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Dynamics of the Management and Implementation of Colonial Health Policy at Pandeglang Hospital (1925–1935)

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Abstract
This article examines the management dynamics of Pandeglang Hospital from 1925 to 1935 in the context of changing colonial health policy in the Dutch East Indies. The study applies the historical method through heuristics, source criticism, interpretation, and historiography using colonial health reports, government regulations, and supporting literature. The findings show that institutional change from a military-oriented system to civilian health services shaped administrative standardization, patient classification, subsidy mechanisms, and medical supervision at Pandeglang Hospital. The hospital became important in handling endemic disease, serving as a regional referral center, and strengthening local medical personnel, yet its impact on mortality remained limited because poverty, poor sanitation, and the global economic crisis constrained colonial medical intervention. This case highlights how colonial health policy was implemented unevenly at the local level.

Keywords
Pandeglang; colonial hospital; health history; Dutch East Indies; health policy

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Introduction

In the colonial structure of the Dutch East Indies, Pandeglang occupied a strategic position as both a productive and an administrative region that supported colonial economic interests through plantation commodities such as coffee and pepper, transportation infrastructure such as the Rangkasbitung–Labuan railway, and the promotion of colonial tourism (Hidayat & Arif, 2024). As a region that held significance in the colonial economic and bureaucratic configuration, Pandeglang inherited a range of government buildings and public facilities, including a hospital (Nofiandi, 2015).

Even so, the historiography of Pandeglang is still dominated by administrative and economic studies, while social aspects—especially the history of health—have not received sufficient attention. The former Pandeglang Hospital building still stands and has now been repurposed as a regional library, serving as a material trace of colonial health services at the local level. The lack of studies on the hospital's establishment, management dynamics, and role in society indicates a gap in local historiography, particularly in the fields of social and health history.

In general, studies of colonial health policy have been undertaken by a number of scholars, but most of them remain focused on the macro level. The article "Transformasi Lembaga Medis di Hindia Belanda: Potret Sejarah Kesehatan di Indonesia dalam Perspektif Politik (1850–1942)" by Rendy Kurniawan and Rahmawati Agustia (2021) emphasizes that the development of medical institutions was inseparable from colonial political dynamics, beginning with the formation of the Militair Geneeskundige Dienst and continuing through the differentiation between military and civilian medical institutions such as the Burgerlijk Geneeskundige Dienst. Their study shows that health formed part of a colonial strategy of power institutionalized systematically through policy and institutional restructuring.

Similarly, the article "Pelayanan dan Sarana Kesehatan di Jawa Abad XX" by Dina Dwi Kurniarini, Ririn Darini, and Ita Mutiara Dewi (2018) highlights the development of health services in Java as a response to the high incidence of infectious disease, marked by the establishment of institutions such as the Burgerlijk Geneeskundige Dienst (BGD) and the Dienst der Volksgezondheid (DVG), as well as the construction of hospitals and the training of local medical personnel. Meanwhile, the article "Layanan Kesehatan Modern di Jawa sebagai Penyokong Kolonialisme, Penyebaran Agama dan Budaya Abad XVII–XX" by Dadan Adi Kurniawan and Ilham Putra Pratama (2025) broadens the perspective by positioning health services as instruments of economic colonialism, religious mission, and the penetration of Western culture.

Although those three studies provide an important conceptual framework for the relationship between colonial policy and health services, their discussions remain general and do not specifically address the management dynamics of hospitals at the local level, particularly in Pandeglang. Yet the institutional changes of 1925, which separated civilian medical services from military ones through the formation of the Dienst voor de Volksgezondheid, had direct implications for the governance of health institutions in the regions. The effects of that policy were reflected in the improvement of Pandeglang Hospital's facilities, including the provision

of clean water and adequate lighting, as well as supervision by government physicians (Bedding, 1925; Landsdrukkerij, 1928).

In the 1930s, a synergistic welfare-oriented policy approach—for example, irrigation development that simultaneously contributed to malaria control (Kanter, 1934)—shows that health increasingly came to be viewed as an integral part of colonial development strategy. However, the global economic crisis of the early 1930s altered that direction through budget reductions and the decentralization of hospital management, which eventually led to the transfer of Pandeglang Hospital to the district government in 1935 (Darini, 2018; Kolf & Co., 1936).

Based on this background, the present study departs from the problem of how the management dynamics of Pandeglang Hospital from 1925 to 1935 unfolded in the context of changes in colonial health policy. The study aims to analyze the hospital's development, the relationship between institutional transformation in colonial health at the central level and its implementation at the local level, and the extent to which those policies affected the functions and role of the hospital for the people of Pandeglang. By taking Pandeglang Hospital as its object of study, this research is expected to fill a gap in local historiography while also enriching the historiography of colonial health through a micro-historical approach. Academically, it contributes to the development of social and health history in Indonesia, while practically it may serve as a reference for understanding the legacy of colonial health institutions and the dynamics of their management in the context of regional health development.

Method

Historical research has distinctive methodological characteristics because it focuses on the reconstruction of past events in a systematic, critical, and objective manner through the tracing of valid and relevant sources. In this study, the historical method is used to analyze the management dynamics of Pandeglang Hospital from 1925 to 1935 within the context of health policy in the Dutch East Indies. The historical method was chosen because the study is centered on past developments and seeks to obtain a deeper understanding of the development and policy of colonial health services at Pandeglang Hospital. The research process was conducted through four main stages: heuristics, source criticism, interpretation, and historiography.

Data collection was conducted through library research and the tracing of archival materials. The data consisted of primary sources in the form of colonial health reports and government regulations, as well as secondary sources in the form of books and previous studies relevant to the topic. At the heuristic stage, the researcher identified and gathered these materials, followed by source criticism to assess the authenticity and credibility of the data. Data were then analyzed through historical interpretation using a social-history approach and Kuntowijoyo's Central Circle Model, adapted from Emmanuel Le Roy Ladurie. This model allows both synchronic and diachronic analysis in order to trace causal relationships between colonial health policy and social change in Pandeglang. The final stage was historiography, namely the descriptive-analytical presentation of the findings in order to reconstruct the development and policy of colonial health services at Pandeglang Hospital in a coherent and contextual manner.

Results and Discussion

Background to the Establishment of Pandeglang Hospital

The establishment of Pandeglang Hospital cannot be separated from the alarming public-health conditions of the early twentieth century. Like many other regions in the Dutch East Indies, Pandeglang faced various disease outbreaks that had serious effects on the social and economic life of the population. Skin disease was one of the most prominent problems, as shown by the large number of patients visiting the hot springs at Cibiuk in the Cimanuk District. In 1910, 2,339 people were recorded as having come for treatment, an increase from 2,304 in 1907 (Boekliandel & Drukkerij, 1910). Besides skin disease, there were also many sufferers of rheumatism, leprosy, and syphilis.

The high incidence of skin disease was closely related to the endemic spread of frambusia, a tropical disease attacking skin and bone that could cause permanent disability (Kolf & Co., 1923). This condition even caused some sufferers to lose their capacity to work and forced them into begging. In addition, the dysentery outbreak of 1921–1922 produced a relatively high death toll, namely 23 deaths in 1921 and 35 deaths in 1922 (Kolf & Co., 1923, 1924), followed by malaria, which had already spread widely since 1910 and rose again in 1924 (Bedding, 1925; Boekliandel & Drukkerij, 1910). Typhoid fever associated with poor sanitation, as well as hookworm and eye diseases such as trachoma among schoolchildren, further demonstrate that health problems in Pandeglang were structural and complex (Cramer Putman, 1931).

These epidemiological conditions formed one of the main backgrounds to colonial intervention. Within the context of colonial health policy in the Dutch East Indies, which was then undergoing an institutional transformation from military orientation to civilian service, the colonial government began to devote greater attention to indigenous public-health services. In 1915, an expansion of health services in Pandeglang had already been planned with a budget allocation of *ƒ* 64,100 (De waterstaats-ingenieur; orgaan der Vereeniging van Waterstaats-ingenieurs in Nederlansch Indie, 1915). This planning indicates that Pandeglang was regarded as a region requiring a permanent medical facility to address its high disease burden.

The hospital was finally completed in 1919. The facility was relatively complete for a regional town, consisting of a front building, male and female wards, pavilions for Europeans, a pavilion for indigenous aristocrats, an infectious-disease ward, a ward for psychiatric patients, a mortuary, laundry facilities, a church, and covered corridors (Landsdrukkerij, 1919). This completeness shows that the hospital was designed as a modern institution with patients segmented according to social status and disease type, reflecting the colonial social order.

Yet in its early operational phase around 1920, the hospital did not function fully. No permanent doctor had yet been appointed, management was handled only by a European head nurse, and basic facilities such as running water and adequate lighting were still unavailable (Thieme, 1920). This condition indicates that the hospital was still in a transitional phase between the completion of its physical construction and full medical operation. A turning point came in 1925, when the clean-water network was connected and electric lighting became available. In the same year, the hospital came under the supervision of the government doctor Dr. Anderman, assisted by other government doctors (Bedding, 1925). From that point onward, Pandeglang Hospital can be said to have begun operating effectively as a modern medical

institution. Although its inpatient capacity remained limited, the high number of visits shows that it had become an important referral center for the people of Pandeglang and surrounding areas.

Policy Implementation in the Management of Pandeglang Hospital

The development of Pandeglang Hospital's management cannot be separated from the gradual standardization of health policy in the Dutch East Indies. From the late eighteenth century to the mid-nineteenth century, colonial health services were oriented primarily toward military interests. Health services were placed under the military medical service, and standards of professional competence remained low. Many medical personnel were recruited from non-medical backgrounds such as barbers and blacksmiths (Boomgaard, 1993). Early reform was undertaken by S.J. Brugmans through the improvement of professional standards, promotion systems, and medical specialization, and it was later continued by J. Hepperner.

During the era of Herman Willem Daendels, the creation of the Militaire Geneeskundige Dienst (MGD) further strengthened military supremacy in health services, and even non-indigenous doctors were required to join that service (Gritantin, 2024). As a consequence, military medical facilities developed more rapidly than health services for the civilian population, especially for indigenous people. Awareness of the importance of a more systematic public-health regulation only emerged in the mid-nineteenth century.

The first standard regulation pointing toward an organized public-health system appeared in Staatsblad van Nederlandsch-Indië No. 58 of 1865, which provided the legal basis for public-health investigation and the development of civilian health institutions (Kurniawan & Agustia, 2021). Efforts to separate civilian and military services were reinforced by the Reglement op de Burgerlijke Geneeskundige Dienst of 1882. This regulation affirmed that the leadership of public-health institutions should not come from the military, although structurally the institution still remained under the shadow of military medical authority. A definitive separation was only achieved through Staatsblad van Nederlandsch-Indië Nos. 649 and 650 of 1911, which established the Burgerlijke Geneeskundige Dienst as an independent institution with full authority over public-health policy. From then on, military intervention in civilian health services was formally abolished.

These institutional transformations had a direct impact on the management of regional hospitals, including Pandeglang Hospital. Administratively, the hospital already possessed an operational legal basis even before it functioned effectively in 1925. This was stated in Bijblad op het Staatsblad van Nederlandsch-Indië No. 9545 of 1921, which regulated the governance of government hospitals. The regulation stipulated that hospitals could receive patients of different sexes and social backgrounds. The main authority to determine treatment eligibility was placed in the hands of the doctor or the doctor's deputy. The policy also guaranteed patients' rights to adequate wards, lighting, food, and clothing. In this way, the hospital was positioned not only as a curative facility but also as a standardized institution of social service.

In practice, this policy divided services into two classes based on socio-economic status. The first class was intended for patients with greater economic means, with a fee of *f* 8 per day for adults and *f* 4 for children. The second class was intended for local residents and lower-income groups, with payment calculated according to a percentage of income and a maximum

charge of *f* 1.50 per day. This structure reflected colonial social stratification while also demonstrating the existence of a cross-subsidy mechanism in health services.

Interestingly, the policy also provided social flexibility. Doctors had the authority to reduce or waive fees for patients experiencing economic difficulty. Particular groups, such as prisoners, detainees, persons with mental illness, and government employees injured in the course of duty, were exempted from medical costs. In cases of death, expenses were borne by the Department of Justice and then accounted for through the Department of Education and Worship. These provisions indicate administrative coordination across departments in the management of colonial health services.

As a government hospital, Pandeglang Hospital also had the capacity to receive European patients, provide training for nurses, and maintain a special ward for infectious diseases. When yaws spread, the hospital functioned as a treatment center, although still with limited supporting facilities (Bataviaasch Nieuwsblad, 1921). This indicates that the administrative policies that had been established were beginning to be implemented functionally in practice.

A second phase of standardization appeared through Bijblad No. 11446 of 1928, which was connected with colonial health-subsidy reform in Staatsblad No. 540 of 1928. The most fundamental change lay in the classification of hospitals according to the number of beds rather than the number of patients, together with the transfer of subsidies directly to patients through bed financing (Uddin, 2006). This policy reflected a shift in orientation toward broader access to services, especially for indigenous people and lower-income groups. The institutional transformation of 1925 into the Dienst voor de Volksgezondheid further strengthened this direction (Boomgaard, 1993).

As a consequence, Pandeglang Hospital adjusted its operational system. Services were divided into three principal classes: class 2, class 3, and class 4, the latter being subdivided into 4a and 4b. These categories were not based solely on financial condition but also took patients' wishes into account insofar as they did not conflict with regulations. The tariff structure was clearly set at *f* 6 per day for class 2, *f* 3 for class 3, and *f* 1.50 for class 4. These charges already included lodging, food, clothing, laundry, lighting, medical and surgical treatment, midwifery, medicines, and bandages. The hospital thus operated within an increasingly systematic and administrative framework.

Although this class structure clearly showed social differentiation, the hospital was still positioned as a service institution for lower-income groups. Mechanisms of fee reduction and fee exemption were retained. Regulations also governed the authority of the hospital director, the status of civil servants and military personnel receiving treatment, payment procedures, the care of detainees, and the handling of bodies. This demonstrates that policy implementation affected not only the medical sphere but also administrative and bureaucratic dimensions.

A third phase of standardization was recorded in Mededeelingen van den Dienst der Volksgezondheid No. 4 of 1936, which stated that as of 1 January 1935 the management of Pandeglang Hospital had been transferred to the local government. This policy cannot be separated from the effects of the global economic crisis of the 1930s, which sharply reduced colonial health expenditure from around 40 cents per capita to 22 cents in 1936 (Uddin, 2006). Under those conditions, the colonial government adopted decentralization as a strategy of

budgetary efficiency. This decentralization was in line with the views of conservative figures such as Hendrikus Colijn as well as the thought of Cornelis van Vollenhoven, both of whom emphasized the importance of local management and adaptation to local social conditions (Pols, 2019). Thus, the transfer of Pandeglang Hospital to district government control was not merely an administrative decision but part of a broader restructuring of the colonial health system in response to global economic pressure.

The Impact of Pandeglang Hospital on Society

Since it opened in 1921 and became more active after 1925, Pandeglang Hospital brought tangible changes to the health landscape of Banten. Its presence formed part of the expansion of a more organized colonial health system, marked by the application of modern treatment methods, the strengthening of medical institutions, and greater public-health supervision. Yet these effects were not entirely linear. On the one hand, the hospital showed substantial clinical progress, but on the other hand it revealed structural limitations in addressing broader public-health problems. Its impacts may be outlined as follows:

Colonial health services in the 1920s were supported by the introduction of vaccines, the distribution of quinine for malaria, and the development of tropical medicine (Maharani et al., 2025). In the context of Pandeglang, the treatment of yaws with neosalvarsan was one of the clearest interventions. Previously, this disease caused long-term disability and reduced the working capacity of the population. Once treatment was applied more systematically, many sufferers experienced physical recovery that enabled them to return to normal activity. The hospital also handled dysentery through the use of modern serum therapy (Bataviaasch Nieuwsblad, 1925), demonstrating the adoption of relatively advanced medical treatments. These efforts were complemented by hygiene campaigns, the construction of sanitation facilities, and health propaganda through Medisch Hygienische Propaganda (Amalia, 2023), so that intervention was not only curative but also preventive.

Pandeglang Hospital developed into a referral center for surrounding areas. Serious accidents and severe illnesses from places such as Rangkasbitung were treated there (Het Nieuws van den Dag voor Nederlandsch-Indië, 1928). Even victims of unrest and shootings received medical treatment at the hospital (De Sumatra Post, 1927). During the economic crisis of the 1930s, the hospital also became a place where people sought help more generally, including medicine to suppress hunger (Overzicht van de Inlandsche pers, 1934).

Strengthening the Capacity of Local Health Personnel

The strengthening of human resources can be seen in the arrival of Indies doctors by the end of 1933 (Kanter, 1934). Training programs for village medical assistants and campaigns for cleanliness also extended the reach of services into rural areas (Pols, 2019). The presence of local health personnel, including indigenous doctors who had earlier been involved in treating yaws, marked the expansion of non-European medical roles within the colonial system. This step was intended not only to meet rising service needs but also to strengthen public acceptance of colonial health programs.

Although medical services at Pandeglang Hospital continued to develop, their impact on general mortality was not immediately significant. Between 1912 and 1921, the mortality rate in

Pandeglang ranged between 20 and 30 per thousand inhabitants (Kolf & Co., 1923), and in 1921, when the hospital began operating, the rate still stood at 26 per thousand. Data on patients for 1921–1924 show fluctuation: in 1921, 2,012 patients were treated with 32 deaths; in 1922, 1,299 patients with 46 deaths; in 1923, 1,197 patients with 36 deaths; and in 1924, 1,376 patients with 57 deaths (Kolf & Co., 1924, 1925, 1927). These figures show that improved services were not matched by a consistent reduction in mortality. Limited facilities, insufficient medical personnel, and the high prevalence of infectious diseases remained constraining factors.

In the mid-1930s, mortality in fact rose sharply, reaching 4,700 deaths in 1934 and 4,828 in 1935 (Kolf & Co., 1936). This condition was closely related to the effects of the Great Depression, which worsened poverty, unemployment, and malnutrition. Colonial press reports described people walking long distances in search of work, while others came to the hospital not solely for medical treatment but in order to cope with hunger. In such circumstances, the hospital operated within a curative framework directed at individuals who were already ill, while the roots of the problem—malnutrition, poor sanitation, and economic inequality—lay beyond the reach of direct medical intervention. Thus, although health infrastructure developed, the ability of the colonial system to reduce mortality in a comprehensive manner remained limited.

Conclusion

The management dynamics of Pandeglang Hospital from 1925 to 1935 formed an integral part of the transformation of colonial health policy in the Dutch East Indies. Institutional change from military orientation to civilian service, particularly through the formation of the Burgerlijke Geneeskundige Dienst and later the Dienst voor de Volksgezondheid, had direct implications for hospital governance at the local level. Pandeglang Hospital underwent administrative standardization, patient classification based on socio-economic class, subsidy mechanisms, and strengthened medical supervision by government doctors.

In practice, the implementation of these policies encouraged the hospital to develop as a center of modern health services for Pandeglang and its surrounding region. The hospital played a role in handling endemic diseases such as yaws and dysentery, became a regional referral center in emergency situations, and contributed to strengthening local medical personnel. Its presence shows that colonial health policy did not remain merely normative at the central level, but was implemented concretely in the regions.

Even so, the effectiveness of those health services had structural limits. Mortality data show that although the number of patients treated was relatively high and medical intervention continued to develop, the death rate did not decline significantly and even rose in the mid-1930s. This was closely related to broader socio-economic factors, especially the impact of the global economic crisis, poverty, malnutrition, and poor environmental sanitation. The hospital worked within a curative framework focused on the individual, whereas structural determinants of health lay beyond the immediate reach of medical intervention.

Thus, Pandeglang Hospital can be understood as an institution that reflected the ambivalence of colonial health policy: on the one hand it represented administrative and medical progress, but on the other hand it revealed the limitations of colonial rule in overcoming public-health problems comprehensively. Through a micro-historical approach, this

study fills a gap in local historiography and underlines the importance of examining the implementation of colonial policy not only from the perspective of the center, but also through concrete practice at the local level.

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