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INTRODUCTION

Imperial and post-imperial healthcare before welfare states

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ABSTRACT

The goal of this special issue is to connect work done in colonial and post-colonial history and in European history through a focus on imperial and post-imperial healthcare. To date, imperial and post-imperial histories of healthcare have focused overwhelmingly on developments in European colonial empires. Europe's land empires, such as those of Central and Eastern Europe consolidated by Austria-Hungary and Prussia, have received comparatively less attention in English-language scholarship. This introduction highlights key debates in imperial and post-imperial histories of healthcare, and brings material and epistemological transformations in health and social welfare across different imperial formations and their successor states into dialogue. The editors also delineate some of the challenges and payoffs of a comparative approach in relation to the articles in this special issue, which encompass experiences in 10 imperial and post-imperial states, *ca*. 1870 to 1970. Finally, the editors review the articles, identifying a set of connecting themes that offer opportunities for future research making global comparisons.

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This special issue originated in the 'European Healthcare before Welfare States' project, awarded funding by the University of Huddersfield's University Research Fund in 2015.[1] The project's immediate research focus was healthcare systems in Central Europe between the First and Second World Wars, with an emphasis on hospital provision.[2] However, our broader aim was to consider global and transnational changes in how healthcare outside the home was delivered, funded and managed before the creation of 'welfare states', not only in Europe but also across European global empires.[3] Alongside a collaborative research project led by Barry Doyle on the post-imperial states of Czechoslovakia, Hungary and Poland, two workshops were organized. The first, held in Huddersfield in 2017, considered developments in Britain, Germany, Spain and Hungary alongside discussion of the politics of international health. The second, hosted at Charles University in Prague in 2018, gathered 30 participants from 14 countries to present research on 15 different states ranging from the late nineteenth-century multi-ethnic empires of Germany and Austria-Hungary, to the settler colonies of Algeria and Canada in the early twentieth century, to small interwar countries such as Northern Ireland and Czechoslovakia. Through cross-fertilization of our diverse contexts, we

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considered different perspectives on how structures of formal state healthcare and welfare provision developed across the span of the nineteenth and early twentieth centuries. We also asked if and how developments in healthcare were linked or shared across metropole and colony, or indeed across disparate imperial, colonial and national states, and debated which cases made for appropriate comparison. The articles in this special issue collectively advance these lines of enquiry.

Our research was conceived before the Covid-19 pandemic – nevertheless, the articles speak to some of the political questions and health inequalities of our own historical moment. What should healthcare (by which we mean the day-to-day delivery of public health and personal medical care outside the home) look like? What does healthcare cost, who pays for it, and how does payment determine access? Which products and services are covered? How is provision organized nationally, regionally and locally? Which approaches to combining public and private sectors are most efficient and equitable and which, conversely, are unequal and discriminatory? How have racism and xenophobia extended to healthcare? Despite influential calls (now decades old) to place colony and metropole in the same analytical frame in considering such questions – from David Arnold's observation that 'there is, indeed, a sense in which all modern medicine is engaged in a colonizing process', to Ann Laura Stoler's and Frederick Cooper's invitation to rethink research agendas in terms of metropolitan–colonial connections – the response has been decidedly asymmetrical, with most of the effort coming from colonial historians.[4] In the midst of the Covid-19 pandemic, Helen Tilley and others have reminded us (if we needed reminding) of 'colonial hangovers' in global health governance and reporting on Covid-19.[5] The extent of outbreaks of the novel coronavirus in US prisons by April 2020, argued Edna Bonhomme, reveals how 'colonial and racial legacies and geographies create conditions for sovereignty and, ultimately, the "capacity to dictate who is able to live and who must die"', with Black Americans, who are disproportionately incarcerated, placed at substantially higher risk of contracting Covid-19.[6] In illuminating some of the different ways healthcare was organized and negotiated by states and sufferers, providers and payers in different historical periods and geographic regions, this collection of articles contributes to putting imperial origins and legacies in healthcare governance under a spotlight.

Four articles in the special issue bring together historical experiences of healthcare in imperial states. Two different types of imperial formation are considered: British and French colonies of settlement and exploitation on the one hand, and the Central European land empires of Germany and Austria-Hungary on the other.[7] Another four articles explore health histories of countries as they built independent identities in the twentieth century – Czechoslovakia, Hungary, Poland, Ireland and Nigeria – or were significantly transformed in the case of the province of Northern Ireland. In addition to the fact that we combine consideration of imperial examples with the study of national ones, what makes this collection of articles distinctive is that only a few of the historical cases discussed here have featured prominently in English-language literature. Imperial histories of medicine and health have ranged widely across African, Asian, Oceanian and South American contexts.[8] Historical studies and social and public policy scholarship on the rise of health systems have centred on developments in the industrialized nations of Western and Northern Europe and the United States.[9] Meanwhile, modes of managing medical services and welfare in Central and Eastern Europe have mostly been considered

within national historiographies or an area studies framework, disregarded by scholars of colonial history and 'Othered' by historians of Western Europe.[10] Yet the practical challenges of implementing horizontal healthcare provision for underserved, majority rural populations in Central and Eastern Europe – especially as states dealt with the economic, social and political sequelae of imperial rule – shared important features with experiences in colonial states as well as reflecting developments in comparatively wealthier, more urban states in Western Europe. By introducing a new set of empirical examples, we hope to lay the ground for future research making global and transnational comparisons.

Comparison involves questioning the assumptions and perspectives we have developed from studying phenomena as if they unfolded within territorially or temporally limited containers. It also helps reveal shared patterns across cases, which might otherwise be overlooked due to segmentation in intellectual markets and patterns of professional socialization, as well as practical challenges of language training and archival access. Considered together the articles in this special issue yield greater awareness of inter-imperial and international filiations and circulations of social welfare laws, policy models and personnel, as well as the complex legacies that empires bequeathed to successor states, particularly in the form of healthcare infrastructures (fiscal, physical and human).[11] In this way, we can more easily recognize and challenge teleological tendencies in the historical evidence and literature, whether these take the form of a 'welfare state escalator approach' to history in powerful, Western countries or nationalist visions of welfare history in states that established their independence from imperial, colonial or Soviet occupation, to give just two examples.[12] But reading the individual articles should also help scholars of national histories and area studies appreciate how and why those developments that were indeed exceptional or unique to their field of study emerged, enabling 'new understandings of established national stories'.[13]

This collection of articles examines a range of themes that hold interest beyond the sub-discipline of history of medicine. For historians of the state, healthcare offers a focused lens through which to study processes of modern state-building before the era of 'welfare states', particularly as reflected in the shifting relationships among central, regional and local government authorities, and in how the allocation of healthcare costs was negotiated. The study of healthcare also provides extended opportunities to reframe shifts from one imperial formation to another, or from empire to nation state(s), as less of a rupture and more of a transition, at least where welfare infrastructures are concerned (however much successors asserted the distinctiveness of their efforts). Historians of religion and historians of medicine and health reading this special issue will find new evidence for the evolving and enduring significance of religious confessional identities in healthcare into the twentieth century. They will also see a new emphasis on the importance of ethnolinguistic and/or religious divisions and discrimination in determining how services were designed, delivered and accessed in different imperial and post-imperial contexts, that complements and intersects with existing work that documents exclusions based on class, gender and race.[14] The challenges of adapting urban healthcare models to rural settings, particularly in the case of hospital provision, are discussed by several contributors, providing useful case studies of the development (and often failure) of public services in less urbanized contexts. Finally, the articles provide new evidence of the impact of external factors – including epidemics, the First World War and economic

inflation – on healthcare provision. The rest of this introduction will further delineate the conceptual framework that underpins the special issue, focusing on the themes of finance and access to healthcare, and critically summarize the articles in the collection.

What is imperial about imperial healthcare? And what has happened to post-imperial health?[15]

Historical studies have emphasized the importance of healthcare and welfare structures to empire- and state-building projects.[16] Although this theme pulls through many of the contributions to this special issue, it is important at the outset to acknowledge that healthcare outside the home was not solely or even primarily the responsibility of states (imperial or otherwise) in the late nineteenth and early twentieth centuries. Instead, it was provided by a congeries of charities and benevolent individuals, religious bodies, voluntary groups, labour organizations and private labour in addition to central and local state authorities, with tensions as well as cooperation existing among public and private providers.[17]

Patterns of healthcare finance, hospital finance in particular, have been a locus of research for historians of Western Europe and North America for the past 20 years.[18] Scholars have pointed to the complexity of so-called 'mixed economies of welfare' that combined public and private financing in interwar France, Franco's Spain, Germany and especially Britain.[19] Much of this research initially examined the rise of universal health insurance, but more recent work has examined 'welfare pluralism' whereby social services and healthcare are organized at the regional or local level.[20] Debates in social policy and resource constraints on healthcare have undoubtedly contributed to scholarly interest in this area: funding for health and social care is a contentious issue in the United Kingdom, for example, and is becoming relevant in other European nations as the provision of services is privatized, raising the prospect of direct charges for procedures which were previously free at the point of delivery.[21] It is no accident, then, that recent historiography has sought to illustrate how and why different countries within Western Europe and North America diverged in their funding of healthcare, and the implications different paths had for populations' ability to access treatment.[22] Empire has been absent from or incidental to these accounts, even though many of the countries concerned were imperial nation-states at the point they initiated centralized public health and social welfare programmes.[23]

Decades of scholarship in imperial and global history has shown that colonial medicine comprised more than just tropical medicine, vertical programmes of disease control, and the importation of 'Western' medicine.[24] Scholars of South Asia, sub-Saharan Africa and North Africa and the Middle East have identified the significance of colonial developmental states before the Second World War while also recognizing that welfare pluralism was integral to their design.[25] Differential access to healthcare has primarily been understood in terms of the racial and legal hierarchies of colonialism, with broad distinctions made between facilities for European settlers (modern, urban and often state-funded) and those for autochthonous populations (limited, rural and left to the private and voluntary sectors).[26] Detailed studies of the mechanisms for funding colonial healthcare and their legacies in the present remain unusual, however, for reasons which include problems with sources, discussed later and in several articles in this collection.[27]

These articles begin to reveal new complexities and common challenges in how private and public provision were funded and combined across imperial and post-imperial states. For example, Presbyterian missions on the traditional territories of First Nations people in British-ruled Canada, as documented by Helen Vandenberg and Erin Gallagher-Cohoon, mobilized a range of financial resources and social and cultural capital to establish new infrastructure targeted at White settlers, at a time when investment in public health by the regional government was limited. Hannah-Louise Clark shows how the French colonial state in Algeria radically transformed the financing of welfare by expropriating and outlawing Islamic endowments, adopting taxes used by its imperial predecessors the Ottomans, seizing control of customary gift-exchange, and ultimately enacting taxes exclusively on the Algerian Muslim population to fund broader healthcare provision. Welfare pluralism was even evident in imperial Germany, often held up as a model of state centralization, explains Axel Hüntelmann, where the path-breaking national health insurance scheme was mainly delivered by pre-existing civil society associations in partnership with the state. Imperial mixed economies of welfare created challenging legacies, especially for countries that drew their inheritance from more than one former empire or where the new state was made up of a very loose federation of provinces, as John Manton shows for Nigeria. The new nations of Central Europe examined by Frank Grombir et al. struggled to shape modern healthcare infrastructures on the back of two, or even three, different modes of funding.[28]

The articles also highlight the ways imperial and post-imperial institutions aligned with and even intensified ethnolinguistic, religious and geographical inequalities in Central European states, as well as in demographically shifting regions of the British and French empires. Donnacha Seán Lucey finds that local authority reforms of the British voluntary hospital and poor law system in interwar Northern Ireland benefited the dominant Protestant and Unionist population of the industrial northeast while limiting choices for Roman Catholic nationalist communities in the rural south and west.[29] Zoltán Cora traces how healthcare reformers in 1930s and 1940s Hungary continued Bismarckian-era legislation, drew on elements of the Beveridge model, and looked to developments in organizational management in the US, Spain and other European countries. This progressive agenda was undermined by inherited health disparities between central and peripheral regions and antisemitic legislation aimed at Jewish doctors and providers, which reduced coverage. Central authorities in many states failed to address significant weaknesses in the level and standard of care provided in rural zones and to minority and marginalized communities.[30]

Several articles shed light on gatekeeping in healthcare. The most common requirement for relief was residence. In the French healthcare landscape, people in need had to demonstrate a period of recent residence to receive free treatment from local authority providers.[31] But in Algeria, juridically part of France from 1848, this system was only applied gradually and incompletely, Hannah-Louise Clark explains, and communal obligations were circumvented by local authorities who misspent funds or transported destitute patients to their commune of origin to avoid liability.[32] Similar rules applied in England and Wales; as in France, these were often flouted.[33]

Along with residence requirements, access was invariably underpinned by a need to demonstrate 'indigence' or inability to meet the normal cost of treatment.[34] Towards the end of the nineteenth century, payment options in institutional care multiplied and

became more complicated. The introduction of patient payments has been attributed variously to the emergence of health insurance, stricter residence regulation that saw authorities charging each other, mutual payment schemes, the parsimony of central states and local authorities, the rising costs of new technologies, and the demand from better-off groups in society to access rapidly improving facilities in hospitals.[35] For the Irish Free State, Donnacha Seán Lucey shows that the introduction of charges altered popular perceptions of district hospitals previously associated with the stigmatizing poor law, leading 'persons of small or moderate means' to seek private treatment there.[36] Insurance and patient payment, however, were out of the reach of rural residents in cash-poor economies where subsistence or very low-wage farming dominated. This was the situation not only in colonial states in Africa, but also in Central and Southeast Europe and even in Canada, as contributors to this special issue show.

Locality was less significant for charitable, voluntary and private providers, which usually limited themselves to discrete populations of service users. For example, Marina Hilber reconstructs how German-speaking Jewish women in the crownland of Bukovina, Austria-Hungary, travelled considerable distances to receive medical attention from a German-speaking physician with an established reputation and family ties to their community.[37] Finally, medical criteria rather than locale determined access to some institutions. Voluntary hospitals in England drew their funding from a wide geographical base and consultants often demanded a range of 'interesting' cases to develop their professional expertise and teach their medical students.[38] Conversely, pregnant women close to term, very young children, those with 'incurable' conditions and those with infectious diseases were often excluded from these establishments, prompting the development of specialist institutions (but also forcing people to rely on domestic care).[39] Developments went the other way in post-colonial Nigeria, as John Manton explains, with specialist institutions from the colonial era, such as leprosy control stations operated by the Qua Iboe Mission, undergoing Nigerianization to become a component of general rural public health provision.[40] Even as we look for shared patterns across metropole, colony and post-colony, it is important not to flatten out or ignore differences and inequalities, as demonstrated in the examples given here.

To conclude this section, the same features that make finance and access to healthcare provision such appealing topics of historical study also pose difficulties for historians of imperial and post-imperial states. Specifically, the survival and accessibility of archival documentation (including but not limited to the languages in which they are written) raise significant barriers to research.[41] For example, the collaborative and multi-lingual character of research by Frank Grombir et al. enables them to address comparisons across Poland, Hungary and Czechoslovakia using documentation written in official languages of administration. But since Central European governments played only a limited part in personal and curative services, the archival materials mobilized by these researchers overwhelmingly represent top-down perspectives on healthcare policy and control, and allow them to reflect only a portion of the ethnolinguistic diversity of Central Europe, encompassing as it did Czechs, Slovaks, Germans, Poles, Ukrainian/Ruthenians, Hungarians and many Yiddish speakers, some of whose voices are hard to find in archives.[42] To give another example, John Manton mobilizes substantial qualitative data on health planning and policy from external surveys, reports and campaigns conducted by twentieth-century international organizations such as the Rockefeller

Foundation, the League of Nations and the World Health Organization (WHO) to complement findings in state records. These materials are of limited use, however, for understanding the transition from colonial to post-colonial healthcare on the ground and the daily work of public health, and so they must be rounded out by local and non-governmental perspectives such as can be gathered from oral testimonies.[43] Ultimately, problems of source availability, accessibility and perspective are not accidents of the history of healthcare: they reflect the welfare pluralism that was the default in imperial states, and which had enduring legacies, as discussed in the following summaries.

Healthcare in imperial states

The four essays in this section discuss healthcare across nineteenth- and early twentieth-century European land empires (Wilhelmine Germany and Austria-Hungary) and settler colonies (Algeria under French occupation, and Canada under British imperial rule). These cases have typically been considered within their respective imperial and/or national historiographies, in which (inevitably) the tendency is to trace the emergence of imperial and later national healthcare systems. This means that similarities across these different imperial contexts, as well as the post-imperial states considered in the next section, have not been documented, let alone understood.

In 'The Shifting Politics of Public Health in Germany between the 1890s and 1920s', Axel Hüntelmann seeks to surface narratives of the history of healthcare in Imperial Germany before the horrors of National Socialist-era eugenics, racism and the Holocaust, focusing instead on the plural, competing visions of public health and social medicine that preceded it. By evaluating a broad sweep of German-language historiography, Hüntelmann brings to light the significance of long-established organizational structures, such as the Imperial Health Office – which prospered thanks to its association with Robert Koch – demonstrating that centralized and 'institutionalized public health existed long before the Weimar welfare state'. He also documents how officials at the imperial, state and local levels competed and collaborated to define and enact public health measures along bacteriological and social lines, although power to determine welfare policies gradually shifted away from individual states into imperial offices. Although imperial welfare and public health policies were often restrictive and aimed at control of the population, nevertheless, many of the services provided were welcomed. Ultimately, Hüntelmann argues, 'various alternative paths to a future [. . .] existed in the 1920s that did not automatically culminate in the racial hygiene of National Socialism'.[44]

Turning to Austria-Hungary, Marina Hilber's article 'Obstetric Expertise in the Austrian Periphery: Ludwig Kleinwächter's Private Practice in Czernowitz, Bukovina (1884–1904)' follows a single physician as he established a practice at the edge of the Austro-Hungarian empire. In contrast to Wilhelmine Germany, where medical policing and public health were centralized, in Austria-Hungary medical provision and its costs were devolved to individual crown lands. The eastern periphery of Bukovina haltingly came under medical and sanitary regulations but lacked the infrastructure – especially human infrastructure in the form of licensed doctors and midwives – to deliver improved health services. Infectious and social diseases attracted most attention from crown officials, a bias replicated in the extant historical literature, but women's health and obstetrics were also areas of high demand. This created an opening for Kleinwächter, the

professionally gifted but socially difficult doctor at the centre of Marina Hilber's article, who was pushed out of a university position in Innsbruck and rusticated in Bukovina. What emerges from Hilber's study of Kleinwächter's case notes is the practical significance of religious confessional and linguistic divisions in a multi-ethnic empire such as Austria-Hungary. These distinctions mattered not only for the success (or failure) of individual careers in medicine, but also to delivery of healthcare provision, as exemplified in Kleinwächter's private practice in Czernowitz and its hinterlands.[45]

The themes of religious and linguistic difference are also central to the two final articles in this section. In 'The Islamic Origins of the French Colonial Welfare State: Hospital Finance in Algeria', Hannah-Louise Clark brings together the study of religion, law and finance to explore how French officials appropriated local resources to support the construction of a colonial welfare system and hospital network. The deed of *habous* (endowment, also known as *waqf*) established by wealthy Algerian al-Hajj ʿAbd al-Rahman Ibn ʿAli al-Qinʿai in 1866 and decades of documentation from the archives of the French *Cour des Comptes* (court of audit) studied by Clark have not previously attracted attention from historians. Clark uses these sources to reconstruct archival recordkeeping and accounting processes carried out under the auspices of the French colonial state, particularly at the level of *communes mixtes*, the rural zones where most Algerians lived. She shows how French officials took over al-Qinʿai's substantial *habous* to fund a new Muslim Welfare Bureau in Algiers and reconfigured Ottoman-era taxes and levies to establish a 'native' infirmary network. Providing an alternative view to the classic interpretation of Fanon, Clark finds that the provision of healthcare in Algeria was underpinned by a complex mix of legal and discursive strategies, illegal methods of revenue collection, dubious accounting practices and outright theft in which French authorities invoked Islamic tradition to transfer the costs of the wider welfare system onto poor Algerians.[46]

In the final article in this section, 'Health, Charity and Citizenship: Protestant Hospitals in Rural Saskatchewan, Canada 1906–1942', Helen Vandenberg and Erin Gallagher-Cohoon describe small, individual prairie hospitals established by Protestant missionaries in rural Saskatchewan. Seen in the context of Canadian healthcare historiography, prairie hospitals have featured as part of a narrative of 'the road to Medicare'; viewed within a comparative framework, parallels emerge with themes in the broader historiography of hospitals, particularly the hospital as a social and colonizing institution.[47] The authors describe how the hospital in Wakaw, for example, carried out social work functions and offered religious services alongside medical treatment – but only for White settlers, and not for the Cree, Nakota and Saulteaux peoples on whose traditional territories the hospital stood. Missionary doctors at the hospital supported the social reproduction of Protestant families by fostering abandoned White children born at the hospital or brought there for medical treatment.[48] Indigenous children living on the prairie were sent to missionary-run boarding schools, since implicated in causing cultural genocide and intergenerational health inequalities.[49]

Like the segregated infirmaries in Algeria discussed by Clark, access to hospitals in Saskatchewan was shaped by racialized hierarchies and attitudes to religion that served the economic dominance of White settlers.[50] This fact might seem to set the cases of Algeria and Canada apart from those of Imperial Germany and Austria-Hungary, except

that a major problem across all four cases was the implementation of public health legislation, particularly as it affected rural populations. This was typically stymied by the unwillingness of central states to contribute funding and a lack of human infrastructure, which meant that services were inadequate to meet growing demand. This produced healthcare inequalities shaped by class, gender, geography and discrimination along the lines of religion and race. Similar problems can also be detected in the four articles that cover post-imperial developments.

Healthcare in post-imperial states

The end of the First World War saw a major redrawing of the world's pre-war empires. In Central Europe, the German, Austro-Hungarian and Russian empires collapsed, breaking into numerous successor states stretching from the Baltic to the Ionian Seas. For Britain and France, the Mandate System under the League of Nations extended colonial control in Africa and the Middle East, but at home Britain saw most of Ireland gain de facto independence, leaving the autonomous province of Northern Ireland to determine its own health and welfare policies. In the aftermath of the Second World War, the global empires of Britain and France saw rapid decolonization, first in South Asia at the end of the 1940s then across Africa following the independence of Sudan, Morocco and Tunisia in 1956. Health, welfare and body politics were essential to nation building in these newly independent and autonomous states. However, opportunities for effective reform were limited by the need to work with complex and imperfect imperial inheritances in multi-ethnic nations with predominantly poor, rural populations, as the articles in this section show.

Frank Grombir, Barry Doyle, Melissa Hibbard and Balázs Szélinger explore the challenges faced by the independent states of Czechoslovakia, Poland and Hungary in their article, 'Hospital Provision in Interwar Central Europe: A Review of the Field'. Alongside an historiographical review and source evaluation of healthcare in these nations, they consider three themes central to understanding post-imperial medical services, not only in Central Europe: hospital provision and ownership; spatial distribution, especially urban and rural differences; and finance, a major determinant of access to treatment. They show how the ambitions of new nations to create improved healthcare infrastructures considered as modern and democratic were curtailed by patchy provision (especially away from urban areas), multiple systems of ownership and finance, and inadequate health insurance systems that excluded most of the population, and often left hospital providers critically underfunded. These weaknesses were compounded by marginalization or exclusion of specific ethnic, linguistic and religious confessional groups which undermined pretensions to 'national' healthcare provision – a situation also experienced in some nations achieving independence from European colonizers in the 1960s and 1970s. But there were also signs of success. Bed numbers rose impressively, many areas saw the creation of new, modern institutions and specialist services spread to the provinces, leading to more people receiving institutional treatment in the late 1930s.[51]

Post-imperial states did not always achieve independence on their own terms. Some, like interwar Hungary, were reduced in scale and status when territory was reallocated to other states. In 'Hungarian Health Care in the 1930s and 1940s: Health Care at a

Crossroads in East Central Europe before World War II', Zoltán Cora explores how Hungarian policy makers attempted to rebuild the country's much reduced health infrastructure and then, when the opportunity for revanchism offered itself, deployed health policy to reintegrate recovered territory. Three themes are explored: advances in health policy between the wars; the uneven distribution of doctors; and the attempts to raise standards in the restored territories of northern Hungary and Transylvania to the levels found elsewhere in the country. The architect of many of these reforms was Béla Johan, who advised ministers from the early 1930s and devised plans that would lay the foundation for the system introduced by Communist governments after the Second World War. Johan aimed to level geographic disparities, improve rural health and integrate new regions by bringing together Bismarckian insurance with a commitment to universalism inspired by Beveridge. The limited success of policies designed to address geographical inequalities in healthcare resources is evident from continual disparities in the number of doctors between the capital and rural areas and the exclusion of agrarian workers from national health insurance. Johan's objectives were further undermined by antisemitic restrictions on Jewish doctors and the punitive cost of Hungary's involvement in the Second World War.[52]

The smallest country case study in the special issue considers the devolved government of Northern Ireland. In 'Irish Partition and Poor Law Reform in InterWar Northern Ireland', Donnacha Seán Lucey examines the development of a more democratic and modern hospital system for the six counties built on the workhouse infirmaries of the Irish Poor Law. By the early twentieth century, these infirmaries offered minimalist living conditions with limited medical facilities for the elderly, children and the disabled or chronically ill. Policy adopted in Northern Ireland differed not only from the Irish Free State, where the Poor Law was abolished in 1921 as an act of independence, but also from Britain, where the system's medical functions were municipalized in 1929. Responsibility for modernizing and reforming services was devolved to local authorities, leading to different outcomes across the province. In the Protestant and Unionist urban and industrial northeast, the government in Belfast favoured reform of the National Insurance system and local authorities converted Poor Law Infirmaries to District Hospitals offering general services to the wider population. But in the rural west and south, where Roman Catholics and nationalists formed most of the population, official gerrymandering meant councils remained in the hands of Protestant elites who proved unwilling to spend their money on improved services, and insurance coverage and general hospital services were weak.[53]

Relations between religion and the state in the shaping of post-imperial health policy also feature strongly in the final article, 'Qua Iboe by Motorcycle and Launch: Brokering Public Health Coverage in 1960s Southeastern Nigeria', by John Manton. At Nigerian independence in 1960, the newly Nigerianized medical bureaucracy reconfigured the inherited structures of British missionary-run leprosy control and rural public health work. But this was not a simple takeover. Rather, as in the post-imperial states of Central Europe, a precarious balance existed between the inherited missionary hospital-based system and the new bureaucracy of inspectors operating on a pharmaceutical outpatient model. Manton tracks the development of an increasingly complex mixed economy of rural disease management following the Second World War, as government and international agencies like the World Health Organization

entered the field, reducing the traditional dominance of medical missionaries in leprosy control. The central part of the article focuses on case studies of inspectors' everyday experiences as they sought to develop common standards in the face of patient resistance, financial weakness, shortage of materials and contested legal and administrative boundaries. Building on the work of Hunt, Kalusa and Lachenal among others, Manton highlights the role of Nigerian health workers as 'interpreters, translators, brokers and neighbours' who made biomedicine and its practices intelligible to rural populations.[54]

Scholars who work on imperial and post-imperial healthcare before 'welfare states' need to read across literatures to understand shared patterns. To this end, in this introduction we have sought to connect work done in colonial and post-colonial history and in European history, especially histories of Central and Eastern Europe. We have urged consideration of policies and practices in empire and metropole in the same analytical frame and have shown how infrastructures and patterns of delivering healthcare endured through the imperial to post-imperial transition. Overall, five connecting issues have emerged from our site-specific studies of health care governance and delivery in states with complex ethnic, demographic and geographical environments. The mechanisms through which healthcare was financed were central to access and coverage. Disparities between urban and rural provision are vital to understanding health inequalities and should play a much greater part in the study of healthcare systems than they have to date. Religious and voluntary associations played a crucial role in delivering medical services in a mixed economy of welfare well into the twentieth century, but religion and ethnolinguistic difference also raised barriers to care. Health systems formed around local projects and funding sources, and central–local relations were always a site of conflict. Finally, one overarching theme of this collection concerns health services as an essential but underresourced tool in envisioning and building late nineteenth- and early twentieth-century imperial states that left complex and uneven inheritances for the leaders of independent and autonomous nations in the post-imperial age.

Notes

1. "European Healthcare Before Welfare States," *CHPHM Blog*, 2016. https://bmdoyleblog.wordpress.com/2016/01/31/european-healthcare-before-welfare-states/, accessed January 31, 2021.
2. Doyle et al., "The Development of Hospital Systems in New Nations."
3. The rationale for our use of inverted commas is explained in Powell, *Understanding the Mixed Economy of Welfare*, 22.
4. Arnold, *Colonizing the Body*, 9; Cooper and Stoler, *Tensions of Empire*.
5. Tilley, "COVID-19 across Africa." See also, e.g. Pouget, "Quarantine, Cholera, and International Health Spaces"; and Birn, "How to Have Narrative-Flipping in a Pandemic."
6. Bonhomme, "Troubling (Post)colonial Histories of Medicine," 831.
7. Works that compare different European imperial systems in the nineteenth and twentieth centuries, particularly from a legal standpoint, include Belmessous, *Assimilation and Empire*; Benton, *Law and Colonial Cultures*; and Burbank and Cooper, *Empires in World History*.
8. For a typology of colonial medical relations and examples see Michael Worboys, "Colonial Medicine." See also the section "Places and Traditions," in Jackson, ed., *The Oxford Handbook of the History of Medicine*.

9. See, e.g., Fox, *Health Policies, Health Politics*; Hennock,*The Origin of the Welfare State in England and Germany*; Marmor et al., *Comparative Studies and the Politics of Modern Medical Care*; Powell, *Understanding the Mixed Economy of Welfare*, although see also Gorsky et al., *Political Economy of the Hospital* for a broader analysis.
10. For current historiographical trends in history of science and medicine, see Ash, "History of Science in Central and Eastern Europe"; Duančić, "Recent Trends"; Surman, "Productive Marginalities"; Zemplén, "History of Science in Hungary." Views on the divergence between social medicine as practised in Eastern Europe and Western Europe are discussed in, e.g., Silverstein, "The Periphery is the Centre."
11. See Cooper and Stoler, *Tensions of Empire*; Stoler, *Duress*; Stoler, ed., *Imperial Debris*. For an example of 'human infrastructure' see Lucey's discussion of Lieutenant Colonel McCormick's part in the colonization of Saskatchewan and Irish partition. Lucey, "Irish Partition," 799.
12. Gorsky, "'Voluntarism' in English Health and Welfare," 31–60, reference on 33. The original quotation referenced by Gorsky is from Finlayson, *Citizen, State, and Social Welfare*, 3.
13. The quotation is from Grombir et al., "Hospital provision." See also comments by David Dutton on how French and American academics viewed their own, and the other's, healthcare systems. Dutton, *Differential Diagnoses*, 1.
14. For current historiographical trends, see Gorsky et al., *Political Economy of the Hospital.*
15. This sub-heading evokes the title of Shula Marks' 1996 presidential address to the Society of the Social History of Medicine conference, "What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?" Quoting David Arnold, Marks warned historians to guard against 'establishing too rigid a barrier between colonial and metropolitan medicine'. Marks, "What is Colonial about Colonial Medicine?" quotation on 206.
16. Examples of the relationship between health and the state include, Arnold, ed., *Imperial Medicine* and Porter, *Health, Civilization, and the State*. For specific examples, see, Clark, "Administering Vaccination"; Lucey, *End of the Irish Poor Law*; and McPake, "Hospital Policy in Sub-Saharan Africa."
17. See, e.g., Gorsky, "Political Economy of Health Care"; Gorsky, Vilar-Rodríguez and Pons-Pons, "Introduction"; Ragab, "Religion, Law and Public Health: Introduction."
18. Donzé and Pérez, "Health Industries in the Twentieth Century"; Dutton, *Differential Diagnoses*; Gorsky et al., *Political Economy of the Hospital*; Pérez, *Emergence of Modern Hospital Management*; and Stevens, *In Sickness and in Wealth.*
19. Cherry, *Medical Services*; Domin, *Histoire economique de l'hôpital*; Doyle, "Healthcare before Welfare States"; Hüntelmann, "Hospital Funding in Germany"; Smith, *Creating the Welfare State*; Valat, *Les Marchés de la santé*; Vilar Rodríguez and Pons Pons, *Un siglo de hospitals*; and Vilar-Rodriguez and Pons Pons, "Competition and Collaboration." For a recent discussion of the British situation see Doyle, *Politics of Hospital Provision*, 1–9.
20. For studies exploring the United Kingdom, Ireland and British settler colonies see, e.g., Lucey and Crossman, eds., *Healthcare in Ireland and Britain*.
21. For a recent assessment of privatization in the NHS, see "Is the NHS being Privatised?" *The King's Fund*, https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatized, accessed March 1, 2021.
22. See, e.g., Gosling, *Payment and Philanthropy*; and Dutton, *Differential Diagnoses*.
23. An exception is studies that look at migrant labour within national health systems. See, e.g., Brown, "Huddersfield and the NHS: The Caribbean Connection"; Dewachi, *Ungovernable Life*, chapter 7; and Simpson, *Migrant Architects of the NHS*.
24. Numerous studies have demonstrated how colonized peoples creatively and selectively engaged with medicine considered as 'Western', and, how, in some places at least, colonial sanitary interventions created a body of civil servants, and to a lesser extent an informed populace, prepared to make claims on the state in public health matters. See, e.g., Au, *Mixed Medicines*; Clark, "Administering Vaccination" and "Expressing Entitlement"; Das, *Vernacular Medicine in Colonial India*; Flint, *Healing Traditions*; Greenwood and Topiwala, "Visions of Colonial Nairobi"; Masakure, *African Nurses*; and Mukharji, *Nationalizing the Body.*

25. Sehrawat, *Colonial Medical Care in North India*; Conklin, *A Mission to Civilize*; Thompson, *Colonial Citizens*; and Tilley, *Africa as a Living Laboratory*.
26. Greenwood, *Beyond the State*; Doyle et al., "The Blessings of Medicine"; Harrison, Jones and Sweet, eds., *From Western Medicine*; and Masakure, "Tensions between Integration and Segregation."
27. Sehrawat, *Colonial Medical Care in North India* is a notable exception.
28. See also Lucey, *End of the Irish Poor Law*, on the Free State's complex relationship with its health and welfare inheritance.
29. For the wider background of Irish welfare reform, see Crossman and Gray eds., *Poverty and Welfare in Ireland 1838–1948*.
30. Barona and Cherry, eds., *Health and Medicine in Rural Europe*; Connor and Curtis, eds., *Medicine in the Remote and Rural North*.
31. See Crowther, *The Workhouse System*; Doyle, *Politics of Hospital Provision*, 65–7.
32. Lemay, *Étude Historique*, and Clark, "The Islamic Origins of the French Colonial Welfare State."
33. Crowther, *The Workhouse System*; Doyle, *Politics of Hospital Provision*, 65–7.
34. Doyle, "Contrasting Accounting Practices"; and Hüntelmann, "Hospital Funding in Germany."
35. Clark, "The Islamic Origins of the French Colonial Welfare State"; Domin, *Histoire economique de l'hôpital*, 210–20; Doyle, "Soins hospitaliers en Grande-Bretagne"; Vandenberg and Gallagher-Cohoon, "Health, Charity and Citizenship"; Hüntelmann, "Hospital Funding in Germany"; and Stevens, *In Sickness and in Wealth*.
36. Lucey, "Irish Partition."
37. Hilber, "Obstetric Expertise." For a longer view of developments in central and southeast Europe see Turda, "Private and Public." The role of confessional, missionary, associational and ethnic institutions in providing care are also discussed in Cora, "Hungarian Health Care", and Grombir et al., "Hospital Provision."
38. Reinarz, *Healthcare in Birmingham*.
39. Weisz, *Divide and Conquer*; Granshaw, "Fame and Fortune."
40. Manton, "Qua Iboe." For parallels with missionary activity in colonial East Africa and US-occupied Philippines, see Anderson, *Colonial Pathologies*; and Vongsathorn, "The Treatment of Leprosy in Uganda."
41. Clark, "The Islamic Origins of the French Colonial Welfare State"; Grombir, "Hospital Provision."
42. Grombir, "Hospital Provision."
43. Manton, "Qua Iboe."
44. Hüntelmann, "The Shifting Politics of Public Health."
45. Hilber, "Obstetric Expertise."
46. Clark, "The Islamic Origins of the French Colonial Welfare State."
47. For discussion of the hospital as a social institution within a wider community, see Gosling, *Payment and Philanthropy in British Healthcare*.
48. Vandenberg and Gallagher-Cohoon, "Health, Charity and Citizenship."
49. See, e.g., Woolford, *This Benevolent Experiment*; Mosby and Galloway, "Hunger was Never Absent"; and Wilk et al, "Residential Schools and the Effects on Indigenous Health and Well-being in Canada."
50. There is extensive work in the field of British imperial history on this subject. See, e.g., Hall, *Civilizing Subjects*; Hall and McClelland, eds., *Race, Nation and Empire*. For medical case studies, see, e.g., Digby, "The Medical History of South Africa"; Greenwood, *Beyond the State*; Masakure, "Tensions between Integration and Segregation;" and Pam, *Colonization et Santé au Sénégal*.
51. Grombir et al., "Hospital Provision."
52. Cora, "Hungarian Health Care."
53. Lucey, "Irish Partition."
54. Manton, "Qua Iboe." See also Clark, "Of Jinn Theories"; Hunt, *Colonial Lexicon*; Kalusa, "Medical Auxiliaries"; and Lachenal et al., "Neglected Actors."

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