The history of health care in Mittenälvsborg – then, now and afterwards

Part 1 – The time of district doctors (Provinsialläkartiden)

The time until 1920

The period until about 1800 can be denoted as a time when the Swedish economy was in a bad state. The population was then entirely dependent on agriculture. The majority lived on the margin and were extremely sensitive to reverses in the form of wars and poor weather that often resulted in crop failure and a year of famine. Deficiencies in industry, hygiene and the residential environment made people susceptible to various diseases and epidemics. This period can therefore be called the era of epidemics and famines. These factors caused considerable increases in mortality. The mortality was about 30 per 1000 inhabitants with peaks in the middle of the 1700s of 55 per 1000, and in the beginning of 1800s of 40 per 1000.

The period 1800-1920 was characterized by the epidemics and famine's still being in the picture. Smallpox, dysentery, cholera and typhus occurred at longer and irregular intervals during most of the 1800s, but the trend was clear. The mortality peaks were no longer so high or so common. The improvement in people’s health was clearly demonstrated in medical statistics. Between the 1800 and 1920 the average life expectancy increased in Sweden from 37 to 60 years. Women lived on average somewhat longer than the men.

The growth towards a longer average length of life was the same to both sexes. An important underlying explanation was that mortality earnestly begun to fall during the first decades of the twentieth century.

This was the beginning of a trend against increased length of life.

At the beginning of the nineteenth century, the infant mortality (i.e. mortality in the first year of life) was still very high. In the years around 1820 one baby in
four died in Sweden, but a hundred years later, fewer than one in ten died. During this period, the infant mortality accounted for much of the total mortality. At the start of the 1800s, there was a large difference in mortality town and countryside. Depending on population density and sanitary, economic and social circumstances, mortality was substantially higher in the towns compared with the countryside. However, during the 1800s the towns developed better sanitation. It was also in the towns that the medical organisation was first built up. This was reflected in a strongly falling mortality in towns. Although the mortality also decreased in the countryside, it took place more slowly, accounting for people surviving longer in the towns than in the countryside.

The above-mentioned factors contributed to a reduced the risk of epidemics. In the years around 1900, those big epidemics, as had earlier hit Sweden, had substantially played out their role. However, tuberculosis was not yet under control. Certain, more sporadic epidemics would also become more prominent, such as the Spanish influenza pandemic in 1918, and poliomyelitis on many occasions in the 1900s. To sum up, the period 1800 to 1920 can therefore be called the “era of diminishing epidemics”. A popular movement against tuberculosis was started and the first sanatoria were built as a private initiative at the start of 1900s, with the county council later taking responsibility.

The end of the 1800s and the beginning of the 1900s saw great developments in knowledge about causes of disease and thereby also their treatment. The midwives' numbers were increased as was their knowledge. Vaccination against smallpox was successful. The number of district doctors increased at a slow rate and were relieved of much administrative work when the first medical officers of health took these on. The politicians better informed about how the society could be helped to avoid the epidemics, and what could contribute to improving the public health as above mentioned.
The period 1920 to 1960

For Sweden the period 1920 to 1960 meant a trebling of GNP per head, in real terms. This development created good conditions for the population's standard of living and welfare. An important factor behind the economic growth was the change from agriculture with lower productivity to the industrial sector, where the productivity was appreciably higher. In this perspective, the 1930s can be seen as the critical point, since the numbers working in industry then passed the numbers who worked in the agriculture.

When it comes to the economic growth rate, the period 1920-1960 is divided into two different phases. The first covers 1920 to 1945, the second 1945 to 1960. During the first phase, the growth was held back by depression and wars, while the picture was different during the later phase. After the end of the war in 1945 a long period of expansion was came, that would continue until after 1960.

Within health care, several private and voluntary initiatives of various kinds were undertaken. Examples of such private initiatives were the health care that the factories managements conducted in the factory societies such as the Red Cross's nurse education and private hospitals, the association Mjöldroppen (Milk drop) and local May flower committees. (Majblommekommittees). (“May flowers” are sold since 100 years often by children and for childrens aid. “Majblomman” is Swedens biggestt organization for collecting money to help poor children. It was established in 1907 and has 800 local committees. These initiatives were still in full force during the period between the wars. Once the socio-economic situation became more favourable and the public resources more extensive, it often happened that the State, county councils or municipalities took over the private activities.

Between the wars, thoughts and plans were formulated for a Swedish welfare state with improved public health. But economic realities and major obstruction against social reforms led to only a small part of the plans being implemented. The post-war period's more favourable economy offered appreciably better conditions to implement those plans. In line with the improved economy, resistance to social reform decreased.

Axel Höjers plans concerning “open care” reorganization were a clear example of how earlier negative attitudes during 1950s changed to general acceptance. Open
care moved increasingly over to the hospitals, that under county council management had grown much stronger. At the end of 1930s hospital doctors had become as numerous as the district doctors.

The State's interest in health care was low. That resulted in stagnation in the numbers of district doctors and psychiatrists. The district doctors decreased to 12% of total number of physicians and many vacancies remained unfilled.

The county councils, who had powers to levy tax, used this to improve health care. Midwives and nurses increased in numbers. Mother and child health care advanced. These activities had the county councils as responsible authorities. Programmes of child vaccination started during 1950s resulting in a decrease of children’s diseases.

The failure of open care to develop outside hospitals was noticed by Axel Höjer, chief of National Board of Health and Welfare during the 1940s. His vision of one district doctor per 4000 inhabitants and surgeries with several doctors was not implemented owing to obstruction from politicians and from the physician’s collective, that now was dominated by hospital doctors. During the 1950s, several official reports worked against a revival of open care in the spirit of Höjer.

The period 1920 to 1960 was marked by a clear increase in the standard of living in the form of better hygiene and residential environment, social welfare and education, that in the end resulted in improved public health. An expression of the improvement in public health was the increased average life-span. During the 1800s and until 1920 there had been a 100% increase in the average life-span in Sweden. At the latter time, the population achieved on average an age of 60 years – longer for women and lower for men. The rise in life-span continued after 1920, but naturally it could not increase at same rate as before. In 1960 the mean life-span amounted to approximately 75 years for women and to approximately 70 years for men.

The transition from a Sweden with economic weakness to a welfare society also meant a new panorama of diseases. The previous infectious diseases were definitively back, while cancer, heart and blood vessel diseases and the entire field of “welfare” diseases increased appreciably. Tuberculosis was still a threat as was pneumonia. Diphtheria and scarlet fever were periodically common. One
infection relatively new in Sweden disease was poliomyelitis which came in waves during the emergence of the welfare society, partially to break the pattern. Effective cure against the infectious diseases came firstly when antibiotics were introduced in the 1940s. Antibiotics for scarlet fever, but surely immunization for diphtheria and poliomyelitis.

**The 1960s**

In historical illustration, the period after the second World War seems until beginning of 1970s as a period of uniquely rapid and even economic growth. Growth was quickest the during the 1960s. The golden 1960s were years with abnormally favourable conditions. The economic growth created resources that permitted a considerable increase of public as well as private consumption. The economic realities could now meet the social aspirations. The public sector was enlarged. It mainly concerned public central activities such as health care, social care and education. During 1960s the expansion of health care was noticed in several areas, especially in the strong increase in numbers of hospital doctors, district doctors and doctors in the country as a whole. It became also apparent characteristic that, to a large extent, it was female labour that applied for jobs in the public sector. Women had already begun to go out to work in greater numbers in the 1950s, but by the 1960s this began to have a major impact.

The expansion of child care particularly made it easier for married women to be gainfully employed. In turn, this led to bigger household incomes and choices regarding private consumption. Possibilities of better accommodation, food and hygiene resulted, for the most part, in improved public health and increased average life-span. The 1960s was also a decade characterized by structural transformation, with people moving from sparsely populate areas to large towns. It was during this decade that the expanding suburbs Lerum, Floda and Gråbo began to take shape, which among other things resulted in more posts for district doctors.

Attitudes and expectations during the 1960s became firmly rooted and continued to grow. People found it difficult to adapt to the changed economic reality of weakened trade conditions in the 1970s. It follows that the success during the 1960s indirectly contributed to the problems in the 1970s.
General health insurance was introduced in 1955. People would be safe even when they fell ill. The “seventh-kronor reform” was confirmed. To visit the health care system would cost nearly nothing for the population. Both reforms were expensive.

Investigations which followed on Axel Höjers visions of the 1940s about future operational and expanded open care resulted in amendments to law and broken promises. The doctors became socially secure with tolerable hours of work. The schedule with 42.5 hours a week was introduced. Improved education and supplementary training for the doctors within the working day became possible. The salary structure allowed doctors to pursue work other than direct patient care, and this was encouraged in the new directives for the formulation of care e.g. initiatives within preventive care.

With the regulation of working time including out-of-hours work, the total time that doctors worked was nearly halved. Vacancies were not all filled and the interest in becoming a district doctor fell. The education system had not fully developed in that time. According to the new intentions it took 10 to 12 years to “make” a competent doctor. The transition rules made the district doctor’s job unattractive. The education of general practitioners then became one of the biggest problems for the near future in order to implement the new objectives of changed open care.

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Interviews, personal documents, lectures

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