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Health Services in Surabaya in 1906-1938

Aditya Indrawan[1]; Isawati Isawati[2]

[1]Sebelas Maret University, Magister of History Education, Faculty of Teacher Training and Education, Surakarta, Central Java, Indonesia

[2] Sebelas Maret University, History Education, Faculty of Teacher Training and Education, Surakarta, Central Java, Indonesia

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Abstract

The hospital is one of the health care centers built by the Dutch during the colonization of Indonesia. In Surabaya, a hospital was established in the 19th century and is an intersection military hospital. The development of Surabaya as a Gemeente area led to developments not only in the aspect of buildings and regional expansion but also in population growth. The increasing population in Surabaya has led to various problems, especially in health and hygiene. The hospital initially focused on military patients and became a general hospital. Still, in reality, the hospital prioritized patients from European groups and indigenous people who worked on plantations. It was because the Dutch wanted the workers always to be healthy so that the productivity of the plantations would also increase. The difference in treatment at the health center causes indigenous people to look for alternative ways, namely going to a shaman or healer. It was also because the hospital treatment cost is still relatively high, and the distance from home to the health center is quite far. This study aims to describe how the development of health services in Surabaya. This study uses historical research methods, including topic selection, source collection, verification or criticism, interpretation or interpretation, and historiography. The result of this study is that the indigenous life in Surabaya can be said to be a stepchild because they live in slum areas. After all, the area they inhabit was initially used as a government center development, and not only that, in terms of health services, they experience discrimination. The forms of discrimination are differences in services, where hospitals are more concerned with patients from European nations and workers on plantations.

K*eywords:* *Health Service; Hospital; Surabaya*

Introduction

Health is a right owned by every human being, and everyone has the right to access resources in the health sector. According to article 28 (1) of the 1945 Constitution, everyone has the right to live in physical and spiritual prosperity, have a place to live, have a good and healthy life, and have the right to obtain health services. Obtaining health safely, independently, and responsibly will determine how health services are needed. Health service itself is an essential aspect of influencing human health. One of the

goals of health service itself is to treat people exposed to disease and prevent people who have the potential to get sick.

Since the colonial period, public health itself has been classified as very bad, and this is because there is discrimination between indigenous and non-indigenous people from the health aspect. At first, health services were only in the interests of the colonizers, especially the government members. The medical sciences brought by the Dutch colonial were only intended for themselves, whose activities were centered on military-owned hospitals (Baha'uddin, 2006). The development of Health services is connected to the Chinese, Arabs, and natives. Although it is only limited to those with a special relationship with the colonizers, such as the elites, the medical actions taken are less than optimal because they are only limited to preventing infectious diseases. The limitation causes various kinds of diseases to spread among people who do not have such good health.

In the 19th century, Java had spread endemic diseases such as cholera, malaria, smallpox, and bubonic plague. Smallpox cases were found in Java in the early 17th century (Reid, 1988). In 1781, it was estimated that out of 100 Javanese people who had smallpox, 20 of them died (Boogard, 1987). Diseases such as bubonic plague and influenza also hit several areas, causing people to panic. As a result of these various diseases, many victims fell, and the community experienced material losses due to various diseases, such as the bubonic plague, which caused financial losses due to rats eating the residents' houses, the majority of which were still made of wood.

The attention of the Dutch government for its development is growing to the indigenous community, especially to the labor class who work on Dutch-owned and private plantations (Baha'uddin, 2006). There was an effort from the Dutch colonial government to maintain and increase production in the plantation industry. The efforts made by the Dutch can also be regarded as capital so that the profits they get will increase because the workers will feel lucky because their health is taken care of so that they are more productive to work.

People who panic due to various diseases need qualified health services. But at that time, they had no choice but to seek treatment from a healer or shaman because the hospital was more concerned with patients who came from employees. The government or plantation workers and the community also did not have sufficient funds to treat general practitioners because the costs at that time were relatively expensive (Boomgard, 1993).

Since being used as a Gemeente area, Surabaya has experienced physical development and increased population. It is like what was said by (Burgess, 1921) in Introduction to the science of sociology; humans naturally tend to be as close as possible to urban centers. As a result of the increasing population, the facilities available in urban areas must increase to be able to overcome various kinds of problems that will arise (Soetopo, 1999). As a result of the expansion of the city and the increase in population, it gave rise to villages in several areas. These villages have the impression of being quite a slum because the land used is relatively narrow.

The impact of the increasing population in Surabaya itself also gives rise to quite complicated problems. This kind of phenomenon occurred in cities in the 19th century. Cities in Java such as Jakarta, Surabaya, and Semarang began to experience various problems when there was a drastic change from traditional to colonial cities (Wertheim, 1999). Government built facilities to support the city of Surabaya's development and overcome various problems, one of which is health.

Methods

The research method used by the researcher is historical research, which includes four stages: heuristics, criticism, interpretation, and historiography. The first stage is the process of searching and

finding the sources needed by the author. The author, in his search, found sources in the form of archival data and documents related to city health records in Surabaya from 1906-1938, which were found from the East Java archives service with the title Burgerlijke Openbare Werken Serie Gezondheid. The archive contains reports about the health conditions of the population, epidemic diseases, and population mortality data, as well as newspaper sources. Dagblad (1909), in an article in the newspaper, discussed the horrible health conditions in Surabaya. The Niew Schiedamsche Courant (1907) discusses how the health condition in Surabaya is. On the other hand, De Indische Courant (1925) discussed the discharge of Dr. Soetomo from Gemeenterad, the city of Surabaya. The newspapers are obtained through the website www.delpher.nl. Another source used is Niew Soerabaia's book: De Geschiendenis van Indies Voor Namste Koopstad in de Eerste Kwarteew Sedert Hare Instelling 1906-1931. One of the chapters in the book discusses how health facilities are available in Surabaya and explain clearly the various types of health facilities available in Surabaya. The author also uses the book Kromoblanda Deel II, Over't Vraagstuk van het women in Kromo's Groote land, which shows health reports from Surabaya, and there are also sources in the form of photos obtained through ANRI (National Archives) and journals. Related to the themes studied, such as the Poor and Struggle for Urban Space in Surabaya in the 1900-1960s (Basundoro, 2013) and from Subsidies to Decentralization of Colonial Health Service Policies in Java 1906-1930s (Bahaúddin, 2005).

The next stage is source criticism which means starting, testing, and selecting sources to get authentic. This study used two types of source criticism. First is internal criticism, which conducted content testing by comparing one source to another to get credibility. Second, external criticism leads to the time of making archives that are used by taking into account the temporal limitations of the study. The last stage is interpretation, namely by analyzing and then interpreting the theoretical view of the facts contained in the source through the facts that have been interpreted. This step is followed by the last stage, historiography, the history writing.

Discussion

Situation in Surabaya

In 1906 Surabaya was designated as a Gemeente area. As a result of the determination, the city of Surabaya began to grow from rural to urban areas. As a city that is growing dynamically as an industrial city, Surabaya has long been a destination for migrants from rural areas to the surrounding area (Ingleson, 2004).

Year	European	China	Arab	Indigenous	Total
1906	8.063	14.843	2.482	124.473	150.188
1913	8.063	16.685	2.693	105.817	133.632
1920	18.714	18.020	2.593	148.411	187.903
1921	19.524	23.206	3.155	146.810	193.058
1922	20.105	27.565	3.410	148.000	199.614
1923	20.855	30.653	3.639	149.000	204.791
1924	22.153	32.005	3.818	150.000	208.823
1925	23.314	32.868	3.922	196.825	257.799
1926	24.372	33.370	4.040	188.977	251.740
1927	23.782	35.077	4.078	188.977	252.922
1928	24.625	36.850	4.208	188.977	255.699
1929	25.346	38.389	4.610	188.977	258.489
1930	26.502	42.768	4.994	265.872	341.493

1931	27.628	43.288	5.298			265.872	343.470
1932	26.411	40.781	5.564			274.000	352.129
1933	26.882	39.792	5.227			280.000	365.524
1934	27.297	40.533	5.175			286.000	365.524
1935	27.599	41.749	5.209			290.000	370.709
1936	28.548	43.650	4.998			294.000	377.096
1937	29.783	46.219	4.961			294.000	380.853
1938	30.687	43.779	4.921	294.000	390.989		

Sources: Faber, 1936; Gemeenterad Soerabaja, 1941; Bureau van Statistics Soerabaja, 1932.

The development of the city of Surabaya as a Gemeente area led to the expansion of the city. In various areas, several houses were built Europeans would inhabit that. Government offices were also built as a result of this stipulation. Pathologically, the southern region, a dry area, is used as a development center. In contrast, the western region is a swamp area, and the east and north are coastal areas that are less focused.

Various kinds of facilities were built separately. Dutch colonial government built European settlements in Ketabang, Sawahan, Gubeng, and Darmo. In contrast, Ngagel and Gresik street were used as industrial areas. The impact of this development causes houses owned by indigenous people to be evicted because the area is still private, so the local government can take it over as development land.

The impact of expropriation of land where indigenous people live and increasing the number of residents from Europe causes the need for sufficient living space. It led to the need for new villages belonging to the natives because they had lost their land, and migrants from outside Surabaya had arrived.

Figure 1. A village in Surabaya with a mosque background
Source: ANRI. East Java KIT No. 0852/002

Surabaya's population growth was inseparable from its strategic location as an economic area in East Java. Surabaya itself has become the primary destination for migrants from rural areas in the surrounding (Ingleson, 2004). Surabaya is surrounded by hinterland areas such as Pasuruan, Sidoarjo, and Mojokerto as plantation areas that support the economy in Surabaya. Surabaya, as the axis of the economy in East Java, has triggered massive urbanization that has increased population density. The increase in population causes new problems in the fields of poverty to health.

As a result of the increasing population in Surabaya, causing the emergence of areas inhabited by indigenous people, many villages have sprung up in Surabaya since it was made as a Gemeente area. However, the village had a different situation from the Dutch-owned residential area. The village area which emerged in Surabaya has poor conditions ranging from houses made of woven bamboo, which rats gnaw. Rats have consumed a lot of bamboos that should have been used for building and house materials, so rats cause not only bubonic plague but also a cause of economic hardship (Neelakantan, 2017). In addition, the distance between houses is narrow to an unhealthy environment. The limited urban space caused the narrowness of land to live in and the lack of economic conditions causing the indigenous people to build houses only with materials that met the requirements of houses (Koesmen and Pangestu, 1957). It all started with one or two huts as a place to live, and then from day to day, the number of huts became more and more so that these villages were formed. Starting from the hamlet wall area, Dupak and Masigit in the west Surabaya area, in almost ten years, the area became a village inhabited by 1,742 people with a total of 375 houses (Clombijn: 2015).

Health Problems

The result of the living environment is so bad, and the condition of the community that has a low level of cleanliness also causes various diseases to infect him. Indigenous people were considered primitive and backward by Europeans because they had low health standards. A significant difference is seen in the particular death rate between the natives and Europeans, and this explanation is strengthened based on records (Tillema, 1923). In 1910 the number of people who died from the bubonic plague that hit Surabaya was Bumiputera 7,548, Europe 272, Chinese 874, Arab 193, and the Foreign East 19. The high mortality rate of the indigenous population in Surabaya indicates that the spread of bubonic plague is caused by the daily life of the indigenous people with a slum environment and unhealthy lifestyle.

Various infectious diseases became a scourge in society from the 19th century until the early 20th century. Java is an area with a very high acceleration of population growth. Still, this acceleration is not balanced with an adequate quality of life, causing the death rate of the population to be high, resulting in a significant change in the number of residents (Boomgard: 1993). The city of Surabaya, which has become a Gemeente, has experienced a high population spike, but environmental and health conditions are considered inadequate, especially for indigenous people.

Table 2. Percentage of deaths due to disease in Surabaya in 1924

Typhoid fever	4.8
Malaria	11.6
Chickenpox	1.2
Influenza	2.4
Dysentery	0.8
Pajama	0.7
Tuberculosis	9.2
Syphilis	0.4
Cancer	6.8
Diabetes	4.0
Suicide	1.6
Violence	2.0
disabilities related aging	2.7
Other diseases	7.1

Since the beginning of the 20th century, the leading cause of death for the population in Surabaya has been caused by various infectious and deadly tropical diseases. The emergence of various diseases is also accompanied by a lack of knowledge about low health among the indigenous population. Lack of public awareness to keep the environment healthy and clean is the cause of the high population mortality.

It can be seen from the environment in Surabaya, which seems shabby and poorly organized. Various villages in Surabaya, especially those belonging to indigenous people, have poor sanitation and dirty drinking water.

Several government policies also complicate the life of the indigenous population in Surabaya, which causes overcrowding, especially in the indigenous area. Many indigenous people live in slum areas and are easily flooded by water because the Waterleiding system is not working well. It was different from the area inhabited by Europeans. For example, the Ketabang area, which is an area inhabited by elite people from Europe, the area has adequate lighting and a sound drainage system so that no flooding occurs.

Figure2. Floods in Indigenous villages in Surabaya
Source: National Archive. KIT East Java
No. 0852/002

Indigenous residents are like stepchildren in their own homes. They are discriminated against because they have to live in slum areas. The condition of the indigenous villages can be said to be far from livable because the environment is so dense that it causes narrow distances between houses and is not well organized. The building was poor because it was only made of bamboo, which is very liked by rats and is the cause of the bubonic plague.

It doesn't stop there. The indigenous people's habits in Surabaya also cause them to be easily attacked by diseases, especially tropical infectious diseases. Indigenous people have poor sanitation, and dirty drinking water, store water made of clay, and are breeding grounds for disease. The water channels owned by various villages are inadequate, causing flooding when the rainy season arrives, coupled with the habit of people who defecate in rivers and make unique holes to make dirt on the ground causing various diseases such as cholera and high rainfall. It also harms health, which can cause infectious diseases to spread quickly. According to (Tillema, 1916), this habit causes disease-causing bacteria to infect the natives easily. It happened for a long time because the people did it based on their natural living conditions. For example, a river used to clean their bodies and clothes and their habit of only washing their hands using water because they did not know soap.

Health Services

The VOC built the first hospital in Indonesia in 1641. The hospital was initially located in the city of Jakarta. Several hospitals were also built in areas outside Jakarta or trading posts outside. These hospitals were initially used to isolate sick workers who suffered injuries because they were not treated well.

After the VOC went bankrupt, various hospitals were taken over by the Dutch government, especially the military. Daendels built various hospitals during its development, one in Surabaya. The first hospital in Surabaya was the Simpang Military Hospital, established in the 1800s. The hospital is next to the Goebeng Bridge, which is now Jl Pemuda No.33 or Delta Plaza; this hospital was built in the area so that it is far from residential areas so that it does not cause pollution and spread infectious diseases. The hospital was intended for military purposes only at the time.

The hospital initially only focused on patients from the military. Still, due to the development of more and more plantation companies and plantation workers, the government collaborated with various plantation companies to build a hospital for workers working on plantations. The company and the Dutch government collaborated to produce three crucial points, namely:

1. If there is a plantation company in the same area as a government hospital, the company must share responsibility for the number of treatments calculated per bed.
2. If the plantation cannot pay for the number of beds that the company is responsible for, it will be charged to the hospital.
3. The government and plantation companies build hospitals that are shared.

The impact of this collaboration caused the Simpang military hospital to change to Centrale Burglijke Ziekeninrichting te Soerabaia or shortened to C.B.Z Simpang in the 1900s. The hospital shifted from initially concentrating on patients from the military to a general hospital. Since then, all aspects of society have been able to experience health services that were previously only experienced by soldiers. Initially, the intersection hospital accommodated up to 860 patients from several different departments, and there was also a particular room for infected patients. The number of medical personnel has also increased. This increase in the number of health workers is to adjust to the needs of health services such as dentists to pharmacists.

Table 3. The increase in the number of health workers

		1920	1925	1930
1	Government Doctor	65	127	153
2	Native doctor	171	179	231
3	General practitioners	87	57	56
4	Dentist	-	63	66
5	Pharmacist	-	3	8
6	pharmacist assistant	-	13	20
7	European nurse	83	133	195
8	Native Nurse	161	562	979
9	Vaccinator	411	390	394
10	Midwife	58	49	91
11	Technician	28	21	10

Source: *De Zorg Voor De Volkgezondheid in Nederlandsch-indie*, Van Hoeve, p. 188.

Although the status of the hospital has changed to a general hospital, and there has been an increase in the number of medical personnel, it prioritizes patients who work on plantations. The government also provides subsidies to hospitals focusing on patients from plantation workers or religious organizations, such as the St. Catholic Hospital. Vincent de Paul. Due to this difference in service, the indigenous people have to undergo general treatment, which causes many people who are less able to make payments due to the high cost of the hospital.

Health facilities in Surabaya for indigenous people were very minimal. A small polyclinics and Stadveband, which are responsible for public health care, have in practice become shelters for prostitutes,

forced laborers, prisoners and people with mental illness as efforts to prevent infectious diseases from spreading to the community. People who want to go to the hospital also have to travel long distances because of the long distance from their homes to this government-owned hospital. So they inevitably have to do traditional treatment, where they prefer to go to a shaman or healer who lives near their residential area.

The Dutch government seemed reluctant to take care of the health conditions of the indigenous people in Surabaya, and this can be seen from the results of the meeting of Gemeenterad Surabaya members in 1924. At that time, Dr. Soetomo, R.M Hario Soenjono, Sastrowinangun, and Soendjoto voiced suggestions to improve the city of Surabaya, especially in terms of health and villages. They wanted to raise the health standard of the natives. However, this proposal was rejected by members of the Dutch side, who were represented by Dutch political associations, namely Politieke Ekonomische Bond, Vandrlansche Club, and Indo Europeesch Verbond. The suggestion from Dr. Soetomo was rejected because the Dutch political association was more concerned with luxurious parts of the city inhabited by Dutch residents, such as the Darmo area. It was not the first time that this rejection had happened. Sometime before, any proposal from Dr. Soetomo, interested in the indigenous people, had always been rejected. As a result of these refusals, Dr. Soetomo and his colleagues left their membership as Gemeenterad.

The colonial government, especially the health service (Geneeskundige Dienst), in 1927 in collaboration with one of the foundations in America called the Rockefeller Foundation. Initially, this activity was carried out in Batavia with a program of cleaning activities because sanitation there was also poor and then spread to several areas, one of which was Surabaya. The concept of this collaboration is to introduce the basics of hygiene and modern medical treatment by visually showing them. One of the activities is to teach the community how to live clean and healthy, to show the community about acute diseases by showing the causes of diseases such as mosquitoes which cause malaria and worms, using a microscope, and educating the public about how to prevent various diseases. However, a dispute occurred between the foundation and the health department in this collaboration. The two sides had different approaches. The colonial government was more inclined to carry out the business of providing medicines in government-owned pharmacies and asking for help from the regions so that the community could build a clean place. At the same time, the Rockefeller Foundation had a different approach. They want to cooperate with Javanese doctors to conduct educational activities first to the population that maintaining the cleanliness of the environment must begin with personal hygiene. The dispute between the two parties was triggered by the desire of the colonial government to obtain funds from the Rockefeller foundation without involving officers sent by the foundation and not wanting to use the method used (Engel & Susilo, 2014).

Under these two approaches, the colonial government and the foundations operated separately. The results of the two are pretty different. The health department has built quite some hygiene places in various areas in Surabaya, but only a few are used. While the Rockefeller Foundation does not make too many clean places, everything they build is enthusiastically used by the general public, especially the natives (Hull: 2007). Based on these two things, it can be seen that the Dutch government itself does not seem to want to create an environment and provide good health facilities for the natives. They only want to make profits for their interests.

In its development, several groups of the Chinese community and private organizations provided a care center for sick people. Darmo Hospital had 78 beds for patients, Oendaan Hospital had 36 patient beds, William Booth Hospital had 132 beds, Ophthalmic Clinic Odean had 60 beds, and Soe Swie Tiong Hwa Le Wan had 12 patient beds. Of these hospitals, only the William Booth Hospital is devoted to women and children, and the nurses who work there have training for midwives from Europe. Although established by various institutions, the standards of cleanliness and service at least have something in common. It was because the colonial government had regulations governing the standards of cleanliness

and service from a hospital or health service. Not only Chinese and Dutch-owned hospitals are growing, but the natives themselves also have a contribution to make in the health sector.

Dr. Soetomo himself, one of the lecturers at the NIAS (Nederlandsche Indische Artsen School) health school, has established the Indonesische Studiedclub organization in Surabaya. This organization consists of educated youths, priyayi. The purpose of this organization is to increase the dignity of the indigenous people, especially in Surabaya. Some of the movements carried out by the organization formed by Dr. Soetomo are establishing farmer associations and establishing orphanages and health centers/clinics in Surabaya.

Even though these clinics did not receive assistance from the government, they became one of Dr. Soetomo's movements to raise the dignity of the natives in the eyes of Europe. Dr. Soetomo wanted an idea where the Indonesian people could stand independently without the help of other nations. Therefore the first thing needed was a good health condition. Not only that, but several indigenous-owned organizations also carry out activities in the health sector, one of which is Muhammadiyah. The religious organization established its hospital and clinic on the advice of Dr. Soetomo. The government approved the construction of these clinics because the necessary conditions had been met, such as:

1. Having a doctor who is a doctor who has performed his official duties or retired with honor so that he can practice medicine throughout the Dutch East Indies
2. Midwives or nurses who help practice health must be midwives or nurses who have obtained permission and passed the test.
3. Pharmacists must have skills in understanding prescriptions written in Latin and know about medicines.

The increasing number of hospitals in Surabaya has improved community health. It is also due to increasing knowledge of hygiene owned by the community and health facilities. Various kinds of actions were also taken to prevent disease entry into Surabaya. On 13 October 1932, the Indische Courant reported that a ship was going to dock in Surabaya, but all the crew had to get vaccinated first and have a medical test. When the test results were positive, the crew had an infectious disease. Will be subject to strict quarantine.

Hospital Economy

The condition of health services in Surabaya itself does not always run smoothly. Since the malaise crisis occurred in 1929, various countries have experienced a drastic decline. The health sector was also affected by the crisis. There was a reduction in the lines of most doctors in the Dutch East Indies by the health department. In fact, in 1932, there were rumors that doctors in Indonesia who had just been hired from Europe received a much lower starting salary than Indian doctors; because of this, the public's interest in receiving medical educators to have an established life vanished. As a result of reducing funds in the health sector, the government has reduced health personnel.

In 1931 372 doctors were working in hospitals, but the number decreased. In 1934 the number of doctors who served in the field became 344, then in 1935, it became 322. The cuts in the budget also impacted the field of medical education, one of which was at the Nederlandsch Indische Artsen School (NIAS). Initially, the school would be closed due to budget cuts by the government. Since 1933, students who have graduated are not required or released from official ties as employees at the Health Office because the funds needed to pay salaries are reduced.

In 1936 the government issued a policy on decentralization of health which was regulated under Staatsblad No. 582 of 1936. The regulation regulates the transfer of state affairs regarding people's health to the provinces, municipalities, and regencies in Java and Madura (Baha'uddin: 2005). As a result of this policy, the maintenance of various hospitals and polyclinics was handed over to the local government

except for the Simpang General Hospital in Surabaya, which still received maintenance from the central government. Another impact of this policy is the reduction of health workers in Surabaya to help the surrounding area. At that time, health service activities were disrupted because other regions did not want the doctors who were there to address health problems in other regions. Vaccination activities also encountered problems because most of the doctors who were doctors specialized in vaccination were from CBZ in Surabaya.

The government also eliminated subsidies given to certain hospitals, and this caused a change in the management system at hospitals which initially implemented a Non-Profit policy to become Profit Oriented (Baha'uddin: 2006). As a result of this change in management, the hospital made a policy, namely making classes in health services so that people pay more to get qualified health facilities so that they recover quickly and prioritize their services.

Conclusion

Since the 1800s, health services in Surabaya itself have been available. However, the health service in Surabaya was more focused on the activities of the Dutch military. In its development, the hospital, which became the center of health services, was changed to CBZ Simpang. Still, the existing services prioritized patients from plantation workers so that the general public received different services. The Dutch government also doesn't seem to care about the health conditions of the indigenous people because, in the various actions they take, they always put the interests of their people first and only want profit for them. As a result, people prefer to seek traditional treatment, such as going to a shaman or healer, and this is also because the costs incurred for treatment at the hospital are still not affordable.

The number of hospitals was increasingly developed because many institutions also participated in the welfare of the Surabaya area, one of which was Dr. improving health standards in Surabaya due to discrimination against indigenous people. Dr. Soetomo also teaches various organizations to develop health facilities in Surabaya. One of the organizations is Muhammadiyah which established its hospital and clinic. Although health services in Surabaya have increased, there is a malaise crisis that causes problems in the economic field. As a result, the health sector experienced a decline because the funds needed were significantly less, so they had to reduce the number of medical personnel. Not only that, the medical personnel in Surabaya had to help other areas due to a shortage of health personnel. It was the colonial government's decentralization policy that caused it happens. The government also abolished its policy regarding subsidies given to hospitals so that hospitals had to find ways to keep them standing.

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