

Colonial Corporate Social Responsibility: Company Healthcare in Java, East Sumatra and Belitung, 1910-1940

FRANK OCHSENDORF

Leiden University, The Netherlands

Abstract

This article discusses the impact of investments by foreign firms in healthcare and hygienic measures on indigenous society in late-colonial Indonesia (1910-1940), focusing on three principal centers of foreign investment activity: Java, East Sumatra and the island of Belitung. Such facilities, although primarily intended for workers and their families, were sometimes accessible for members of indigenous society without contractual or family connection to the private company furnishing them. In rare cases, private companies invested directly in the welfare of local communities. The article concludes that the impact of the social investments on the state of health of indigenous communities was generally positive and a much-needed addition to scarcely available public healthcare. While such social investments can be regarded as examples of proto-corporate social responsibility strategies, the improvement of welfare was always a means through which the ultimate goal could be achieved: survival of the company and maximization of profits.

Keywords:
foreign
investment;
healthcare;
corporate
social
responsibility

Abstrak

Studi ini menjelaskan dampak dari investasi oleh perusahaan-perusahaan asing dalam bidang pelayanan kesehatan dan sanitasi terhadap masyarakat pribumi pada periode akhir kolonial di Indonesia (1910-1940). Penelitian ini fokus pada tiga wilayah yang menjadi pusat investasi asing; Jawa, Sumatera Timur, dan Pulau Belitung. Pelayanan kesehatan dan sanitasi yang pada dasarnya ditujukan bagi pekerja dapat diakses oleh masyarakat pribumi pada umumnya tanpa kontrak ataupun hubungan kekeluargaan dengan perusahaan yang menyediakan fasilitas tersebut. Sangat jarang ditemukan bukti bahwa perusahaan-perusahaan tersebut berinvestasi secara langsung kepada kesejahteraan masyarakat pribumi yang tidak bekerja pada perusahaan tersebut. Studi ini berkesimpulan bahwa investasi sosial pada bidang kesehatan terhadap masyarakat pribumi secara umum berdampak positif dan mampu mengisi kekosongan pelayanan kesehatan publik. Investasi sosial secara umum dipandang sebagai strategi tanggung jawab sosial jenis proto-korporat namun perbaikan kesejahteraan berperan dalam melanggengkan kelangsungan hidup dan peningkatan keuntungan perusahaan.

Kata Kunci:
Investasi
Asing;
Layanan
Kesehatan;
Tanggung
Jawab Sosial
Perusahaan

Introduction

‘What meaning does public healthcare hold for us? None! On average 12 doctors per year become available for a population of 50 million. What’s more, many of them reside in the larger cities that have hospitals. This is how much the state cares for our health.’ (*Handelingen van den Volksraad*, 1918: 444).

With these words Abdoel Moeis, a leading figure from the nationalist movement, criticized the limited access that indigenous Indonesians had to Western healthcare. At the time he held his speech in the People Council, public healthcare had actually started to improve compared to the early-colonial period, when the colonial government’s official stance was that it had no obligation towards the indigenous population in this regard. Emphasis in medical care was placed on the European part of the population.

After 1900, the Ethical Policy motivated the colonial government to invest more in healthcare for the indigenous population. Outside of the main urban centers in Java however, the indigenous dwellers for the greater part remained deprived of public healthcare. Yet, for Indonesians throughout the archipelago, healthcare was sometimes available through affiliation with or proximity to companies.

During the first three decades of the twentieth century the hospitals that were established by Western firms increased almost tenfold, from 32 in 1910 to 310 in 1930. In the same period the number of Government Civil Hospitals increased from 78 to 79 (*Koloniaal Verslag*, 1911; *Indisch Verslag*, 1931: IV, 66-67). After the crisis the strong development of company hospitals was obstructed. Nevertheless, in 1940 the remaining 238 company hospitals combined had almost three times the bed capacity of the 69 Government Civil Hospitals (20,076 vs. 7,501) (*Indisch Verslag*, 1941: IV, 81).

In this article I discuss the impact that foreign capital had on indigenous society in Indonesia through the provision of healthcare and hygienic measures in the late-colonial period (1910-1940). Such facilities, although primarily intended for workers and their families, were sometimes accessible for members of indigenous society without contractual or family connection to the private company furnishing them. In rare cases, private companies invested directly in the welfare of local communities. In my discussion of these social investments I focus on three principal centers of foreign investment activity: Java, the residency ‘East Coast of Sumatra’ (*Sumatra’s Oostkust*, now part of North Sumatra, hereafter East Sumatra) and the island of Belitung.

Company hospitals in Java

In Java the greatest part of company medical facilities was established by the sugar industry, mainly in the Central and Eastern parts of the island, the ‘sugar belt’. In 1919, the Sugar Syndicate held an enquiry among its members to

investigate the state of healthcare at its members' estates. The results showed a diverse picture, ranging from only the most rudimentary of facilities, to modern, fully equipped hospitals. Most factories had small polyclinics. Out of the 138 companies, only 6 had private hospitals with infirmaries and nurses and doctors in permanent employment. Companies commonly had a subscription to the medical services of a doctor that would visit the estates once a week. Such once-a-week doctor visits were insufficient to fulfill the medical needs of often very large groups of estate laborers. Light injuries were commonplace, as well as requests for medicines from day laborers and the surrounding population to treat frequently occurring physical discomforts such as fever, diarrhea, and skin and eye infections. In the absence of a medical doctor, the factory's manager or chemists treated less acute cases. European and Indonesian permanent employees suffering severe cases of injury or illness were sent to centrally located clinics, jointly financed by sugar factories, in Cirebon, Tegal, Pekalongan, Mojokerto and Purwokerto. Day laborers and members of local communities in need of hospitalization had to rely on missionary hospitals and government hospitals. As these were also situated in cities, they were out of reach for people from rural areas. This does not mean that the factories completely neglected the local community. The majority of factories provided people with free quinine, not in the least because this had a positive effect on the number of day laborers showing up for work. However, these efforts did not go beyond treatment of symptoms as no efforts were made to address the cause of malaria through mosquito eradication programs. Only a few factories took a more thorough approach to combatting cholera through campaigns in which tens of thousands of people living in the surrounding of the factories were inoculated (van Lochem, 1920: 846).

The only medical infrastructure, consisting of a hospital as well as several polyclinics, financed by a sugar factory that was open to company personnel as well as the surrounding population was located in Jatiroto in East Java at a sugar factory, owned by the Amsterdam Trading Company (*HandelsVereeniging Amsterdam*, HVA). A private hospital was a necessity for Jatiroto. There was no European medical care nearby, the closest options being in Jember and Lumajang at 40 kilometers distance. This was a prohibitive distance considering the poor state of roads and means of transport (van Lochem, 1920: 841-843).

Contrary to most sugar estates on Java, which were located in areas where irrigated rice fields and labor could be procured from the surrounding villages, Jatiroto was established in a sparsely inhabited, swampy area on undeveloped grounds. For the most part its workforce was migratory. To house its workers, Jatiroto built several 'factory villages', with one-room houses in pairs of two or five under one roof for coolies, two-room houses with a balcony for factory mechanics (*tukang*) and overseers (*mandur*), and

more luxurious *priyayi* houses for the 'Higher Indigenous Personnel', which besides private kitchens also had their own bathrooms and toilets (Penris, 1930: 12-17).

Factory villages were common at the sugar estates of Java. More than half of all factories offered housing to their permanent personnel. Jatiroto was unique in the sense that it offered housing to the surrounding population. The reason was that the three large factory villages (*kampung tukang*) on the factory's premises, housing the permanent Indonesian employees, were too small to ensure a sufficiently large workforce. In an attempt to enlarge its pool of workers for the harvest campaign, Jatiroto built another 25 villages in the immediate surroundings of the factory and its estates. By taking care of the construction of the houses in its villages, Jatiroto was able to achieve healthier living conditions for its permanent and casual employees. Besides a sewage system that offered sanitary hygiene, drainage systems prevented the formation of puddles which were breeding places for mosquitoes and hookworms (Penris, 1930: 85). Most importantly, the Jatiroto factory villages offered clean drinking water pumped up from artesian wells, a facility available only at a few other sugar estates in Java (van Lochem, 1920: 854).

Considering the high demand for labor, the HVA had a vested interest in keeping not only the inhabitants of the factory villages healthy, but also the people from the local communities living around the estates. A healthy local population surrounding its own villages would provide more workers and preclude the spread of diseases. From 1924 onwards, the HVA established polyclinics on each of its estates as part of a health promotion campaign. The Dutch medical doctor Penris was appointed as company doctor with the task of establishing the first polyclinic at Jatiroto. This proved to be so successful that in 1925 a second clinic was opened at the fringe of the estate for the benefit of inhabitants of the surrounding villages. Within three years four more clinics were established, one on the Jatiroto estate and the other three at the newly built factories of Gunungsari, Semboro and Bedagung. Qualified, indigenous *mantri* nurses permanently staffed the polyclinics with a European doctor visiting once a week. During the five years following the opening of the first polyclinic, a total of 43,000 persons, mostly from the free villages surrounding the estates, were treated at the polyclinics. In 1929 a central hospital was added to the network of polyclinics, containing five wards with a capacity of 28 Indonesian patients each, and 8 private rooms for European patients (Penris, 1930: 44-47).

Participation in the healthcare programs of the sugar factories was voluntary. Penris complained that he would have liked to see mass administration of quinine and *chenopodium* oil for the combatting of malaria and hookworm disease in the estate villages. However, such grand schemes were not put into practice because they carried the risk that inhabitants

would relocate to places outside the estate area. Rural Indonesians generally had a deep-rooted distrust towards Western medicine. In Aceh for example, the scar that resulted from the cowpox vaccination was popularly known as *tjap kompenie* (company brand), which incidentally shows that the colonial administration was still equated with the VOC by the Acehnese. Penris noted that at the estate villages in Java inhabitants believed that European medicine would 'turn people into Christians, or worse, make them impotent!' (Penris, 1930: 76).

Nevertheless, after 1900 the growing number of indigenous outpatient visits indicates that indigenous thinking about Western medicine was changing. The increasing availability of Western healthcare, the outcome of treatments demonstrated by family, friends and neighborhood and above all the fact that it was free of charge made these new developments more acceptable to indigenous Indonesians. By the end of 1929 the sugar industry had established a number of 8 central hospitals, 16 subsidiary hospitals, 12 auxiliary hospitals and, 8 clinics and 64 outpatient clinics.

In 1930 the total number of company hospitals located on Java was 59. Although we lack detailed statistical information on the hospitals for this year, the average bed capacity for the year 1940 enables us to estimate their joint capacity at 4,956 beds, compared to a total bed capacity of 5,076 of the 47 Government Civil Hospitals in Java and Madura (Indisch Verslag, 1931: IV, 66-76; 1941: IV, 81). In the Outer Islands the total number of company hospitals was 251 with a total bed capacity of 21,084, compared to 31 public general hospitals with a total bed capacity of 3,348. In 1940 company hospitals had more than 30 per cent of all hospital beds in the Netherlands Indies, including those offered by missionary and charity organizations.

It seems odd that in 1930 there were only 59 company hospitals in Java, compared to more than 200 in the Outer Islands. However, this is explained by the larger number of government and subsidized private hospitals (mission and charity) present in Java, to which private firms could outsource their healthcare (Zondervan, 2016: 168). In the Outer Islands, the largest number of company hospitals was found in the plantation belt of East Sumatra.

Doctors in Deli

Different from Java, in East Sumatra the provision of medical care to workers arose from an obligation for employers laid down in the Coolie Ordinance. They had to provide free 'reasonable' medical care to workers and their families. The provision did not specify what was 'reasonable'. The Labor Inspectorate (*Arbeidsinspectie*) offered clarification by interpreting it as 'treatment by an expert and nursing in an appropriate hospital', which left ample room for further interpretation (*Arbeidsinspectie*, 1913: 79). The contract coolies had an obligation at the receiving end. By signing the coolie

contract they committed themselves to undergo medical treatment when required, whether in case of illness or injury or as part of mass vaccination or other collective treatments.

In the early years of the estate agriculture of East Sumatra, when tropical hygiene as a science was still in its infancy and advances in epidemiology were just starting to be made, the disease and death rate among plantation workers were high. At the Senembah Company, crude death rates among workers in the period 1890-1894 amounted to 71 per thousand per year, and in the period 1895-1899 63 per thousand (Kouwenaar, 1948: 1299). These figures are even more distressing considering that most laborers were young adults, a group with generally the best chance of survival, and that the Senembah Company was considered the foremost company in healthcare provision (Gooszen, 1999: 201). This leaves to imagination what the situation was like at less well-managed companies.

A change for the better set in around 1900 when the Senembah Company appointed the German doctor W. Schüffner, who initiated a systematic investigation of tropical diseases. To facilitate this research, a change had to be made in the organization of health care in the estate area. Medical care at the plantations was decentralized with most estates having their own clinics or small hospitals, although in its most primitive form it consisted of makeshift treatment by the employer in an outbuilding or a shed. Commonly a doctor in private employment at the estates had to attend to several hospitals. The time spent travelling diminished his capacity to properly study the diseases he encountered. At Schüffner's insistence, the estate hospitals of the Senembah Company were replaced by a central hospital where patients were medical professionals treated patients in a more consistent way (Kouwenaar, 1948: 1293-1294). The practice at the Senembah Company was emulated by other estates companies in East Sumatra.

Another important factor in the development of medical care in East Sumatra was the establishment of a central pathological laboratory in Medan in 1906 by a consortium of the Deli Company, the Senembah Company and the Medan Tobacco Company. The pathological laboratory played an important role in the improvement of medical care through research in the fields of bacteriology, serology, clinical chemistry and anatomical pathology, and the development of vaccines. Furthermore, the importance of preventative measures was recognized and in addition to the hospital service, effort was put in the development of hygiene at the plantations (Haneveld, in: G.M. van Heteren, A. de Knecht-van Eekelen and M.J.D. Poulissen [eds], 1989: 77-79).

Reports of the Labor Inspectorate show that the measures taken in East Sumatra in housing and medical care had a positive effect: mortality among plantation workers declined substantially (AI, 1916-1938). Chances

of a twenty-year old laborer to die before the age of 50 were less than for his peers who remained in their villages in Java. Still, the difference in survival probability was not as big as one might expect considering the large investments in healthcare at the estates. This was due to the accommodation of new laborers in extremely unhygienic 'recruitment depots' before transport to Sumatra under equally unhygienic conditions. These practices caused the import of infectious diseases such as tuberculosis, pneumonia and influenza, the main causes of death at the estates in the late 1920s. Inadequate healthcare for family members of workers was another contributing factor to the dissemination of disease. While the Coolie Ordinance prescribed free provision of medical treatment to family members, in practice little aid was given. The company hospitals were often located too far from the estate to travel for family members of the workers. Also, hospital admission did not apply to family members with minor complaints. In this way, the centralized health care system in East Sumatra partly defeated its own purpose. A more comprehensive care for family members, for example through a network of polyclinics, would have reduced workers' chances of getting infected while at home (Straub, 1928: 1-5).

Clean water

One of the greatest causes of death among coolies in East Sumatra was dysentery, the prevention of which presupposed the availability of potable water. At the Deli Company, the demand for drinking water led to an initiative with social benefits extending beyond the company's grounds to the city of Medan. After becoming the seat of the Resident of East Sumatra in 1886, Medan grew from a small provincial town to a bustling metropolis. This was largely the result of the expansion of the tobacco industry in the sultanates of Deli, Langkat and Serdang. Medan also became the center of the railway network of the DSM. The sultan of Deli chose Medan as his residential town and built a palace. The city's European, Chinese and indigenous Indonesian neighborhoods grew together with its rapid population growth. When in the late 1920s Governor-General De Graeff visited Medan, an accompanying journalist from Batavia lyrically described his impressions:

'Nowhere are there this many expensive cars to be seen, and no Javanese city can boast about such an excellently organized and extensive dancing scene. Neither does one find on Java such a number of worshipers of the noble grape juice that can afford the luxury of very clear and distinct sacrifices on the altar of the widow of Cliquot.'
(*Bataviaasch Nieuwsblad*, 8 March 1927)

Besides fine wines, mostly enjoyed by the small community of planters anyhow, the inhabitants of Medan wanted clean drinking water. The need for a steady supply of water, not only for drinking, but also for fire extinguishing

and the sewage system had long been recognized by the local authorities in Medan, but it proved to be difficult to raise the necessary funds for the establishment of a water company. Towards the end of the nineteenth century the sultan of Deli had already considered the construction of a supply system in Medan, but was deterred by the high costs of the project (National Archives, The Hague (NL-HaNA), Ministerie van Koloniën (Koloniën): Memories van Overgave, 2.10.39, inv. nr. 181).

As a result, the inhabitants of Medan were for drinking water dependent on wells and water from the Deli river, and, for those who could afford it, artesian well water delivered to Medan via the DSM railroads. Water for bathing, clothes washing and the fire brigade was also obtained from the river and from wells (National Archives, The Hague (NL-HaNA), Deli Maatschappij (Deli Mij.), 2.20.46, inv. nr. 228). The lack of clean drinking water meant that infectious diseases were rife. In 1901 the mortality due to cholera and typhoid was high, at 4 per cent (Boshuyer, 1904: 8).

Similar to the story of the Senembah Company and doctor Schüffner, things changed when shortly after 1900 the Deli Company commissioned the German medical doctor H. Dürk to study tropical diseases at its estates. All man-hours lost to disease constituted a financial loss to the Deli Company, and the management was eager to find ways to avoid such expenses. The main focus was on beriberi, a disease of the central nervous system caused by a lack of vitamin B1 (thiamine), which was a major health problem at the estates in East Sumatra. During his research Dürk identified dysentery as the most pressing health problem at the estates, claiming far more coolie lives than beri-beri. To combat the spread of dysentery he recommended the construction of a supply system for fresh drinking-water to the estates from the springs at Rumah Sumbul, a small village to the south of Medan (Annual Report Ajer Beresih 1904, in: NL-HaNA, Deli Mij., 2.20.46, inv.nr. 228).

Although the Deli Company considered the construction and exploitation of a mains system for fresh water supply to be a government task, the firm eventually decided to resolve the water problem by using its own resources (Annual Report Ajer Beresih 1904, in: NL-HaNA, Deli Mij., 2.20.46, inv.nr. 228). In 1905 it obtained a concession for the construction and exploitation of a high-pressure water pipe to supply Medan and four adjacent tobacco estates, including three owned by the Deli Company (the estates 'Deli Toewa', 'Mariëndaal' and 'Polonia'). For this purpose it established a daughter firm, and named it Ajer Beresih (literally 'Clean Water'). The prospected water pipe would measure 38 kilometers running from the springs at Rumah Sumbul to the water tower in downtown Medan. A condition for granting this concession was that the water company would freely provide 130 cubic meters of water per day to the inhabitants of Medan through ten hydrants, five public drinking fountains and three public baths. Also, free water was

to be provided to eighty fire hydrants for the purpose of fire extinguishing and practice (Annual Report Ajer Beresih 1905, in: NL-HaNA, Deli Mij., 2.20.46, inv. nr. 228).

Initially Ajer Beresih was supposed to serve a total of 14,227 people in Medan. The connected tobacco estates each counted a coolie population of about 1,000 persons. Delivery of water expanded commensurately with the growth of population at Medan. In 1907, a total of 283 parcels had been connected to the mains, growing to 4,521 in 1930 (Annual Report Ajer Beresih 1905, in: NL-HaNA, Deli Mij., 2.20.46, inv. nr. 228). Apart from the private parcels attached to the system, water was supplied to the inhabitants of Medan at 64 public hydrants. In terms of water supply, Medan had better facilities than cities of similar size, for example Makassar in Sulawesi or Malang in East Java. In these cities the colonial authorities were responsible for the water supply. The number of private parcels connected to the water system was 3,938 in Malang and 2,277 in Makassar, while both cities had fewer public hydrants than Medan (*Statistical abstract*, 1931).

When Ajer Beresih was established, Resident Schaap euphemistically praised the Deli Company for its initiative and its aim not to turn the water supply system into a profitable enterprise, but to 'do the inhabitants of Medan a great service' (NL-HaNA, Koloniën. Memories van Overgave, 2.10.39, inv.nr. 181). Although Resident Schaap correctly observed that the piping system was not being constructed for the pursuit of profit, it was not a philanthropic deed either. It had been ordered by the colonial authorities, and from the company's perspective primarily intended to service the estates with the intention of reducing costs. As to the benefit for the indigenous population of Medan: the vast majority of connected houses were owned by Europeans, which implies the significance of the Ajer Beresih for the indigenous population was probably quite slight. However, the free supply of water at the public hydrants was undeniably an advantage for them.

The Billiton People's Fund

As a rule companies in Java and East Sumatra provided medical care to employees and their families, but only by extension to the local community. On the island of Belitung, the Billiton Company assumed a quasi-governmental role, providing healthcare specifically for the local indigenous population.

In July 1925 A. Groothoff, a member of the Billiton Company's board of directors, outlined a plan for the establishment of a fund for the sake of the indigenous population. The aim of the fund was 'to create means of existence for the indigenous population of Belitung, independent of the tin extraction, aiming to lessen the negative impact on the people's prosperity that resulted from the exhaustion of the tin reserves in Belitung as much as possible'. Groothoff saw good prospects in the cultivation of rubber by the people of

Belitung. He envisioned large rubber gardens on land held in long lease by the fund, providing employment to the indigenous population. The profits of rubber exports would be invested in public services such as healthcare, housing, and vocational and physical education. The Board of Director's eventually decided to put Groothoff's proposal on hold, because doubts had risen whether it would be permissible from a statutory point of view. This was confirmed in a director's meeting in September 1925, when chairman A.W.E. Weyerman showed his disapproval. He noted that investment in education would 'pull away the people from the island', which was contrary to the Billiton Company's articles of association. He considered the cultivation of rubber a good idea since it would 'bind the people to the island' (National Archives, The Hague (NL-HaNA), Billiton Maatschappij (Billiton), 2.20.51, inv. nr. 489).

Further internal deliberations at the Billiton Company about the People's Fund displayed the paternalistic view held by the Billiton executives about of the indigenous population of Belitung. In a letter to the board of directors in The Hague in February 1926, the representative of Billiton in the Netherlands Indies explained that:

'The creation of means of existence for the population would pose no problems for the company, if only one could deal with an industrious population. This is not the case here. Besides a few favourable exceptions, the Billitonese can only with great difficulty be convinced to work. The Assistant Resident for example, despite proper payment, cannot find enough men to maintain the roads. At the G.M.B. there is more than enough work. All attempts to get the population to regularly deliver firewood, construction wood, roofing material (*sirap*), etc. - retried over and over - have failed repeatedly. The population is not used to regular work and cannot be persuaded to do so (...) the Billitonese people prefer to be left alone.'

The representative mentions that he had observed Belitung people starting to plant rubber trees on the island, encouraged by the high rubber prices and the great profits that were being made elsewhere in the archipelago. According to the latest count already one million trees had been planted by 1926, of which 867,500 only in the previous year. The export of rubber from the Belitung's capital Tanjung Pandan increased enormously from 1,400 KG in 1921 to 98,651 KG in 1925. This led the representative to conclude that the population 'no longer needs the Billiton Company's support for the planting of rubber'. He did however worry about the tendency of the people to sacrifice planting of rice for the expansion of rubber gardens, which he feared would lead to food shortages if rubber prices were to slump (NL-HaNA, Billiton, 2.20.51, inv.nr. 489).

The representative considered improvement of public health on Belitung crucial. The proposal for the People's Fund considered that 'child

mortality among the indigenous population of the island is very high, the understanding of hygiene, treatment of diseases, help with childbirth etc. are still very primitive'. Because long travel distances precluded people from the countryside to visit the medical clinics in the urban centers of Pandan and Manggar regularly, the representative proposed to open local clinics in the villages. In March 1926, Groothoff defended his proposal for a fund, by stating: 'In times of a favourable economic climate, I would gladly do something for the people' (NL-HaNA, Billiton, 2.20.51, inv.nr. 489). Billiton was widely known for its profitability (Lindblad, in: J. Thomas Lindblad [ed.], 1996: 217-220). The proposal got accepted and in the director's meeting of 10 June 1926, it was decided that a fund endowed with a capital of 500,000 guilders would be established. The interest over the capital stock, estimated at 25,000 guilders yearly, would be used to finance the projects aimed at improving the welfare of the indigenous population of Belitung. The fund's spending policy was not immediately clear for everyone. The company representative in Tanjung Pandan, wrote that 'many high *kiai* (Islamic scholar), with their genealogies in hand to prove they were descendants from the old *dipati* (district head), came by to ask when the money would be split' (NL-HaNA, Billiton, 2.20.51, inv.nr. 489).

The fund was officially set up on 12 October 1926 and named People's Fund Billiton (*Bevolkingsfonds Billiton*). The statutory aim was 'to advance the economic and hygienic interests of the population of the Billiton district', which was to be achieved through a vocational course in Manggar and the provision of medical care throughout the island. For the latter task an indigenous physician (*dokter Jawa*), R. Soeselo Wiriosapoetro, was appointed. In his 'mobile polyclinic', a car named 'Moestika Belitoeng' (Talisman of Belitung) – ironically so, or perhaps intentionally to speak to Indonesian superstition - he drove from village to village to treat those in need of immediate medical care. From 1929 onwards, polyclinics were erected at scattered locations so that the doctor on duty could travel around in a faster car and serve the entire island in one week. Besides the doctor, the medical staff consisted of two indigenous nurses and a Chinese pharmacy assistant. In addition, medical education was provided through demonstrations at cinemas and schools and through posters. Due to overwhelming demand, the fund's doctor proposed to further improve the availability of healthcare on the island with the establishment of a central hospital. The company board's reply was that this would 'far exceed the goal for which the fund was created' and that 'such grand plans were not capable of being realized' (NL-HaNA, Billiton, 2.20.51, inv.nr. 489).

The significance of the medical service provided by the foundation to the population of Belitung was considerable. Before the People's Fund started its activities, the people in Belitung depended on traditional healers (*dukun*)

for something at best resembling medical care. There were no government hospitals on the island. With largely ineffective medicine, these traditional healers treated the three most prevalent diseases on the island: yaws, malaria and skin diseases. In Belitung, yaws rendered people incapacitated to work already at a young age due to the forming of ulcers on the soles of feet and skeletal deformation. Malaria was potentially lethal while skin diseases such as scabies led to a social stigma, with those affected being shunned and unable to find partners for marriage. All three diseases could be treated fairly easily with modern medicine. Out of a total population of 73,400, a number of 6,900 people received treatment from the People's Fund's medical service in 1930. Ten years later, the annual number of patients had increased to 26,750. The People's Fund medical service became so popular that soon the annual rent of 25,000 guilders was insufficient to cover all costs, and the director's board in 1928 decided to donate a one-off sum of 250,000 guilders. Total investment in the People's Fund in the period 1928 to 1941 amounted to 930,178 guilders. Total profits of Billiton in the same period were 38.5 million guilders, which implies that during these fourteen years on average 0.2 per cent of annual net profits was invested in the social advancement of local society.

Motives for colonial Corporate Social Responsibility

Although the modern, formal literature on Corporate Social Responsibility (CSR) began in the 1950s with the seminal publication *Social responsibilities of the businessman* (1953) by Howard R. Bowen, the roots of the concept have a much longer history. A starting point is found in certain business activities and practices that originated in the Industrial Revolution. In its earliest form, CSR was predominantly concerned with the question of how to make employees more productive. In Great Britain, there was criticism of the oft-poor working conditions in factories, in particular of the employment of women and children. Examples of investments that sought to prevent labor unrest and improve labor performance included the provision of medical care, bathhouses and recreational facilities. There was no clear division between decisions motivated by business considerations and those inspired by a sense of social responsibility (Carroll, in: A. Crane *et al.* [eds], 2008: 2-3).

From the late nineteenth century, business firms started to invest in social causes outside the walls of the company. Although wealthy business people for centuries had already used their own money to support social causes, social contributions by listed companies were generally perceived in a negative light in the United States and Europe, as a hand-out stockholders' money without their permission. Besides moral considerations, a major issue with corporate philanthropy was the question whether listed companies had a legal basis for charity. Court rulings indicated that corporate philanthropy, besides benefitting the general community or specific groups in society,

needed to provide benefits to companies themselves in the first place (Carroll, in: A. Crane *et al.* [eds], 2008: 2-3).

Judging from statements made at business congresses, this point of view remained dominant in the sugar industry in late colonial Indonesia. Shortly before the ninth Sugar Congress in Surabaya in March 1911, a programme for the Sugar Syndicate was introduced. Chairman Paets tot Gansoyen wrote in the introduction:

‘In order to remove all misconceptions from now on, it will be clearly stated here that the sugar industry is and must remain a commercial enterprise, established and run with the intention to bring profit to entrepreneurs. They [the entrepreneurs] did not start their businesses with the intention to have them in the first place benefit the indigenous population, nor can this be asked from them. What can be asked from them is that the indigenous people are treated decently, and that everyone gets their fair share.’

(Algemeen Syndicaat van Suikerproducenten in Nederlands-Indië, 1911: 11)

Years later, during his opening address of the tenth Sugar Congress in Surabaya in 1928, the Chairman of the Sugar Syndicate, Jelgerhuis Swildens, confirmed those words:

‘It is actually one of our habits to declare at every possible occasion that philanthropy as such is foreign to the sugar industry. Obviously this does not appear to be very noble, but then again one has to admit that it is the only possible standpoint that a corporation working with the money of others, including small investors, is allowed to take [...] This does not mean that the sugar industry should ignore the interests of the population; nor that she does not have the possibility or better yet the *obligation* to actively serve and protect these interests. Quite the contrary, the protection and serving of the interest of the population is a duty of the sugar industry, but nevertheless a duty to itself: it is well-understood self-interest.’ (Algemeen Syndicaat van Suikerproducenten in Nederlands-Indië, 1928:15)

Although sugar factories on Java and estates in East Sumatra invested in social causes such as housing and healthcare, the underlying motive was always the interest of the company. At the Billiton Company, to the outside observer the People’s Fund may have appeared as an expression of philanthropic corporate generosity. Nevertheless, the investments in public health on Belitung were inevitably motivated by business economics and corporate self-interest. This transpires from a letter written by the Billiton Company representative to the board of directors in The Hague, which reads ‘the restoration to health of the natives of Billiton is important for the general state of health of our workers and our European personnel.’ Furthermore, while Groothoff, the man behind the initiative, initially referred to the People’s Fund as ‘a philanthropic endeavour’, at a later stage he argued that

the fund would help to improve the public image of the Billiton Company and forestall criticism in times of high profits. Also, he remarked, it would considerably brighten the 75th anniversary of the company (NL-HaNA, Billiton, 2.20.51, inv.nr. 489). It is unclear whether such arguments were a tactical manoeuvre to convince the Billiton executives of the beneficial effects of the ‘uplifting’ of the people of Billiton for the company and its shareholders, or whether his main motivation was exactly that: furthering the interest of the company.

Conclusion

The impact of investments by foreign firms in healthcare and hygienic measures on indigenous society was generally positive, especially considering the limited availability of public healthcare outside the major urban centers and the ineffectiveness of traditional healing. The number of company hospitals increased dramatically during the first half of the twentieth century, and their combined hospital bed capacity grew to at least one-third of total capacity in the Netherlands Indies. Medical care was commonly provided to workers, but more restrictively also to their families and to the wider community. Without aiming to glorify or overstate these achievements, it can be concluded that such measures had a beneficial effect on the state of health of the indigenous population through reduction of mortality and combatting of easily treatable non-lethal diseases. They were above all a much-needed addition to scarcely available public healthcare.

As to the motive behind these measures, it is clear that they were not taken out of sheer good-heartedness. In East Sumatra, the scarcity of labor made the maintenance of the healthiness of the workforce a pressing business interest. In Java and Belitung the same business economic assessment was made. At the Billiton Company this incentive was reinforced by the need to influence popular opinion and to acquire some moral legitimacy in times of extremely high profits. While the social investments made by companies in colonial Indonesia can be designated as a form of proto-corporate social responsibility, the improvement of welfare was always a means through which the ultimate goal could be achieved: survival of the company and maximization of profits.

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