

Mutual sickness insurance and national health insurance in England and the Netherlands between 1870 and 1915

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Conference paper, IASC Utrecht, 10-14 July 2017

Introduction

Over the past twenty to thirty years, several historians have discerned a growing interest in the history of mutual insurance traditions. Threats to the existence of workers' movements, the (re)organisation of existing social health systems within a European context, and societal concerns over the current state of welfare politics have all been put forward as explanations and justifications for the increasing attention paid to mutual aid associations (Van der Linden, 1996b, 11; Companje et al. 2009, 22-23; Harris et al., 2012, 1). Moreover, increased knowledge of the historical operation of mutual insurance is said to enrich our understanding of welfare-state developments as it forces us to reconsider any historical account that builds on the perception that "what we have seen is a shift from Dickensian bleakness in the form of minimal help by members and the community to an orderly abundant but expensive welfare state." (Van Leeuwen, 2016, 4)

Comparative research on the interconnected developments of mutualism and state-organised social security further enables us to acquire new insights on how our welfare states and their crises have developed over time. A comparative approach is important because it allows us to challenge national conventions on peculiarity and normality within those frameworks, thus problematising any notion that the 'rise of the welfare state' was a historical process that inevitably led to the current systems. Finally, a comparison across different European social security systems helps us to distinguish not only how state action has influenced further developments of mutual insurances, but also how different traditions of mutualism have contributed to diverging social security systems.

Following these considerations, in this paper I will trace and compare if and how mutual sickness insurers contributed to offering social security and to developing social policy in England and the Netherlands between 1870 and 1915. Many mutual insurance associations offered insurance against a combination of two or more different concurrent risks, but sickness is a particularly interesting research topic because of the relative feasibility of organising mutual insurance in terms of low, mostly short-term, and predictable costs (i.e.

medical costs and sickness benefits) – although costs have been rising dramatically over the twentieth century.

Assessing the operation of mutual insurers

One of the findings of past research on mutual insurance traditions is that when we broaden our perspective to the more general quest of individuals and states for finding and providing social security, it turns out that mutual sickness insurance formed only one possible solution. States, families, the church, charity organisations, commercial insurers, trade unions, employers, and doctors all offered alternative solutions. Moreover, individuals often relied on a combination of two or more of these institutions. This observation has prompted historians to place the analysis of mutualism within the descriptive concept of the ‘mixed economy of welfare’ (Harris and Bridgen, 2007; Downing, 2015; Van Leeuwen, 2016). Although not new at the time, the term started to be widely used in the 1980s to describe how the state, the commercial sector, the voluntary sector, and the informal sector were all part of what we call welfare states, but that the boundaries between the four sectors were (and are) often blurred (Harris and Bridgen, 2007, 1). How are we to assess the historical operation of mutual insurers within this mixed economy of welfare?

Even though mutual insurance associations faced similar threats, some funds were better in tackling them than others. Explanations for these differences have been attributed to the institutional design of both national systems and the funds themselves. The propensity to claim sickness benefits by fund members has been investigated in relation to the presence of a voluntary or compulsory national insurance scheme, alongside the size, location and financial situation of the funds (Murray, 2005; Downing, 2015; Andersson and Eriksson, 2017). Other studies have focused more on the sustainability of specific mutual insurance traditions by testing the financial viability of investigated associations. Finally, Marco van Leeuwen focuses on the insurance-like character of the associations and describes how the mutual insurers combatted the classical insurance problems of moral hazard, adverse selection and correlated risks (Van Leeuwen 2016).

Generalisation of mutual insurance’s (dis)advantages and more specific research on how institutional design affects the outcomes of mutualist activities has thus provided us with many insights. Yet it does not offer a model that allows for a meaningful comparative study of different and evolving associations operating in different national contexts and their impact on social policy. Evaluating sustainability and morbidity outcomes may be very informative, but only brings us so far in explaining how the associations operated and how they contributed to

or hindered the introduction of social reforms. Even if we were able to explain which mutual insurance model is most efficient and sustainable, that still does not provide us with an answer to the question of how mutual insurance traditions were or were not translated into national regulation. As the political scientist Arun Agrawal describes it, commons theorists emphasise that institutional change cannot merely be explained by a functionalist evolutionary logic, but rather by the perceived gains for relevant political actors (Agrawal, 2008, 47).

Mutual insurance, common-pool resources and corporate collective action

Research on mutual insurance might thus benefit from research on other types of common-pool resources (Largo, 2016). There are some striking similarities between medieval and early modern guilds and commons, together typified as forms of ‘corporate collective action’ by Tine De Moor, and nineteenth- and twentieth-century mutual insurers. According to De Moor, guilds and commons came about in reaction to wider economic and social changes in order to adapt economic strategies and to stabilise both economic and social relationships (De Moor, 2008, 183). Nineteenth-century mutual insurers not only based their operation on former guild practices, but their popularity also coincided with a new period of economic and social change. Moreover, the ascribed functions of mutual insurers were not only to offer insurance; especially in England mutual insurers also facilitated new social ties in a new market environment.

Furthermore, like guilds and commons, mutual insurance associations are not market-based, private property arrangements or publicly owned, state-managed arrangements, but common-pool resources governed on the basis of community and common ownership (Agrawal 2008, 47; Van Leeuwen, 2016, 4; Andersson and Eriksson, 2017, 6). Like other forms of common-pool resources, mutual insurers therefore allocate resources with a high subtractability of use (i.e. granting monetary benefits results in a decrease in resources). Equally, mutuals need to fight free rider problems because it is costly to exclude potential beneficiaries once people join the association (Ostrom, 2005, 24).

Nevertheless, there are also some differences to keep in mind. To start with, commons regulate the collective use of land and its resources; the common-pool resources are natural, renewable sources (De Moor, 2008, 184; Agrawal, 2008, 47). By contrast, mutual insurers first need to create their common pool by collecting contributions, by receiving external donations, and/or by receiving governmental subsidies. Moreover, there is an important difference between offering sick pay (i.e. purely monetary benefits) and offering health insurance (i.e. medical care), as for the latter the insurer is dependent on medical professionals

to provide the service. Although medical care requires the cooperation of external parties and is thus more difficult to organise, the subtractability of use can be lowered depending on the way medical professionals are remunerated (e.g. salaries, fees, or out-of-pocket payment). Resource characteristics thus play a crucial role in the operation of a mutual fund (Agrawal, 2008, 52).

Guilds focused on occupational groups, and their most important goal was to further the economic interests of their members (De Moor, 2008, 187). Mutual insurance, on the other hand, could be organised within occupational groups, but open membership for all occupations increasingly dominated nineteenth- and twentieth-century practices. Moreover, mutual insurers are clearly less concerned with broader economic strategies to protect specific trades or to regulate the access to specific markets. Nevertheless, mutual insurance associations offered protection against the risks and uncertainties of a free market in two ways. Firstly, by offering sick pay (mutual), insurers prevented ill workers from a total loss of income during their sickness. Secondly, (mutual) health insurers provided access to certain medical services that would not have been available for individual members and their dependents otherwise in a totally free market.

Self-regulation and democratic control

An important part of the design principles that describe the (un)successful governance of common-pool resources focuses on the drafting and enforcement of rules (Ostrom, 2005, 18). Even though rules serve to achieve order and predictability, there is a clear difference between rules-in-form and rules-in-use (Ostrom, 2005, 20). One of the factors that increases the chances of adherence of members to existing rules is the involvement of those members in the design of the rules they are subject to (De Moor, 2008, 197). Voluntary agreements among members can lead to better outcomes because intrinsic motivations can be crowded out by imposing external rules (Ostrom, 2005, 95).

Moreover, self-regulation and active member participation in the governance of an association may prove crucial in the evaluation of success by its members. Sustainability and benefit maximisation are not the only values on the basis of which common-pool resources function. Rather, rules and outcomes are evaluated on the basis of efficiency; equity (fiscal or redistributive); adaptability, resilience and robustness; accountability; and conformance to general morality (Ostrom, 2005, 66-67). Thus, even when the monetary or physical outcome of a mutual's operation is positive, it may be perceived as inappropriate – and vice versa

(Ostrom, 2005, 14). In the process of drafting and changing rule configurations, those rules are retained that perform according to the maintained evaluative criteria.

Entry rules and exclusivity

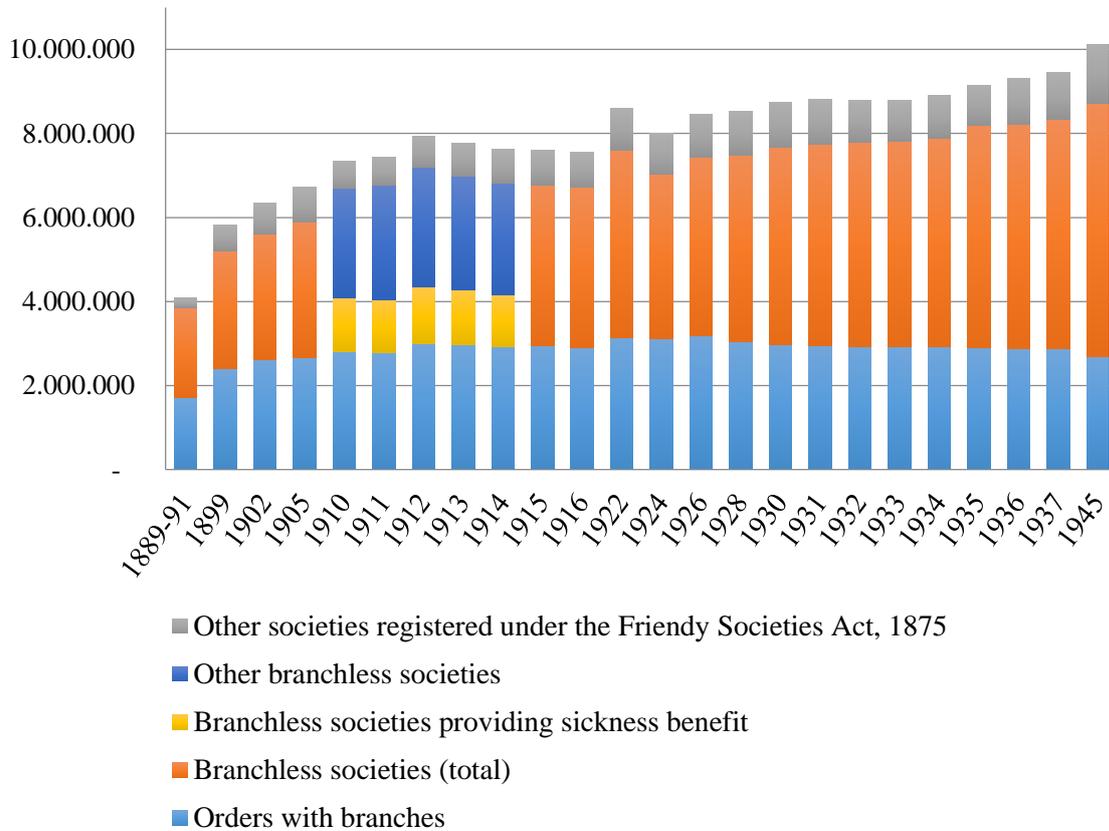
Both researchers working on mutual insurance and more general common-pool resources have paid a great deal of attention to the entry rules of the respective institutions. By defining who does and who does not belong to the group, members are made ‘identifiable’, and “the degree to which participants in collective action know each other personally influences the potential success of their group in terms of reciprocity.” (De Moor, 2008, 193-194) Social cohesion also promotes adherence to the rules and thus helps to overcome the problem of moral hazard (Van der Linden, 1996; Downing, 2015, 23-25; Van Leeuwen, 2016, 264). Although homogeneous, small-sized groups at first sight seem best capable to produce and maintain social cohesion, and thereby increase the outcome, empirical evidence on commons is ambiguous and the impact of these group characteristics on collective action may be mediated by other variables such as resource characteristics (Agrawal, 2008, 54). Homogeneous and small groups may be more successful in overcoming moral hazard at low costs, but less successful in accumulating reserves that can withstand economic or morbidity crises or in negotiating favourable contracts with medical professionals.

Drawing on previous research on welfare-state formation, mutual insurance, and other types of corporate collective action, the remainder of this paper is dedicated to describing and comparing what place mutual insurance had within the mixed economy of welfare in England and the Netherlands between 1870 and 1915, and what the predominant forms of institutional design looked like. Finally, having established the main similarities and differences between English and Dutch developments, the question of whether and to what extent these differences contributed to or hindered social reform up to 1915 will be assessed in the last section.

Mutual insurance coverage

The first mutual insurance associations in England, known as friendly societies, can be traced as far back as the end of the seventeenth century. It is difficult to pinpoint the precise moment when these societies emerged, as they drew heavily from existing mutualist traditions such as Huguenot mutual aid societies, guilds, freemasonry, charity briefs, and local credit networks (Cordery, 2003; Ismay, 2010). In the late nineteenth century affiliated orders (who always offered sickness benefits) had come to dominate the friendly society movement (see Figure

Figure 1: Total friendly society membership in the United Kingdom, 1889-1945



Note: Numbers for branchless societies providing sickness benefits are only known for the period between 1910-1914, but these numbers are presented separately for these years to illustrate the dominance of affiliated orders in the field of sickness insurance around that time.

Source: Harris, 2004, 82-83; 194

1), bringing about regional, national or even international cooperation between otherwise locally operating societies. Arthur Downing’s recent work allows us to say a bit more about coverage rates of the total population (see Figure 2). Although we do not know much about the figures for the years between 1815 and 1876, a growth from 8% to 11% of the total population in 60 years is not particularly spectacular, especially when compared to the growth between 1876 and 1909. This can probably be attributed to different periods of crisis due to aging memberships, war, unemployment and distress up to the 1850s, after which especially the affiliated orders drove a general rise in membership numbers (Neave, 1996, 46). How can we explain rising numbers of friendly society members? Why did people join a friendly society in the first place?

Even though dealing mostly with early nineteenth-century developments, Gorsky’s explanations are very revealing in this respect (Gorsky, 1998). Gorsky is careful to stress the

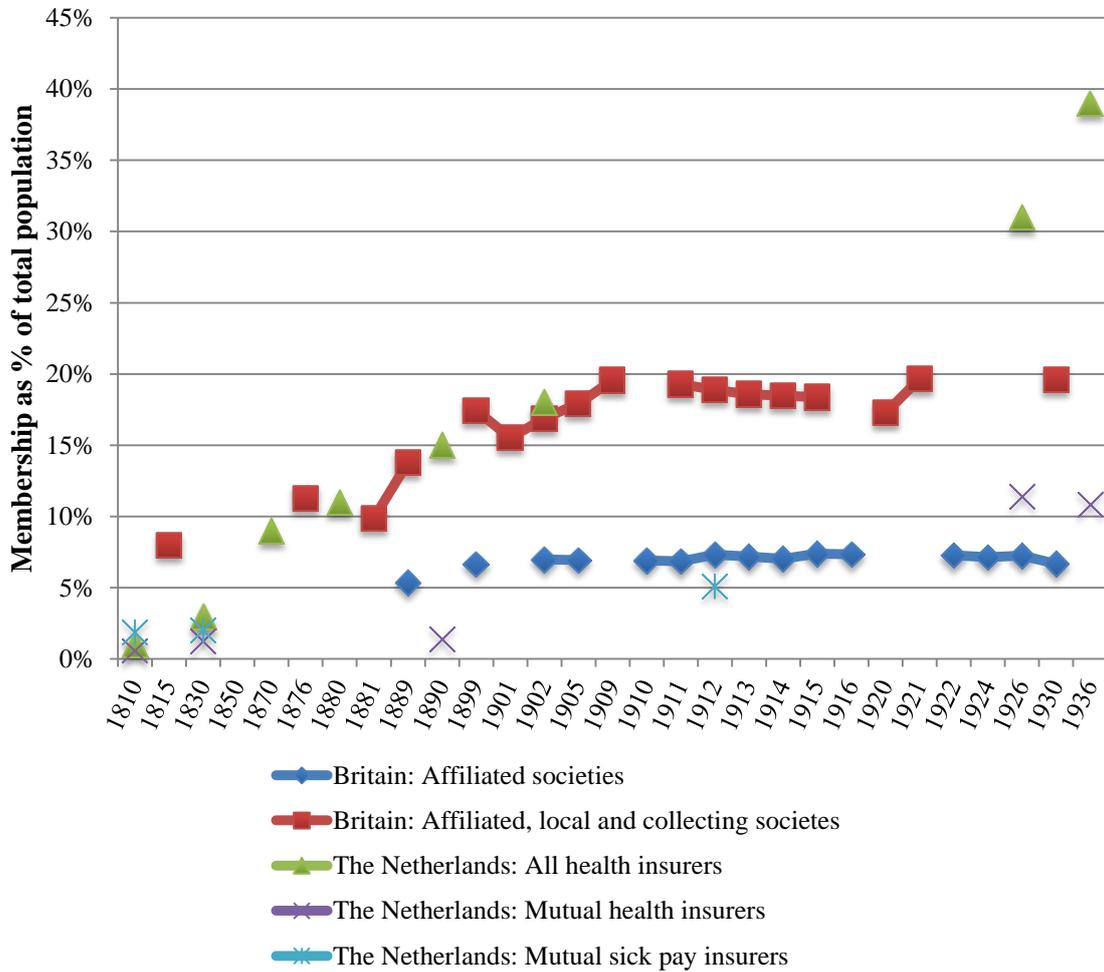
complexity and regional diversity of the matter, but he does point to some general explanatory factors: sectoral labour market change in combination with geographical mobility, of central importance for the manufacturing and mining sectors; female participation (regions with high levels of coverage often held female clubs); town size (middle-range towns had the highest participation rates); and the broader health culture and drinks trade as part of Georgian consumerism.

In reaction to the harsh Poor Law Amendment Act of 1834 and as part of more general working-class activity in the north, affiliated orders started to grow and to dominate the friendly society movement in the course of the nineteenth century. The orders provided an attractive solution to the fear of ending up in a workhouse, and also offered a novel mixture of self-government, secrecy, ceremony, and independence from middle- and upper-class domination (Neave, 1996, 43-48). Migration patterns may also have facilitated the growth of affiliated orders, as migrating members could join a similar branch of the same order in their new place of residence, without having to pay new entrance fees (Gorsky, 1998, 502). However, from the 1870s onwards, centralised societies (i.e. societies where risks and funds are pooled together in central funds, but no branch-structure is in place for decision-making on a local level) had started growing as well, and unlike affiliated orders they would continue to do this after 1900. In contrast to affiliated orders, centralised societies were especially successful in attracting women and other labourers who previously did not want to join or were not allowed to join a friendly society for reasons discussed below (Alborn, 2001, 566).

Historians writing about Dutch society in the nineteenth century have discerned three different social classes, each with their own forms of provision in times of ill-health (Japenga and Van der Velden, 1993; Van Genabeek, 1999; Van Leeuwen, 2016). Generally speaking, the upper classes could provide for themselves by paying their own physicians. Those without any capital or regular income (*de onvermogenden*), meanwhile, could not afford the costs of medical aid, nor did they have any money left at the end of the day to save or pay the premiums for any form of insurance unless they were income-related.

Finally, the upper lower class (*de minvermogenden*) consisted of people who had an income that was sufficient for some form of saving or insurance, but still insufficient to pay the regular fees of private medical care by physicians and pharmacists. It is mostly from this group that health insurers drew their policy holders, and in Figure 2 we can see that insurance was feasible for an increasing group of people between 1810 and 1936.

Figure 2: Membership rates sickness insurers in Britain and the Netherlands, 1810-1936



Note: Data on mutual health and sick pay insurers in the Netherlands for 1810, 1830 and 1890 is calculated by multiplying the number of funds by the average number of members from those mutual funds Van Genabeek was able to retrace the data of. These numbers are therefore not accurate, but serve as an indication of the growth in the number of people joining a mutual fund. See: Van Genabeek (1999), 85.

Sources: Britain: 1815: Gorsky (1998); 1876-1930: Downing (2015); The Netherlands: 1810-1890: Van Genabeek (1999); Van Leeuwen (2016); 1902: Japenga and Van der Velden (1993); 1911: Directie van den Arbeid, 1912; 1926-1936: CBS, 1936. Population estimates for the Netherlands between 1810-1890 are taken from Clio Infra: <https://www.clio-infra.eu/Countries/Netherlands.html> (last visited on 10 June 2017), and for 1912-1936 from CBS online: <https://www.cbs.nl/nl-nl/cijfers> (last visited on 10 June 2017).

According to Caren Japenga and Henk van der Velden, the impressive growth can be explained by two factors (Japenga and Van der Velden, 1993, 180). Firstly, due to the gradual disappearance of epidemics in the late nineteenth century, health insurance risks had become more predictable and limited as compared to other social risks. Since bad risks (e.g. the poor,

the elderly) were by and large excluded and expensive kinds of medical assistance were rarely provided for, the funds could operate with limited financial and administrative resources.

Secondly, economic growth played a major role: where 50% of the working class belonged to the lower working class in around 1900, a majority of the working class and 50% of the total population belonged to the upper lower class in the 1920s. This meant that a growing part of the population could avoid being dependent on free but stigmatising medical and poor relief, and instead join one of the various types of sickness insurers (Van Genabeek, 1999, 98-100; Widdershoven, 2005, 17; Companje et al., 2009, 120-122).

Another characteristic feature of sickness insurance in the Netherlands in this period is also reflected in the graph. Although monetary benefits to replace the loss of income (i.e. sick pay) and medical aid to fight the actual illness (i.e. health insurance) were initially often offered together, they were increasingly treated as separate risks. This makes the gathering of reliable data a bit more complex, as some funds offered only monetary benefits, while some only offered medical aid, and others offered both. As we shall see later, one of the consequences of this separation was the separate treatment of these risks in the national legislation.

A further important difference between England and the Netherlands was the fact that Dutch mutuals operated in a market that also included commercial insurers, doctors' funds and factory funds. In England, direct competition between mutual insurers and commercial insurance companies before 1911 was "almost nonexistent, since the latter stayed out of health insurance and specialized instead in securing against the contingency of working-class burials – something the orders never extensively provided." (Alborn, 2001, 576)

Like their English colleagues, Japenga and Van der Velden point to regional differences: in the northern and southern provinces, only 3.6% and 0.5% of the population had joined any type of sickness fund offering health insurance in 1900/1903, whereas the figures for the more industrialised eastern and urbanised western provinces were 12.6% and 27.2%, respectively (Japenga and Van der Velden, 187). As illustrated in Appendix 1, these regional differences were more or less also reflected in the membership figures of mutual insurers offering sick pay in 1912, although the differences were much smaller and none of the regions surpassed a coverage rate of 6.4% of the total population in the area. For mutual health insurance, I have only been able to retrieve regional data for 1936, at which time interestingly enough mutual insurers in the eastern provinces had the highest coverage rate (17% of the total population in the area), followed by the western (12.3%), northern (6.4%) and southern (4.1%) provinces. Just as in England, these differences point to the importance of

industrialisation and urbanisation: the degree of mutual insurance was much higher amongst industrial labourers than amongst agrarian labourers. As in England, industrialisation and urbanisation meant that people left behind traditional means of welfare provision in the countryside, and since the medical poor relief could be very restrictive, mutual insurance was an attractive solution (Widdershoven, 2005, 59). Higher coverage rates in the eastern provinces relative to the western provinces in 1936 can probably be explained by the high rate of medical professionals in western cities; the funds founded by medical professionals were particularly successful in attracting large numbers of members in the first half of the twentieth century, undoubtedly at the cost of mutuals' market share.

Finally, both Van Genabeek and Van Leeuwen point to the fact that the important role of mutual insurers within the insurance market can partly be explained by the long tradition of mutual insurance in guilds reaching back to the Dutch Republic (Van Genabeek, 1999, 81; Van Leeuwen, 2016, 162). After the abolition of guilds between 1789-1820, many mutual funds managed to continue their operation, although they had to shift from occupation-related, compulsory membership bases to voluntary and general memberships. In contrast to the guilds, these funds provided mainly medical care and medicine to their members and focused less on offering sick pay. In the second half of the nineteenth century, however, trade unions started to join the insurance market, which led to a renewed importance of occupational funds offering sick pay (Widdershoven, 2005, 41-42).

Mutual insurance in the mixed economy of welfare

Does a growing friendly society membership also denote a significant impact on the social security of its members? According to Harris, we need to be careful not to exaggerate this influence; mutual support in times of troubles was still most likely to stem from family or neighbourhood bonds. Moreover, friendly society membership was by and large drawn from the higher sections of the working class, even if a growing number of agricultural workers joined friendly societies in the course of the nineteenth century. Finally, the benefits of membership varied widely between the societies – from affiliated orders that were able to pay a substantial amount of sickness benefits, to local societies that could only offer a limited one-off payment in times of distress. Combining these findings, Harris concludes that “it would be wrong to assume that the growth of these organisations represented a viable alternative to the development of statutory welfare provision.” (Harris, 2004, 84)

Apart from family, informal saving strategies, and formal self-help, England had a long tradition of public poor relief. In 1834, a governmental commission presented their

report on the Poor Law, which included a design for a new system based on the distinction between the indigent and the poor. Outdoor relief was to be limited to the indigent, able-bodied persons, and their families would only be qualified for relief if they agreed to enter a workhouse. In terms of methods applied to fight poverty, not much seems to have changed in practice after the introduction of the New Poor Law in 1834, but poor relief expenses per head of the population most definitely declined. For this reason, the new law of 1834 is considered as “a watershed in British social policy” (Harris, 2004, 58).

The decrease in poor relief expenses has been described by Ismay as one part of the *push and pull policy* to encourage formal self-help, the other part being the friendly society regulations that offered privileges in return for registration (Ismay, 2010, 50). As mentioned before, registration remained voluntary, but an increasing amount of societies did register in the decades before the enactment of the National Insurance Act in 1911. A closer investigation of the Friendly Societies Acts of 1875 and 1896 reveals the primary concern of the authorities with the financial soundness and proper management of the societies. New regulations were formulated as to the registration and appointment of officers for societies with branches, allowing societies with branches to only register the society as a whole (if the rules of branches were all identical), and regulating the secession of branches from the central society to which they belonged. Friendly society legislation before 1911 thus reflected the growing importance of affiliated orders (hence the separate rules), but most of all the focus of civil servants and the national government on the reliable governance of the societies and their funds.

In the Netherlands, the lower working classes also depended on aid provided by neighbours, family and charity, but above all on medical and poor relief provided by local governments. The Poor Law of 1854 officially stated that private-based relief (i.e. mostly church-based) had preference over municipal aid, which should be seen as a last resort. Local churches from different denominations had been providing minimal care to the poor already from the Republic onwards, endowing mostly the sick, disabled, elderly, widows and widowers, children, and seasonal labourers (Van Leeuwen, 1999, 159-160). The growing demand for relief and the increasing complexity of both the administration and the medical care compelled most parishes to hand over the medical poor relief to the new municipal health services (*Gemeentelijke Geneeskundige Diensten*) from 1880 onwards. The organisation and quality of these services varied, but was generally speaking better in towns than in the countryside.

A small part of the resulting gap in health care provision in the countryside was filled by private initiatives. Local departments of the liberal charity organisation *Maatschappij tot Nut van 't Algemeen* founded funds in these regions to provide for funeral and sickness insurance. Although the first of these funds was founded in 1809, it was mostly after 1870 that sickness funds of this type emerged (Van Genabeek, 1999, 177). Founded and governed by outsiders, the funds had on average 100 members, mostly agricultural workers. They provided both monetary and medical aid, but because the contributions were set as low as possible they struggled to accumulate any financial reserves. Next to these funds, general practitioners also founded funds in rural areas to ensure a stable group of patients for themselves, while at the same time offering medical care to a group of people that otherwise would not have been able to afford it. However, this practice was not only limited to the countryside: the largest and most successful health insurance funds managed by physicians and pharmacists were located in urban areas, where they would be involved in heavy competition with commercial and mutual funds.

Unsurprisingly, the fiercest competition between mutuals and doctors' funds took place in the area of health insurance. Whereas commercial insurers were despised by doctors (and others) for their attempts to make profit out of people's health risks, mutual insurers were looked upon a bit more favourably. Nonetheless, the number of complaints listed by the *Nederlandsche Maatschappij tot Bevordering der Geneeskunst* (Dutch Society for the Advancement of Medicine – NMG) in 1900 and 1908 was long: contributions were not spent wisely; members did not have the freedom to choose their own doctors; associated medical professionals had almost no influence on the governance of the funds and were often treated as employees; and financial reserves were insufficient (Westhoff et al., 1900, 114-115; Schreve et al., 1908, 11-12). What is more, the NMG criticised mutual sickness funds for not including medical professionals in their management. After the 1908 report, the NMG therefore adopted the policy that one out of three managers of each fund had to be a doctor, and another third a pharmacist, so that only one-third of the board would consist of insured members (Companje, 2001, 30).

Some industrial labourers were covered by insurance schemes comprising all workers in their factory or several cooperating factories. Almost all existing factory funds offered sick pay, either as a fixed amount or as a percentage of the employee's wage, but in 1901 77% of the funds also provided health care or reimbursed costs made by physicians and pharmacists (Van Genabeek, 1999, 233-234). Most of the factory schemes date from after 1860, with the textile industry in Twente and, to a lesser degree, Braban, playing a pioneering role.

Commercial insurers providing sick pay grew even faster than mutual insurers in the nineteenth century, and this trend was also visible in the field of health insurance: the number of commercial health insurers grew thirteenfold in the period 1800-1890, compared to a four- to fivefold growth of the number of mutual funds (Van Leeuwen, 2016, 127). One of the explanations for this trend may be the competitive advantage commercial insurers had by recruiting members regionally or even nationally (in contrast to mutual funds, who usually functioned locally), thus reaping the organisational advantages of upscaling activities (Van Leeuwen, 2016, 163). Despite this growth, social reformers, doctors, and civil servants alike were highly critical of their profit-based operation (Fondsen-Enquête, 1892, 54; Schreve et al., 1908, 11-12).

The institutional design of mutual insurers

Although English friendly societies did offer medical benefits to their members and dependants, and although many Dutch health insurers did offer sick pay to male members, the main difference between the two countries seems to be that English friendly societies were primarily concerned with sick pay, whereas Dutch mutuals – except for the trade union funds – were first of all health insurers. The kind of insurance offered is reflected in the way the funds were governed, in their size, and in membership participation. Importantly, the differences also had impact on the main debates surrounding the mutual insurers at the end of the nineteenth century: whereas English public debates focused on actuarial soundness and the introduction of graduated scales of contribution, Dutch debates were mostly concerned with the relationship between medical professionals and mutuals.

Self-governance and democratic control

On a very abstract level, all mutuals under investigation were equally self-governing and democratic institutions. Members contributed to the financial operation of the funds by paying their contributions, which in turn enabled them to exert democratic control over the operation of the funds. Through general meetings, members could set and change rules, elect officials, and control the administration. Nevertheless, it is clear that the actual operation of these principles differed widely both within and between countries.

To start with, the institutional outlook of English affiliated orders reflects their highly valued fraternal ideals and local “lodge democracy” (Downing, 2015, 24-89, 177-254). Although being part of an affiliated order meant that a local lodge had to operate within a specific regulatory framework as developed on central and district levels, lodges did not share

assets and liabilities and “each branch was a self-governing entity appointing its own officials, recruiting members, collecting contributions and administering benefits.” (Downing, 2015, 186) Formally, there were many ways in which active participation of the members could be stimulated: members were given direct influence on the admission of new members; each member had to hold certain offices at least once; and contributions had to be paid during the general meeting, thus enhancing the chance that members stayed for the meeting. Moreover, affiliated orders were renowned for planning their meetings in pubs, thereby stimulating attendance of the meetings by offering a *social pint* afterwards (Cordery, 2003, 13). Social interaction was further stimulated by maintaining a high frequency of these meetings (weekly or fortnightly meetings were not uncommon), as well as through ritualization: annual festivities and processions, initiation rituals for new members, and the use of regalia for officers were common practices. For centralised societies, by contrast, sociability and local democracy were neither pivotal to the operation nor to the attractiveness of the funds (Alborn, 2001, 580). Although these societies could also be divided into local administrative units, their operation was only self-governing in the sense that the central managing committees were elected by delegates, who themselves were elected by members.

Despite the pronounced importance of lodge democracy for affiliated orders, participation may have waned over time. Public debates concerning friendly societies in the later nineteenth century increasingly focused on efficiency, financial stability and respectability. In order to prevent the middle and upper classes and the government from intervening in their activities, affiliated friendly societies felt they had to prove that funds were actually used for social security matters, and not to finance revolutionary goals (Cordery, 2003, 99). This, in turn, resulted in a process in which more importance was attributed to their financial goals, at the expense of sociability. Focusing mostly on the largest affiliated order, the Independent Order of Oddfellows Manchester Unity (IOOFMU), Arthur Downing shows that lodge attendance was not only persistently low in the late nineteenth century (in 82.6% of the investigated cases attendance was below 15%), but also that lodges began to meet less frequently between 1845 and 1930 (Downing, 2015, 251-252). Moreover, within lodges it was only a small group of members that held office and recruited new members. Downing attributes these lower levels of member participation to two interrelated factors, the application of actuarial methods and the growth in size of the branches; between 1845 and 1907, the average number of members per lodge of the IOOFMU in England grew from 68 to 204.

If size would be the only indicator of active participation in the democratic governance of a fund, Dutch mutual sickness insurers were highly democratic. In 1895, a committee of the *Maatschappij tot Nut van 't Algemeen* concluded that most of the mutual funds were small, with sometimes less than 25 members (Stroeder et al., 1895, 10). However, the committee also noted that the majority of these small funds only offered sick pay, and at this time most were probably set up by trade unions. Mutual health insurance associations were larger: the six mutuals that in 1913 decided to work together in defending their interests within the *Landelijke Federatie ter Behartiging van het Ziekenfondswezen* (National Federation for the Interests of Health Insurance – LFBZ) had a total of 130,000 members. Although the funds were officially mutually governed, reports noted that external beneficiaries could take office or have the right to vote, members exerted hardly any control over the operation and administration of the funds, and the governance was often in the hands of a specific group of members (Stroeder et al., 1895, 36; Westhoff et al., 1900, 114-115). Finally, contributions were collected by salaried agents, and members were thus not incentivised to join meetings. However, it is hard to judge to what extent this is a fair representation of all mutual health insurers. The founding of the LFBZ serves as an indicator that some of the larger and more well-known mutuals were proud to stress their mutualist character and willing to fight for their autonomy. When faced with competition from the NMG, they fought hard for the right to only have elected officials who were themselves members (Companje, 2008, 288-289). Moreover, Widdershoven shows that management boards of the mutuals were often surprisingly lenient towards their members when it came to the payment of contributions or benefits in times of individual or societal crisis, which suggests at the very least that the managers were not completely insensitive to the needs and demands of their members (Widdershoven, 2005, 255-257).

Dutch trade unions were much more similar to English affiliated orders in their governance structures, possibly due to the fact that they relied heavily on inherited traditions from premodern guilds (Van Leeuwen, 2016, 138). Sociability was a crucial element of the trade union movement in this period and, like friendly society practices, this sociability was enhanced through festivities and drinking, even when local trade unions started to work together on regional or even national levels (Van Leeuwen, 2016, 140). There were further similarities: contributions were not collected at home but had to be brought to the officers; the general meeting decided on the admission of new members; fines were prescribed for missing general meetings without a written declaration; and if they were elected by the general

meeting, members had to serve as officials at least once during their membership (Fondsen-Enquôte, 1892, 25-27; Stroeder et al., 1895, 38).

Entry rules and exclusivity

Although there were some female lodges and societies, the vast majority of friendly society members were men. The focus on fraternalism both reflected wider societal views on masculinity, defining men as breadwinners for the wider family, and allowed men to express their emotional ties to fellow lodge members ('brothers'). Especially the larger affiliated orders found it difficult to adapt to new male consumption patterns (e.g. new leisure activities, pubs becoming less exclusively open for men) and to offer insurance to the millions of women who entered the workforce after 1880. It was only after male membership numbers dropped in the years after 1900 that women were encouraged to join (Cordery, 2001, 7; Weinbren and James, 2005, 94; Alborn, 2001, 574-575).

Alongside gender, other reasons to be excluded from membership could be age (i.e. people under and over a certain age were excluded), ill-health, occupation (i.e. 'hazardous' occupations were excluded), moral status, and place of residence. These restrictions were mostly meant to prevent 'bad risks' from entering the society. However, ill-health and reaching a certain age did not always immediately mean one could not enter a friendly society; societies increasingly used graduate scales of contribution based on age of entry and medical condition. Due to mostly social and practical considerations, local branches demanded that prospective members had to live close to the central meeting place, whereas the moral status of members was guaranteed through the previously mentioned practice of proposers and seconders for the introduction of new members (Cordery, 2003, 26).

Like English friendly societies, one of the main concerns of Dutch mutual health insurers was to exclude bad risks. However, since graduated scales of contribution were not common practice, elderly members could switch funds without paying high entrance fees or higher contributions (Van Leeuwen, 2016, 132). Nevertheless, funds sought to attract mainly those who were young, of good health and of unresolved behaviour. Moreover, although the funds generally speaking did not explicitly exclude women, they were mostly targeted at male breadwinners (Van Genabeek, 1999, 104-105). Male members would pay higher contributions, but in exchange they were eligible for sick pay, medical aid, and funeral allowances, and they also had a right to vote and were eligible as officers. Meanwhile, women

paid lower contributions, did not have any democratic rights and were only eligible for medical aid and funeral allowances.

The main difference between Dutch and English practices was therefore the prescription of an income threshold for prospective members: only persons with an annual income below a prescribed limit were eligible for membership. In 1846, a group of medical professionals in Amsterdam founded the ‘Algemeen Ziekenfonds te Amsterdam’ (General Sickness Fund in Amsterdam – AZA) to provide health care for people who could not afford the regular prices, and they introduced an income limit to prevent those who could afford regular fees from entering (Van Genabeek, 1999, 185). This principle seems to have been promoted successfully by medical professionals throughout the country, as by 1900 most health insurers enforced some kind of income threshold. However, exceptions to this rule were often formed by the larger mutual health insurers that would eventually found the LFBZ. Moreover, one of the complaints of the NMG in 1908 was that members of health insurance funds whose income had grown above the prescribed limit during their membership hardly ever left the fund. Violation of the income threshold was also perceived to be correlated to population growth in the area where the funds were located (Schreve et al., 1908, 27).

Sick pay, health care and the evaluation of mutual insurance

The debate surrounding the levels of contributions and benefits English friendly societies offered was part of a broader concern of actuaries and state administrators with the solvency of the societies (Cordery, 2003, 99; Downing, 2015, 26-40). Until at least the mid-nineteenth century, weekly contribution levels were all equal and mostly based on what other friendly societies in the neighbourhood charged; in many cases the contributions would be slightly lower so as to attract more members. Even in 1874 the Royal Commission investigating friendly societies practices concluded that excessive competition made it difficult for individual societies to raise their contributions to more healthy levels. Since morbidity and mortality risks increased with age and most existing societies faced deficiencies, actuaries called for several reforms, most importantly for the introduction of age-based payment scales and a partial transfer of power to the central authorities of affiliated orders to introduce and enforce the reforms (Downing, 2015, 29-32).

Financial security was not the only reason why outsiders were critical of friendly societies’ abilities to offer social security to their members. Bernard Harris et al. describe how a perceived increase in sickness and morbidity rates within friendly societies in the 1870s and 1890s was equally central to the public debates (Harris et al., 2012). According to these

authors, many contemporary observers attributed the increase in sickness claims not to an actual rise in sickness, but to a growing propensity by members to claim sickness benefits and a failure by societies to police these claims. These arguments are hard to prove and historians disagree as to whether the rise in sickness rates was actually as great as had previously been supposed. Nevertheless, as the authors rightly argue, it is important to analyse how the perception of rising sickness rates may have affected attitudes towards social legislation (Harris et al., 2012, 97).

As mentioned earlier, weekly premiums in Dutch mutual health insurance associations were equal for all age groups except for young children. In return, members could consult a doctor for free, and eligible members also received minor treatments and medicines at no extra cost. Special treatments, maternity care, and hospitalisation were initially hardly ever provided for, so members were mostly insured against 'ordinary sickness'. The duration of care was almost always unrestricted, although people who were considered to have been ill too often or for too long could be excluded (Van Leeuwen, 2016, 132).

Since all of these services required the service of medical professionals (i.e. physicians, pharmacists), one of the main concerns of health insurers was how to reimburse them. There were several options: many funds paid allied physicians and pharmacists a set annual fee per member under their care, others divided a prescribed share of their income over the medical professionals based on the number of consultancies and prescribed medicines, or paid them a set fee for each service (Stroeder et al., 1895, 45). A general complaint from fund members was that doctors treated them poorly compared to the regular patients, which according to the NMG was partially a result of the fact that the contributions of the funds were set so low that the remuneration of doctors was also too low to expect decent care (Schreve et al., 1908, 49). The NMG was fiercely opposed to the practice of hiring doctors for a set salary, but rather wanted funds to introduce a subscription system so that doctors received a reasonable remuneration based on the amount of work done, without having to enter the funds as employees and being dependent on the fund managers (Schreve et al., 1908, 54-56). The NMG also wanted to defend the freedom of choice for the insured: with a subscription system many doctors could be contracted and members could freely choose where to go, whereas most mutual funds preferred to appoint doctors for specific areas without any opportunity to choose. Finally, some of the larger mutual health insurers managed to open and run their own specialist clinics and pharmacies at the end of the nineteenth and the beginning of the twentieth century, much to the dissatisfaction of the NMG.

In order to effectively defend the interests of doctors, the NMG developed a national policy after 1900 regarding the governance of health insurance funds. In reaction to some unfavourable, but failed attempts by the national government to regulate sickness insurance, the NMG formalised their policy in 1912-1913 (Companje, 2001, 33-35). Newly founded funds could no longer negotiate individual contracts with physicians who were members of the NMG (85% of all doctors in 1900), but would always have to negotiate with their central organisation (Companje et al., 2009, 109). Additionally, the NMG started to found its own funds, the so-called *Maatschappijfondsen*. By 1936, these funds were responsible for one-third of all health-insurance members, thus outsizeing all mutuals put together.

Introducing national health insurance

England

As we saw earlier, friendly society regulation prior to 1911 was mostly concerned with the actuarial soundness of the societies. According to Whiteside, this orientation on actuarial science of the authorities was continued and intensified after the enactment of the National Insurance Act (NIA) in 1911 (Whiteside, 2009, 21). Under the new scheme, all manual labourers over the age of 16 and earning less than £160 per year had to insure themselves against sickness either through an approved society or through the Post Office. This meant that, unlike the Old Age Pensions Act, contributions were not tax-financed, but rather the scheme depended on the payment of contributions by employed men and women (four and three pence per week respectively), employers (three pence per week) and the state (two pence per week). The medical benefits were rather basic and did not include services such as hospital treatment, dental care and free medical attendance for dependents, but if the contributors' society realised a surplus, such additional benefits could be granted with the approval of the Insurance Commissioners. However, in practice these additional benefits were hardly granted because conservative valuations from state administrators hindered any initiative from the friendly societies in this respect (Downing, 2015, 265).

Friendly societies, trade unions, and insurance companies could apply for the status of 'approved society', and as such enrol members and pay cash benefits. Competition between approved societies would form an important determining factor in the further development of friendly societies, but this competition was somewhat limited by two obligatory characteristics of approved societies: they had to function on a non-profit basis and they had to be under control of their members. Friendly societies and trade unions already met these

requirements, but commercial insurance companies had to set up new, separate approved societies for the execution of this scheme.

Lloyd George had initially intended to extend friendly society coverage to all working people, but the inclusion of trade unions and commercial insurance companies fits within the liberal outlook of the legislation with its “commitment to competition, choice, and collective/individual responsibility.” (Downing, 2015, 264) The NIA provided contributors the freedom to choose between approved societies, and the societies themselves were supposed to be governed by the members. Equally, societies were free to reject applicants on any ground other than age. In practice, however, in the societies set up by commercial companies, workers’ desires were “molded by the persistent application of a salesman’s influence.” (Alborn, 2001, 583) Moreover, due to a lobby by the commercial companies (stressing their administrative superiority compared to friendly societies), societies were in the end free to organise self-government as they thought fit, which in the case of the Prudential Approved Societies (growing to be the largest company with 4.827.000 members in 1946) meant that a quorum could be formed by twelve members – in practice often clerks (Alborn, 2001, 592). Lastly, competition to recruit new members after the enactment was so intense that the freedom to reject applicants remained mostly theoretical; in practice, societies were willing to accept individuals in any physical condition (Downing, 2015, 270).

In light of the Friendly Societies Acts of 1875 and 1896, it may come as no big surprise that the design of the NIA favoured administrative efficiency. Yet its introduction, together with the Old Age Pensions Act of 1908, has been identified as a “turn away from voluntarism” and “another act in the drama of squeezing sociability” (Cordery, 2003, 174). There are at least three post-1911 developments that led historians to define 1911 as the end of British mutualism. Firstly, whereas the membership of affiliated orders stabilised after 1911, centralised societies grew rapidly. Secondly, although membership numbers of the affiliated orders did not change considerably, their entry rules often did. The process of opening up towards female and juvenile members may have already started earlier amongst friendly societies, but the inclusion of female workers in the scheme further prompted societies who had not done so before to allow women to enter. In contrast to centralised societies and commercial companies, affiliated orders were not always keen to attract new members who had not been insured before, as their motivations for not joining earlier were mistrusted: poor health or a lack of commitment to voluntarism were perceived as the main reasons for not joining, which meant that these people would become a financial burden in later stages

(Alborn, 2001, 587). Since fraternalism and community building were to a large extent dependent on the exclusive character of the membership, these fears may partly have been justified. Both contemporaries and historians have identified increasing problems amongst the affiliated orders to police claim behaviour (also because the state now contributed and malingering was thus not necessarily at the expense of fellow-members) and to uphold fraternal traditions and active participation (Alborn, 2001; Cordery, 2003).

Thirdly and finally, the governmental grip on friendly societies tightened further. Although earlier legislative tendencies were largely continued, contributions and benefits were for the first time set by the government. These rules only applied to the part of societies that administered the NIA (societies often started a separate fund), but since friendly society membership had always been dominated by male workers with a stable income, this scheme came to dominate friendly society-affairs. Furthermore, since the state contributed to the scheme, it also had an interest in restricting access to the scheme by the sick. Rather than expanding the benefits in the years following the introduction of the NIA, governmental contributions were cut back in 1925 (twice) and 1931 (Whiteside, 2009, 9). Administering the scheme, moreover, was an expensive and complicated matter, which in practice resulted in a further undermining of lodge democracy, as many local lodges amalgamated or called upon external experts to administer for them (Weinbren, 2010, 153).

However, the NIA was not only bad news for friendly societies. Downing argues that the new scheme probably had a beneficial influence on the financial situation of the funds, most importantly by providing an influx of new members on the voluntary side. This was necessary as well, seeing as especially affiliated orders were increasingly struggling to keep their expenses under control. Moreover, the trends of declining sociability and active participation had already begun in the nineteenth century, an observation that should warn us not to use the false dichotomy of mutual aid versus welfare state, where the growth of the latter crowds out traditions of formal self-help by default (Downing, 2015).

The Netherlands

Despite several attempts to introduce some form of insurance to cover the costs of illness in the early twentieth century, sickness insurance was only effectively introduced in 1930 (sick pay) and 1941 (health care) in the Netherlands. In contrast, the Industrial Accidents Act was introduced in 1901, the Old Age Pension Act in 1919, and although compulsory state insurance against unemployment was only introduced in 1952, unemployment insurers were subsidised through the Unemployment Benefits Decree of 1917. Why did it take so long

before sickness insurance was integrated into the national system of social insurance? And what were the consequences of this belated legislation for the insurance market?

In 1892, Lely, the minister of Water Management, Trade and Industry in a liberal-democratic coalition, commissioned an investigation on working class legislation abroad in order to determine the options for national social legislation in the Netherlands. The main conclusion of the report was that the first priority was to organise social insurance against disability and industrial accidents. Old age regulations were considered to be too complex for the time being, whereas national sickness insurance was less urgent due to the widespread operation of voluntary funds (Hoogenboom, 2004, 107-109). However, the choice to start with industrial accidents without linking it directly to sickness, old age and disability would also complicate future social legislation, especially regarding sickness (Rigter, 2008, 98). Moreover, the complex mixture of public and private administration hampered the creation of one central medical service that could be used for all future social security and public health measures (Rigter, 2008, 138). Finally, in the process leading up to the enactment of the act, employers organised themselves for the first time into one pressure group. In 1899, the *Vereeniging van Nederlandsche Werkgevers* (Association of Dutch Employers – VNW) was founded to defend the interests of the employers, which it would continue to do in the future.

In 1904, Abraham Kuyper, foreman of the Orthodox-Protestant *Anti-Revolutionaire Partij* (Anti-Revolutionary Party – ARP), proposed a compulsory sickness insurance scheme for permanent employers (Roebroek and Hertogh, 1998, 136). Premiums were to be paid by employers and employees, and the administration would be in the hands of newly founded public funds, approved private funds (existing funds could apply for approved status) or employer funds. The benefits would include both sick pay and health care. However, national elections prevented the proposal from being turned into an act. Equally, a similar proposal in 1906 was never discussed seriously due to the fall of the new cabinet. Although efforts were thus undertaken to introduce compulsory sickness insurance for parts of the population, the timing of Kuyper's proposal arouses suspicion; why propose ideologically charged sickness insurance at the end of one's term? According to Hoogenboom, this was largely due to agreements Kuyper had to make with Savornin Lohman (an aristocratic, conservative Protestant member of parliament) in order to form a government. Savornin Lohman would only support social legislation if Kuyper could provide the means to finance them. However, Kuyper's final proposal to finance the sickness act partly by increasing import duties was not supported by Savornin Lohman, thus making the enactment of the law impossible (Hoogenboom, 2004, 134-135).

Whatever the causes, one consequence of the blockage was that new proposals were initiated by different people with other ideas on social insurance. In 1908, Talma became the Minister of Agriculture, Trade and Industry in a coalition that was formed by Catholics, anti-revolutionaries and a few neutrals. The main innovation of Talma's proposals in 1910 was that sick pay and health care were divided into two separate arrangements, even though sick pay would only be paid out if the insured also received health care (Roebroek and Hertogh, 1998, 137-138; Companje, 2008, 268-269). Ideologically speaking, the separation was based on the legal grounds Talma attributed to the insurance. In his eyes, sick pay was only a working class interest, whereas health care was a public interest. On more practical grounds, both national differences in the quality and quantity of health care between urban and rural areas, alongside German and English practices, led Talma to believe the Dutch government could not guarantee health care provision, as it was too dependent on the medical profession. In his view, private initiatives in the field of health care were developing in a direction that would cover the current deficiencies in rural areas, something governmental intervention could not enforce since it required the actual presence of medical professionals in those areas. Moreover, Talma was afraid that national intervention would disturb the operation of municipal medical relief, as municipalities would decide to cut their budgets. Finally, Talma thought that the separation of sick pay and health care was already common practice amongst sickness funds. This, of course, was only partially true, seeing that especially some of the larger mutual funds did offer sick pay, albeit as an additional insurance that was administered through a separate fund.

Even if the Sickness Act of 1913 was never enforced, Talma's influence was large for several reasons. First of all, health care and sick pay were politically speaking two different matters from this point on. Secondly, both the NMG and mutual funds responded to the legislative process. As we saw earlier, the NMG decreed in this time their binding resolutions on the remuneration of doctors and the governance of sickness funds. Around the same time, the larger mutual funds founded the LFBZ. Both the NMG resolutions and Talma's conditions to receive the status of approved sickness fund contained regulations on the formation of boards of management, the freedom to choose doctors and the payment of medical professionals that could not be combined with the mutuals' practices of self-governance, the running of their own medical institutes, and the hiring of doctors for a fixed salary. The first act of the LFBZ was therefore to publicly announce its objections to the NMG resolution and the Sickness Act. Moreover, those funds that were connected to the LFBZ agreed that the

collective sickness funds contracts with the NMG would only be negotiated by representatives of the LFBZ, and no longer by the individual funds (Companje, 2008, 288-289).

Conclusions

English friendly societies were mainly focused on offering sick pay to their members, and to do so they stressed the importance of local democracy, sociability, and self-help. Over time, however, affiliated orders and the friendly society movement more generally underwent a process of scaling, professionalisation and declining sociability and 'lodge democracy'. Dutch mutual insurers, by contrast, were primarily health insurers. Their membership bases per individual group were larger than those of their English counterparts (excluding centralised societies), and their main concern was how to compete with medical professionals and commercial insurers.

These differences are also reflected in the main (political) debates at the time. English debates focused on the balance between financial viability and social democracy. When the British government sought to alleviate the poorer parts of the population and to improve industrial efficiency at the start of the twentieth century, friendly societies were not only integrated into the social insurance scheme because of their size. Rather, their operation, based on reciprocal relations and participatory democracy, also rendered them suitable for the administration of social-welfare benefits. In terms of efficiency and inclusiveness, however, friendly societies were no match for the newly added, highly competitive industrial insurance companies. Furthermore, the design of the NIA undermined the two elements that lay behind their inclusion in the first place. Both reciprocity and participatory democracy thrived on the fraternal and sociable traditions that had already started to decrease in importance before 1911, but that further waned after the enactment of the NIA due to new entries and tight governmental control.

Meanwhile, Dutch discussions concentrated on the remuneration of medical professionals and the constitution of the boards of management. Despite the observation that Dutch mutuals in general seem to have been less successful in and/or concerned with active membership participation, we have seen that mutuals fought for their autonomy and self-governance. The introduction of national sickness insurance proved to be a difficult project for many reasons. Even if most parties agreed on the desirability of some form of governmental intervention, each party had their own ideas on who should be covered, who was to finance, and who should administrate the schemes. Moreover, as time progressed, employers, medical professionals, employees and mutual insurers all founded their own organisations to defend

their interests. Finally, governmental action to cover the costs of sickness may not have been considered as urgent as in other fields. Industrial accident insurance was prioritised due to its relative feasibility and due to the fact that private initiative was not perceived to be as developed here as in the field of sickness insurance. Kuyper only initiated reforms at the end of his term. Talma was most serious in his efforts, but even he regarded sick pay more relevant than health care, as private initiative in the latter was already developing in a desirable direction. Nevertheless, parliamentary debates on sickness insurance did prompt both doctors and mutual insurers to act. For the time being, the insurance market with its own dynamics remained as open and free as before, but imminent regulation forced the players in the market to formulate and to defend their own interests to each other, to parliament and to the general public at large.

Appendix 1: Regional Breakdown of Mutual Sickness Insurance Coverage in the Netherlands in 1912 (Sick Pay) and 1936 (Health Insurance)

	Sick Pay						Health Insurance		
	1912 (excl. Trade Unions)			1912 (incl. Trade Unions)			1936 (incl. Trade Unions)		
Region	Funds	Members	% population	Funds	Members	% population	Funds	Members	% population
Northern Provinces	222	32.300	3,7%	227	32.577	3,7%	38	68.692	6,4%
Groningen	112	12.637		116	12.888		11	24.521	
Friesland	91	16.680		91	16.680		20	28.233	
Drenthe	19	2.983		20	3.009		7	15.938	
Eastern Provinces	158	40.488	3,9%	180	42.205	4,0%	77	245.704	17,0%
Overijssel	57	22.918		63	23.569		27	168.082	
Gelderland	101	17.570		117	18.636		50	77.622	
Western Provinces	506	177.751	5,7%	616	200.520	6,4%	71	541.987	12,3%
Utrecht	41	6.346		45	7.043		12	46.883	
Noord-Holland	145	63.936		173	77.243		21	208.710	
Zuid-Holland	246	99.279		324	108.044		30	273.641	
Zeeland	74	8.190		74	8.190		8	12.753	
Southern Provinces	87	14.453	1,5%	101	15.520	1,6%	25	63.668	4,1%
Noord-Brabant	59	11.741		71	12.651		22	58.044	
Limburg	28	2.712		30	2.869		3	5.624	
National	1	310		23	18.348				
Total	974	265.302	4,4%	1.147	309.170	5,1%	422	920.051	10,9%

Sources: Population 1912-1936: CBS online: <http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=37556&D1=16-20&D2=13,37&HDR=G1&STB=T&VW=T> (last visited on 18-05-2017); Sick Pay 1912: Directie van den Arbeid (1912); Health Insurance 1936: Centraal Bureau voor de Statistiek (1936).

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