academic research and teaching in the history of public health and medicine—hitherto much neglected—were strengthened by the establishment of professorships and research groups.² And an “official” history, commissioned by the Ministry of Social Affairs and Health, appeared.

The overarching theme of the two-volume study is indicated by the subtitles—“responsibility for subjects’ health” and “a healthy population, the country’s strength”, namely, the close connection between public-health provision, the commonweal, and state/nation-building. At first the expression of

¹The museum is a division of the National Museum of Technology in Oslo and opened officially in June 2003. See <http://www.tekniskmuseum.no/medisinskmuseum/index.htm>

²The medical faculties in the universities of Bergen and Oslo have recently established dedicated professorships in medical history. See also the website of the research group in Bergen. <http://www.rokkansenteret.uib.no/vr/HMH/>

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this relationship was limited to legislative regulation of medical practice. Thus, the law of 4 December 1672 required physicians to be accredited by the medical faculty of Copenhagen, the state's only university, and assigned them controlling authority over both apothecaries and midwives. It furthermore contained a clause of far-reaching portent: practising physicians were required to provide free medical care to the poor. Norwegian reality, however, lagged far behind the law's promise. At the time, and for decades thereafter, there were only five physicians in the entire country; not until the 1740s was there a single qualified midwife.

The establishment of a *collegium medicum* in Copenhagen in 1740 marked the beginning of state initiatives to combat disease and to improve the health of the population that accelerated in the last quarter of the eighteenth century and culminated in the years immediately before the political upheaval of 1814, when Norway was separated from Denmark and forced into a dynastic union with Sweden. The central instrument of state intervention in health matters, strongly inspired by Johann Peter Frank's concept of medical police, was a network of medically trained royal civil servants, who administered state policies and reported on medical conditions in their areas. By 1810 the corps of medical officers numbered thirty-five; at that time there were around 100 practising physicians in the entire country. Between 1811 and 1826 Norway (self-governing from 1814) built up its own training institutions for medical personnel: the medical faculty in the newly established University of Christiania (Oslo) in 1812, the state school for midwifery in 1818, and in 1826 the national teaching and research hospital, *Rikshospitalet*. The fledgling public-health system had few tangible activities but it did undertake two ambitious projects. In 1810/11 obligatory vaccination against smallpox was introduced and carried out thereafter with considerable efficacy despite a number of technical shortcomings and some popular resistance. Within two generations this first national programme of disease prevention had virtually eliminated the scourge from Norwegian

society. Also in 1810 came a midwives' code that defined qualifications and established a state-wide network of publicly paid, qualified midwives. Although the service was incomplete for many years and its effect on infant or maternal mortality difficult to measure, it exemplified the provisioning, or welfare, face of state public health that would become particularly prominent in the second half of the twentieth century.

In the initial decades after 1814 the demands of nation-building—constructing the political, economic, and cultural foundations of the new state—consumed the energy and resources of the Norwegian government. Its activity in health matters was largely limited to continuing smallpox vaccination, expanding medical training, and increasing the number of district medical officers (sixty-three in 1836, seventy-nine in 1854). However, as elsewhere in Europe, the incursion of cholera in the 1830s and 1840s provoked a comprehensive re-thinking and re-building of the framework of public health. Recommended by a royal commission dominated by physicians, the Public Health Law of 16 May 1860—"law on public health boards and on measures relating to epidemic and contagious diseases"—laid down basic principles and institutions of primary health care, preventive health care, and local public-health administration that lasted until the 1980s. The 1860 law was an elastic amalgam of compulsion and discretion, centralism and localism, bureaucratic-professional paternalism and democratic populism. Each commune was required to establish a board of health, composed of representatives from local government and the community, which was presided over by the district medical officer, who represented the central health authority. The board's mandate was comprehensive—"anything that influenced health conditions in the community"—a formulation that could accommodate both miasmatic-sanitationist and contagionist-bacteriological approaches. Its power was formidable in theory; its decisions, if passed by the communal council and approved by the central government, had the force of law. At the same time, the activities of health boards were

constrained by the economic resources and political preferences of communal councils. The 1860 law enabled proactive public-health policies in Norwegian communes but in general did not specifically compel them. For many years the central health authority was tiny with few resources, and its primary activity was compiling and publishing national health statistics based on the annual reports of the district medical officers. Consequently, the actual practice of public health varied a great deal throughout the country. In big towns such as Bergen and Christiania (Oslo) prophylactic and therapeutic health services became highly developed in keeping with current medical thinking and technology, whereas in many rural communes health boards were moribund over long periods.

From the late 1880s professional, charitable, and political associations increasingly advocated public-health proactivism. The Norwegian Physicians' Association was established in 1886 for the express purpose of promoting medical influence—specifically the importance of public and private hygiene—in society. The professional organizations for midwives and nurses (founded in 1908 and 1912 respectively) pushed in the same direction. Democratization and the rise of an organized labour movement occasioned the passage of interventionist social legislation regarding schools, care of foster children, food inspection, factory inspection, building construction, and the like that frequently assigned a consulting or even supervisory role to local health boards and district medical officers. The establishment of the national women's charity, Norwegian Women's Public Health Association (*Norske Kvinnens Sanitetsforening*, or NKS), in 1897 gave rise to a large, popular public health movement that mobilized both considerable sums of money and thousands of volunteers, and was a bulwark of Norwegian public health for over half a century. The NKS supported many projects from childcare clinics to nursing homes, but its central activity was the fight against tuberculosis.

The national campaign to stop TB, which at the time was the country's most frequent cause of death and especially widespread among young

adults, began in 1900 with parliamentary legislation that gave public-health authorities wide powers over individuals in the name of protecting society from a dreadful scourge. District medical officers (health boards) were to register and monitor all persons suffering from TB; they could order specific hygienic controls (for example, disinfection) and compel hospitalization, if necessary by police force. In the following years a network of mostly publicly owned sanatoria and hostels was built; at its peak it included over 100 institutions with over 3000 beds. Whereas the official public-health institutions executed the legislation, the NKS, together with another charity, the National Association Against Tuberculosis (1910), devoted itself to a massive propaganda effort to educate the population about this and similar contagious diseases and in particular about the proper hygienic behaviour that would check infection. Legislative compulsion was extended to include mandatory chest x-ray screening from 1942 and mandatory tuberculin testing and BCG vaccination from 1949. The success of the national anti-TB campaign, in its heyday unparalleled in intensity and degree of intervention, was ensured by the development of antibiotic therapy from the 1940s; in the early 1950s TB accounted for a bare 2 per cent of all deaths, and by the 1960s it had virtually disappeared.

In 1912 parliament legislated a reorganization and substantial expansion of the state medical service. The number of primary medical officers (municipal and rural districts) was increased from 161 to 372 and a new office of county medical officer was created to be an intermediate link between the district and the central directorate of medical affairs. The position of the directorate in the central administration was also upgraded within the Ministry of Social Affairs. Three years earlier mandatory sickness insurance for about one-third of the country's active workforce had been enacted with its own system of administration. The two laws signalled a general increase of public engagement in health matters that included the construction of hospitals and public baths, school physicians, and centres for counselling and medical control of pregnant women, infants

and young children. The active public discussion of health questions took up new matters such as nutrition (the famous “Oslo breakfast”) as well as the controversial issues of social, sexual, and racial hygiene. Throughout most of the interwar period, however, national economic stagnation so weakened public finances that many programmes stagnated or were even truncated. A re-evaluation and renewal of state public-health initiatives began with the Labour Party’s assumption of governmental power in 1935, but the efforts were suspended by the coming of war and occupation.

The construction of the Norwegian welfare state after 1945 under the leadership of the social-democratic Labour Party also occasioned a radical reorientation of public health policy. Until his retirement in 1972 these changes were driven by the medical-political vision of the Health Director, Karl Evang, himself a physician, which derived from left-wing social medicine of the 1930s but also was inspired by British and American public-health practices that Evang had experienced during wartime exile. In this vision public health was an integral part of the welfare state. It was to be egalitarian and universal: all Norwegians, regardless of personal income and place of residence, would be guaranteed both good protection against disease and high-quality treatment of sickness and injury financed by the state. It would also be based on the expansive definition of good health adopted by the WHO in 1948: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Achievement of these goals required the expansion of preventive health care, which would be carried out by district medical officers (*distriktsleger*) assisted by specially trained public health nurses (*helsesøstre*) and supervised by county medical officers (*fylkesleger*). It also required the rationalization of the country’s many small, local hospitals into a network of large, central hospitals with special care institutions for the chronically ill. To be effective, both reforms needed a sufficient supply of well-trained health specialists—physicians and nurses—as well as considerable monies for capital investment and day-to-day operations.

Over the following three decades a steady stream of legislation established a co-ordinated system of comprehensive public health and related welfare services: school dental services (1947), general nursing (1948), universal sickness benefit (1956), public-health nursing (1957), school medical services (1957), home nursing (1959), occupational rehabilitation and disability (1960), mental health and psychiatric care (1961), nurse auxiliaries (1963), universal social security benefit (1966), hospitals (1969), and public health centres (1972). The size of the health sector (public and private) grew enormously. Between 1950 and 1976 its share of the gross national product rose from 3.5 per cent to 8 per cent; the number of certified physicians and nurses doubled; in many communities hospitals and health services became the largest single employer.

For many years the growth of this comprehensive public-health system was managed by a strong central administration—the Health Directorate—controlled by professional medical experts. In the 1970s this so-called Evang system was increasingly attacked as a technocracy that was unsuited to the new political-ideological climate that emphasized popular participation, co-determination, and decentralization. The upshot of a decade of intense debate was a radical political-administrative transformation that was supposed to make the public health system more responsive to local interests: the 1982 law on communal health services disbanded the century-old system of state medical officers and transferred ownership of and administrative responsibility for almost all health services—physicians, public health centres, home nursing, rehabilitation, midwifery, nursing homes (1988)—from the state to the communes; control of the central hospitals was assigned to the counties. The state’s formal role was reduced to laying down the general legislative framework and supervising its application; in 1992 the central administration’s Health Directorate became the State Health Inspectorate.

Despite the epochal organizational transformation, the health sector continued to expand strongly, driven by consumer demand,

changes in lifestyle and population composition (for example, ageing), and medical technological advances. In 1980 public health services employed 181,000 persons, in 2000, 356,000. The cost to the public purse also doubled during the same period: from 36 milliard crowns (6.4 per cent of GNP) to over 70 milliard crowns (8.5 per cent of GNP). Neither did the 1982 law settle the issue of how high-quality health services could be provided equitably and cost-effectively. Controversy over the appropriate scope, quality, cost, and purveyance of public health services has become a fixture of the country's political discussion. In recent years "re-organization" has become a dreaded term for many public-health employees. The most substantial change was carried out in 2002. Twenty years after the "revolution" of 1982, the state took over direct control of all hospitals in the country on the grounds of ensuring equality, improving quality, and reducing expenses. The consequences and permanence of this étatist move are still unclear; however, the simultaneous establishment of the country's first dedicated Ministry of Health underscores the central importance of public health in modern Norwegian society.

Moseng and Schiøtz present a rich historical portrait of "the public health service" in Norway in non-technical language. It is an ambitious portrait, including actual health conditions and changing popular attitudes towards disease and medicine as well as health-care institutions and political activities. A common thread running through both volumes is the decisive role of the health professions in shaping the content and discourse of Norwegian public health. Until the end of the nineteenth century this influence was exercised exclusively by male physicians; thereafter nurses and other female-dominated healthcare occupations also contributed. An innovative strength of Schiøtz's volume is its use of a gender and class perspective to illuminate internal professional conflicts in the health

sector.³ Thus, the professional hierarchy of health care derives not only from differences in medical expertise but also from differences in sex and class. The tension between physicians and nurses partly originates in the contrasting sexual composition of the two occupations. Job and wage competition between regular or specialized nurses and nurse auxiliaries also reflects long-standing differences in the predominant social and educational background of the two groups. Notwithstanding internal rivalry, the expansion of health-care professions has for Schiøtz been a major contributor to the improvement of women's position in Norwegian society.

Inevitably, in a work of this scope details on specific topics are sometimes sketchy, reflecting the state of research as well as the authors' choices within allotted time and length. Readers from Bergen or western Norway will certainly notice, and regret, that concrete examples are predominantly drawn from Oslo or eastern Norway. For the non-Norwegian reader, however, the major shortcoming is the authors' pronounced self-absorption in their assigned subject, a typical characteristic of commissioned history-writing.⁴ Their engagement with the international setting and the larger political context of Norwegian public health is weak. Does the Norwegian case really fit into the "nordic model", which in fact is largely Sweden extrapolated? Was the Norwegian path "exceptional"? If so, how and why and so what? What do the choices taken in this fundamental dimension of social life tell us about "the very political traditions" of the country?⁵ A fuller consideration of such issues—in, for example, a reflective general conclusion—would have added analytical weight to the authors' story. All told, though, Moseng's and Schiøtz's account will clearly inform, stimulate, and provoke additional research in the history of Norwegian public health; and that is no mean achievement.

very common in Norway; they are usually written by university-trained historians. See William H Hubbard, *et al.* (eds), *Making a historical culture: historiography in Norway*, Oslo, Scandinavian University Press, 1995.

⁵Peter Baldwin, *Contagion and the state in Europe, 1830–1930*, Cambridge University Press, 1999, p. 563.

³For example, this perspective was completely absent in the official history that marked the centenary of the Norwegian Physicians Association. Øivind Larsen, Ole Berg, and Fritz Hodne, *Legene og samfunnet*, Oslo, Universitetet i Oslo, 1986.

⁴Commissioned histories to mark jubilees of towns, institutions, organizations, companies and the like are