“TB, Glasgow and the Mass Radiography Campaign in the Nineteen-Fifties,”: A commentary

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Professor Levitt's paper is brief, clear and precise. I read it with great pleasure. In its mere seven pages Ian Levitt manages to summarize lots of historical information, to convey the meaning of it to contemporaries by well-chosen quotations and vignettes, and to raise, in retrospect, the question of the significance of the whole campaign to us, historians and sociologists. As historians tend to do, Ian Levitt does not force his answer upon us. He suggests that, apart from its medical impact, the campaign helped the Conservative party to bolster its image of a 'one-nation party' to which the National Health Service could be safely entrusted.

I am sure he is right. I will merely try to add to his central argument one or two additional interpretations, triggered by a comparison, albeit superficial, of the Scottish with the Dutch case.

The Netherlands did not have a National Health Service in the nineteen-fifties, nor did it have a Conservative government. Yet it did see a prolonged and more or less concerted effort to fight tuberculosis over many decades (appr. 1900-1970), and large-scale screening campaigns in the nineteen-fifties, similar to the ones in Glasgow and Scotland as a whole.1

Before WW II, in the NL, efforts proved to be difficult and met with limited success. During WW II, under German occupation, the health of the population deteriorated and the socio-medical infrastructure more or less collapsed. TB morbidity and mortality rose dramatically. After the Liberation, curative efforts were stepped up immediately. American Marshall Aid, Swedish, Danish and Swiss aid initiatives, and specially earmarked interior resources were directed, a.o.t., at enlarging the capacity of sanatoriums, both at home and abroad, TB wards of general hospitals, and temporary barracks for curing patients. From 1947 onwards, streptomycine became gradually available, and later also para-amino-salicyclic PAS and isonicotineacid-hydrazide INH. It took some time before their effectiveness was fully realized. However, within a decade, sanatoriums and other curative institutions struggled with overcapacity. The successful eradication of bovine tuberculosis had also contributed.

While radiography had appeared as early as the 1920's, and the first collective screening procedures had been organized and in fact institutionalized in the late 1930's - the screening of teaching professionals; large companies like Philips Electronics and the Post Office screening their employees - it was only in the late 1940s and early 1950s that mass screening campaigns of the population

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occurred. In the absence of a centrally steered National Health, they sprang up from a variety of sources on both local, regional, municipal and national levels.

Let me explain. From the 1900s onwards, well before WW I, sanatoria, local committees, charitable associations and funds, and other initiatives to fight TB had proliferated. From 1907 onwards, they had been loosely coordinated, not without arguments and quarrels, by a Dutch Central Association against tuberculosis NCV. Gradually, the national government had started to subsidize its efforts. From the 1920s onwards, also, a network of district and municipal health centers ('consultatiebureaus') had been spreading over the country under the direct aegis of the state. In the 1930s, this rather complicatedly woven web of both privately and cooperatively funded sanatoria, charitable associations with limited state subsidy, and publicly funded health centres, had crystallized into a stable, institutionalized field with well-established patterns of interaction. It atrophied during the German Occupation, but it quickly re-emerged after 1945, like so many other structures of pre-war Dutch society and politics. It was this complex yet well-established infrastructure for combating TB that was the matrix of the mass screening campaigns of the late forties and early fifties. In 1948, the NCV had founded a separate Bureau for Population Screening that became the command centre for the operations.

The campaigns presented a picture similar to the one Ian Levitt paints: highly modern, mobile screening units; mass publicity campaigns; excitement among the public and the press; participation rates of 75 percent and above; but also smallish rates of detection relative to the large numbers of people being screened, giving rise to doubts about the cost-efficiency of the whole operation in certain expert quarters. To no avail, of course. The train had gained speed and needed to run its course. In 1980, dr. F.N. Sickinga, a distinguished lung specialist (pneumonologist) who had devoted a long career to combating TB and then was in his late seventies, wrote, with the lucidity and detachment that comes with old age, at least to some:

> It is impossible to evaluate precisely the contribution of mass screening to the fight against tuberculosis in the Netherlands. In a way, is was a fad, no doubt also stimulated by the radiology industry, who had taken the initiative and provided ever more refined equipment. It has no doubt helped to lower the number of foci of infection, especially in the early stage. But the more tuberculosis decreased, the less efficient the method became [...]. Moreover, much time was wasted on long and fruitless meetings to bring the organisations involved to cooperate or at least to divide their tasks among them, and to guarantee a sound implementation of the population screening. [...] It is difficult to deny that mass screening has contributed its mite to the decline of tuberculosis in The Netherlands, albeit in a overly costly and ineffecient manner. (Sickinga 1980, pp. 324-5)

I quoted Sickinga at some length, of course, because of his casual remark on the role of the radiology industry. There's little further information on it in my Dutch sources, nor is there in Ian Levitt's paper. I feel its role is in need of further exploration both in the Scottish and the Dutch context.
So too is the role of the medical specialists most directly involved: the profession of radiologists. I suspect a medico-radio-industrial complex is to be unmasked, in much the same way as this was done by Stephen Pfohl in his 1977 landmark case study 'The "Discovery" of Child Abuse'. Radiologist took up the ownership of the problem of child abuse, thereby furthering their occupational prestige considerably. I think they did the same with tuberculosis in the 1950s.

It seems to me that the mass radiography campaigns in The Netherlands had less political significance than they had in Scotland and the UK in general. This has much to do with the perennial coalition politics in the NL: since the beginning of full parliamentary democracy under a system of proportional representation, no party has ever mastered a single majority. This goes a long way in explaining the absence of a National Health system. For a brief and fleeting moment right after WW II, the political momentum seemed to be there, but it turned out to be a mirage. It also explains the tendency to de-politicize political issues and to delegate solutions to corporate actors or (and often: and) to professional experts - in this case: to the composite infrastructure to combat tuberculosis that had crystallized before WW II. The dynamics of the political arena in the Netherland are different from those in the UK, and this creates different opportunity structures for corporate actors, experts, and professionals.

A final word on the focus of our session: health inequalities. National Health has an egalitarian ethos per definition, and a radiography campaign under its aegis could underscore the 'democratic' credentials of the Conservative party in charge, precisely by focusing on the unjust tuberculosis risks among Glaswegians. So Ian Levitt has it. No egalitarian or democratic themes have been struck in the Dutch campaign. Tuberculosis had been and continued to be presented as a common enemy, a disease that could be contracted by anyone, high or low in society, and as a threat to the health of the Dutch people as a whole. The discourse or dimension of inequality was conspicuous in its absence.

Was it repressed? Possibly. Or rather, it was compartmentalized and managed behind the social scene in a highly paternalistic and even authoritarian manner. Between 1945 and 1955, and rooted in earlier, pre-war campaigns, a small industry emerged, aiming to discipline and re-educate so-called 'anti-social' families and their life styles. Special villages and quarters were designated, where 'anti-social' people were forced to live under close supervision by housing inspectors, social workers and psychiatrists. Now, efforts were made to bring non-compliant, so-called 'anti-social' or 'non-cooperative' tuberculosis patients, who refused the older, prolonged and often painful types of treatment, under the same regime. A proposed law to force treatment upon them did not make it through parliament, and in the end, the success of modern drug-based treatment made the problem less urgent. In the 1960s the whole genre of re-educating 'anti-social' citizens evaporated into thin air, not however without leaving shameful memories.

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