Nursing as Part of Care for the Poor in Slovak Villages in the First Half of the 20th Century

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Abstract

Caring (opatrovateľstvo) and nursing (ošetrovateľstvo) have evolved in our country as two distinct types of personal services, with a historical relationship that has developed through processes of mutual separation and convergence. The aim is to demonstrate a historically validated method of integrated caring and nursing at a local level. By analyzing valid legal regulations, it is possible to map the real relationship between 1918 and 1938 in present-day Slovakia within the 1st Czechoslovak Republic. In addition to the nursing provided by the public health system nurses, municipalities were obliged to provide care for people experiencing poverty (chudobníctvo) to persons with a domicile right in their municipalities. This care included not only social care but also healthcare, and thus, according to the specific needs of the recipient, social and/or healthcare was provided. Joint nursing and caring, which has already proven its worth in the inter-war period at the municipal level in the context of care for the poor, appears to be the most appropriate approach to the proposed concept of long-term care for older people and other recipients.

Keywords: *caring, nursing, care for the poor*

Introduction

As we will demonstrate in this study, caring (in Slovak: opatrovateľstvo) and nursing (in Slovak: ošetrovateľstvo), as basic types of personal social services, began to develop in the second half of the 19th century in a significant interdependence. Already here, however, one can identify a content orientation of nursing towards medical acts and of caring towards assistance for people experiencing poverty. The fact that both of these areas involved the still nascent local (self)government meant that these activities often clashed in practice, most often in that it was people experiencing poverty who were most often in need of public health services as well. This character was maintained in Slovakia for a century. It was only after the Second World War that the situation could change. Still, by the centralised state not paying due attention to services in general (and social services provided individually in particular), the relationship between nursing and nursing was not addressed systemically at this time either.

The change in the organization of the central state bodies in Slovakia on July 1, 1990, created two new ministries: the Ministry of Health of the Slovak Republic and the Ministry of Labour and Social Affairs of the Slovak Republic. The two types of personal services, which these ministries had already been providing under their responsibility, were thus again separated in terms of legislation and organization, often for the same recipients, who were most often older people, especially insofar as they received these services in their own homes.

Separating these services has caused several problems and complications in practice from the outset. This was most pronounced in long-term residential service provision facilities for older people (Szüdi, Kováčová, Konečný, 2016). For more than three decades, several attempts have been made to overcome this division, while also learning from past developments. In our study, we aim to highlight one period in the development of nursing that was closely tied to caring at the time, specifically during the 1st Czechoslovak Republic, when municipalities in Slovakia performed specific tasks.

At the same time, we aim to set the record straight on some established, traditional, and somewhat inaccurate information regarding nursing and caregiving in our country during this period. These are three types of statements:

The first type is based on the statement that nursing and caring in the interwar period in Slovakia was carried out only on a charitable and voluntary basis - and the role of municipalities is not mentioned at all: „Until the 1940s and 1950s, care for elderly people dependent on the help of another person for every day and instrumental activities was provided in former Czechoslovakia on a charitable and voluntary basis, based on the traditions of Christianity proclaiming love for one's neighbor and the obligation to help each other. Within the framework of this principle, shelters and later institutions for the poor and abandoned were established“ (Bednárik, Brichtová, Repková, 2011, pp. 13-14).

The second type of statement states that nursing and caring were carried out (only) by the Red Cross: „The history of home nursing care in Slovakia begins to be written after 1919 with the establishment of the Czechoslovak Red Cross. Under its auspices, nursing and caring in families started to develop in 1920. The service was mainly provided to the elderly, the invalids, and the bedridden sick. This service provision method persisted until the 1950s“ (Tirpáková, 2022, p. 261).

The third type of claim asserts that a division between nursing and caring already existed during this period: „After the establishment of the First Republic, new facilities for the elderly began to emerge. In addition to state care, voluntary organizations and the church provided care for the elderly. Thus, care was divided into health and social care" (Matišáková, Libová, Gerlichová, 2018, p. 59).

Our study aims to demonstrate that caring and nursing were carried out together in Slovakia during the interwar period within the framework of tasks legally obligatory for municipalities.

And although in the title of our study we have retained only the first half of the 20th century, to which the central analytical part of the study is devoted, especially in the final evaluative part, we have gone beyond this time horizon to put the results of the analysis in the context of more recent practice.

1. Material and methods

The basic material for our study was the legislation that has regulated the field of health and social affairs in different periods. The terminology used to describe the various phenomena regulated by law often changes in response to legislative updates.

It was not just legal terms. From the end of the 18th century until the early years after the Second World War, health and social policy underwent significant changes throughout Europe and, understandably, in this country. In our country, this development was complicated by the state-law system. One of the first laws of the new Czechoslovakia, Act No. 11/1918 Coll., is often referred to as the recipiency norm. Article 2 of this law ensured the continuity of the legal order by temporarily preserving all existing laws and regulations from the Austro-Hungarian Empire, thereby avoiding legal chaos and ensuring a smooth transition to the new state structure. However, this meant that in the new Czechoslovakia, a so-called legal dualism existed, with different rules applying in Bohemia and Moravia than in Slovakia, even for the same area of law (Konečný-Halász, 2024).

Objective economic, social, and cultural differences between the two parts of the republic, which were only gradually being overcome, also hindered the unification of the legal system. Consequently, our analysis has often relied on secondary sources, interpretive literature, and largely incomplete statistical data.

Generally speaking, the analysed legislation, in force in our country from the second half of the 19th century throughout the following century, reflected the contemporary characteristics of the understanding of both public administration (the still nascent separation of local government from state administration) and the system of social protection (similarly, the still nascent separation of social issues from public health issues). The choice of relevant legislation had to correspond to this, as did the framework of the interpretative literature used.

2. Results

The 1st Czechoslovak Republic was a state with a well-developed social protection system. Among other things, Act No 2/1918 Coll. established the Ministry of Social Welfare. There was also a Ministry of Public Health and Physical Education, established by the same law, whose remit included health care: for example, the Ministry set up three state hospitals in Slovakia and also professionally managed some three dozen county, town, and other hospitals (for example, it also set fees for treatment). Its main tasks included fighting epidemics, tuberculosis, malnutrition, diseases, etc., mainly through a network of district and municipal (city) doctors (Rubisová, 2020). It also included health stations, primarily responsible for health education and health care (Kafková, 1992).

Outside of the successfully developed system of social insurance based on public law, as well as a wide range of social policy activities by the state with a well-established system of instruments to combat unemployment, housing, youth care, public healthcare, etc., there was still a significant area of care for the poor, for which the term „chudobníctvo“ (meaning care for people in misery) was coined, which was entrusted to the municipalities. However, the municipalities fell under the jurisdiction of the Ministry of the Interior, and thus, the care of the poor by the municipalities also fell under this jurisdiction. Despite the complexity of the social protection system, it was pretty functional.

Poverty was considered part of social policy. „By analogy with the treatment of disease, social policy must first deal with the treatment of the actual causes of poverty, that is, preventively, by removing the conditions which produce the plight of poverty, and only then palliatively, by treating the individual acute symptoms. From this perspective, securing a higher level of education, health, and employment opportunities, among other things, falls within the general tasks of social policy. At the same time, the cure of acute cases is the task of poverty" (Rosenauer, 1935, pp. 4-5).

In Bohemia, Moravia, and Silesia, the legislation of the Austrian part of the monarchy was reciprocated by the Act XLIII/1863 (Zákon ze dne třináctého prosince 1863, jímž se pořádají záležitosti domovské), which comprehensively addressed the issue of home law in the second and third parts, and devoted the entire fourth part to the „obligation of the municipality to provide for people experiencing poverty.“ Subsequently, a special poor law entered into force in the Austrian part of the monarchy in 1868, making the legislation in the subject area more transparent in the Czech part of 1st Czechoslovakia than in Slovakia, where the Hungarian statutory article governed home law (No. CCXXII/1896) (Munka, 1926; Koržinský, 1932). CCXXII/1896 (Munka, 1926; Koržinský, 1932).

In Slovakia, the original Hungarian legislation remained in force for this area, reciprocated by Act No. 11/1918 Coll. z. a n. It was primarily the Hungarian statutory article

XXII/1886, which in § 21, letter g) explicitly and exhaustively listed poverty among the tasks of the municipalities. Although § 20 of Act No. 76/1919 Coll. stated that the higher-level local government (at that time, the county government) or the state administration would take over several branches of activity previously administered by the municipalities, including poor administration and charitable institutions, this did not occur until the end of the existence of the 1st Czechoslovakia.

Hungarian Statutory Article XXII/1886 did not define the concept of poverty or care for the poor. In the literature from the period of the 1st Czechoslovak Republic, even the idea of poverty was linked only to the entitlement to poor relief or care for the poor: „In general, a person is considered to be poor, entitled to public support, who is not in a position to provide for himself or his family even the most necessary (primary) means of subsistence out of labor income or other pensions, even when claiming other entitlements“ (Rosenauer, 1935. p. 5).

Poverty in the Hungarian legislative system was part of the system of so-called public support, which also included the expenses of public healthcare, as regulated by Hungarian Law Article No. XXI/1898. This scope is interpreted in today's terminology as „social and social-health care“ (Dudeková, 2013, p. 204). In § 8, under a) and b), some obligations of home municipalities in treating the sick were listed. In addition to these provisions, the Hungarian Minister of the Interior issued Statute (general binding regulation) No. 51000-1899 B.M. on the manner of providing public support by municipalities, and in it, on poverty as a duty of municipalities.

Finally, relevant information is also provided by the Statute of the Hungarian Minister of the Interior No. 1422-1889 B.M. on poor administration, which states in point 2 that „support or public provision is to be granted in that case when total indigence, permanent or temporary work and earning capacity, and the unavoidable support of public support are unconditionally proven credibly. In the case of child custody, abandonment by the parents or at least the fact that the parents are unable to care for the child shall be proved."

O. Rosenauer (1935, pp. 30–32), by analyzing the above and some other related Hungarian sub-legislative norms, including the case law of the Hungarian and Czechoslovak Supreme Courts, arrived at the definition that „poor in the sense of care for the poor“ is

1. the able-bodied who is unable to support himself and his family without public support (which follows from § 145 of Law Art. XXII/1886),

2. those incapable of work who are (according to other regulations)

(a) found as well as officially declared abandoned children over the age of 7 years,

(b) the sick who are not in a hospital or other inpatient medical care,

systém patients who are not diagnosed for treatment in a hospital or other medical institution, or who have been discharged from such institutions as incurable,

(d) those who are not dangerous to the public, the insane, the mentally defective (cretins, morons), the deaf and dumb, the blind, and the physically handicapped (cripples).

These persons were obliged by their home municipality to provide public support, as they could not claim it from anyone else.

Meanwhile, the core of our interest became § 8 of the Hungarian Law XXI/1898, which obliged the municipalities to cover the costs of nursing and related transport (but also medicines, disinfection for infectious diseases, etc.) if the insurance company 75ktivi employer was not obliged to cover them and the citizen or his relatives were not able to pay for them. However, it also obliged the municipalities to systém care of the treatment of such poor in hospitals and, what is interesting from our point of view, to systém care of, and in this, the treatment of the incurably ill poor, the poor after their discharge from hospitals and other medical institutions, etc.

In these cases, the competent municipality was always the so-called home municipality, as designated under Law XXII/1886, and carried out these tasks as part of its care for the poor. This meant that it was assessed whether they were indeed municipality members. If they were, the resources designated for pauper care (the so-called funds for the poor) could also be used for their treatment (Konečný, Szüdi, Szüdi, 2016, pp. 30-32).

Care for the poor was provided almost exclusively in the homes of these persons. In 1921, there were 185 villages and towns in Slovakia with poorhouses, old-age homes, and sick homes (Dudeková, 2003, pp. 21-26). However, these usually had a capacity of only a few places, and only in large towns did they reach a capacity of two or three dozen places.

In addition, immediately after 1921, so-called health stations with visiting services, staffed by trained or even diploma-trained nurses, began to operate in our country under the Ministry of Health. In addition to health education, their tasks included providing medicines. The Czechoslovak Red Cross played a significant role in its activities (Kafková, 1992). However, even their activities cannot be considered care without social aspects, as public health care always has some caring aspects (Konečný, 2004).

Conclusion

In general, we can conclude that nursing in the interwar period in Czechoslovakia, and to some extent also in Slovakia, 75ktivity75 primarily as a specialized service within the public health systém. Nursing services were provided by religious and civilian nurses, primarily in

hospitals but also in the field, where their activities were supplemented by the visiting service of Red Cross nurses working in health stations.

At the same time, however, within the framework of care for people experiencing poverty that constituted public support and was based on home affiliation, municipalities provided nursing and caring to their inhabitants as an 76ktivity characterized by a holistic approach to the person to whom these services were provided. Acts that could be described as predominantly caring or predominantly nursing were not separated from each other in the performance of this care, but were provided according to the circumstances of the case and the needs of the person to whom the pauper care was provided.

In 1948, a political upheaval profoundly altered the entire public administration systém. Establishing national committees as local government bodies (by Constitutional Act No 150/1948 Coll.) created the conditions for the abolition of self-government, and therefore, the abolition of the home law by Act No 174/1948 Coll. Was also introduced. As early as 15 April 1948, Act No. 99/1948 Coll. On national insurance was passed, which nationalized the pluralist social and health insurance systém.

The total etatization of all spheres of life went hand in hand with strong centralization. All Czechoslovak and Slovak governments since 1945 had divided the ministries of health and social affairs. For the first time, a joint ministry of health and social affairs was created in the Slovak Republic‘s government on 21 April 1988. As mentioned in the introduction, this joint ministry was only in place until June 30, 1990, i.e., for only 556 days, which appears to be insufficient to reconnect the nursing and caring concepts.

Even in the last relevant pre-revolutionary Act, No. 100/1988 Coll., on social security, caring was one of the instruments. This social care service could also be provided in the home. The district national committee was the competent authority, which, following the delimitation of the nursing service to municipalities by Act No. 416/2001 Coll. On the transfer of specific competencies from state administration bodies to municipalities and higher territorial units, made the performance of caring and nursing even more remote. While the municipalities have been given nursing services within their original scope of competence, they have had little to no impact on providing nursing services. Although Act No. 448/2008 Coll. On Social Services allowed for the provision of nursing services in social service facilities (i.e., not within field services), it was not until the systemic solution of so-called long-term care that real steps towards reconnection were taken.

One of the fundamental elements of the long-term care concept is the integration of nursing and caring services with the recipient, with payment for these services made directly to the individual with long-term care needs (Stratégia, 2021). The basic idea of providing

integrated services tailored to the individual recipient‘s needs makes this remote, yet reminiscent of the concept from the inter-war period.

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