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Introduction

Health and Welfare: Diversity and Convergence in Policy and Practice

Laurinda Abreu

As several authors have pointed out, the history of the health in society is deeply linked to the epidemic experiences of Western Europe but it also goes beyond it. The way the concepts of welfare, health and public health were shaped and evolved ever since the late middle ages were dependent on the specificity of the social, symbolic and cultural representations, the economic resources, the social organization and the characteristics of the political powers, among many other factors. They explain the complexity of the processes, the composite, and sometimes even contradictory, solutions implemented in order to face similar problems in related contexts. However, in spite of the diversity of answers, it is possible to find common institutional patterns all over Europe since the beginning of the process, considered here as the moment of the first systematic and continuous institutionalized intervention of the authorities in terms of poor relief, health care and welfare policies. And this is mostly due to the common religious and cultural background and the political agenda, in other words the emergency of the early modern state. What remains quite amazing is the promptness by which the information circulated since late medieval times, in part accompanying the trade dynamics, but also because the Papacy was an important diffusion center of social policies, and, above all, because the interest of the political authorities to know the best practices, namely on the epidemics control and hospitals administration, mobilized in the search of common answers for common problems.

In the long-term perspective, and in a very broad sense, it is confirmed that each moment of rupture in terms of the social support systems was also an occasion for a general modernisation of health and social solidarity structures. In the present moment the social sciences researchers may have a word to say.

This Hygeia volume results from the conference *Health and Welfare: diversity and convergence in policy and practice*, organized by PhoenixTN – European Thematic Network on Health and Social Welfare Policy, held in Athens in February

2009. Created and financed under the auspices of the European Commission in 2001, in the framework of the Socrates-Erasmus programs, PhoenixTN congregated more than eighty partners, mainly universities, from all around Europe. During several years, the project worked as a very active forum for the discussion of public health and welfare policies, in a very extensive sense. Taking the project' members background disciplinary diversity and multiplicity of methodological and theoretical approaches as an added value, PhoenixTN capitalized it through conferences, seminars and workshops but also in books, journals, educational programs and academic inter-exchanges.

The Athens conference was the final conference of the PhoenixTN and this journal issue is its final publication. As in the previous books, the papers presented reflect the above mentioned diversity, either in terms of methodology or analysis.

Institutions, Political Powers and Health and Welfare Policies

The wide geographic examples and chronologic approaches offered by the papers published here have some positive aspects: for instance, it permits to analyze the historical developments of the processes and even their similarities, which is a crucial factor for the comparative approaches. It also calls our attention for the necessity to put the research in a perspective. Some *revolutions* may only express more attentive and more precise administrative procedures. As Fritz Dross writes in his paper, "Patterns of Hospitality: Aspects of Institutionalization in 15th & 16th Centuries Nuremberg Healthcare", referring to late-medieval and early modern hospitals, sometimes it is not the way to do things that radically changed but how it was registered.

Focusing on the developments of the institutional welfare provided by the Nuremberg hospitals, Fritz Dross examines the organization of the support for the foreign lepers in the framework of a city where, since very early, the hospitals were divided according to the different types of needs and patients, based on a very flexible structure, established on subsidiary principles, adaptable to conjunctural necessities. The use of the hospital care as an attempt of social control, of the lepers as well as of the other sick, not necessarily poor, and the prompt discharge of the recovered inmates, is presented by the author as signals of modernity in the hospitals' history.

Among the poor relief and health care institutions, the *medical* hospitals¹ were, probably, in the European context, the establishments with most common characteristics, no matter the geographic place concerned. In "Healing the body and sav-

1 Taking into account that we are dealing with a polysemic word but excluding from this broad designation the French General Hospitals.

ing the soul in the Portuguese hospitals of the Early Modern Age” Maria Marta Lobo de Araújo and Alexandra Esteves describe the Portuguese example of the diversity of the early modern hospitals, either in terms of capacity, functions and patients. Resulting from the amalgamation process started in the last years of the 15th century, organized according to the Regiment of the Lisbon Hospital de Todos os Santos (1504), and systematically transferred to the lay confraternities of Misericórdia after the Council of Trent, these hospitals reflect the dynamics of the communities where they were placed. In urban communities, for example, the patients were mainly migrant workers while in the workers’ rural areas the hospital clientele was essentially female. If the lack of medical staff was a general feature of medieval/early modern hospitals, a great number of them were provided at least with one physician with academic training, apart from other healing professionals. That this was an ordinary situation also in Spain is confirmed by María José Pérez Álvarez’ paper, “Disease and health care in the North-West of Spain in the early modern period. The Bierzo region”. As expected, the Queen’s Hospital, in Ponferrada, studied by Maria José, didn’t accept incurable people or patients with contagious diseases because it was assumed as a space of *cure*: as frequently contemporaries hospitals’ records refer “good food and a bed is the best therapeutic that the main part of patients need”.

In the broad sense of *cure* when applied to these hospitals, apart from the *medical therapy*, the spiritual care provided could play a pivotal role. But most certainly the early modern authorities had other preoccupations beyond the patients’ souls. The way some of them allowed the workers to use the early modern hospitals is a good indicator of the multiple functions that those spaces could assume. Among manifold objectives was the care of abandoned children, institutionalized in Europe at the early 16th century, financed, in some cases, with local taxes.

The foundlings’ question can’t be isolated from the legislative persecution of beggars and vagrants, also intensified since the beginning of the 16th century, as Alfredo Martín García notes in “Childhood and poverty in Leon in the modern period: Institutional responses”. The European authorities, religious or not, have considerably invested in charitable institutions for children – three in early modern Leon –. The financial problems that they found, in Spain as in every catholic country, impelled them for a paradoxical situation: although created to prevent the children from begging, when we analyze their budgets we realize that part of their incomes resulted from alms collected by the students. In the main part of the cases, the educational and vocational training objectives of these institutions didn’t resist to their precarious economic situation. The same occurred with the children.

The concern of the early modern authorities with the population health and welfare, in a deeper sense than that reported by George Rosen in his seminal book, *History of Public Health*, is also revealed in Laureano Rubio Pérez’s paper, “Barbers, doctors and healers: Community welfare and the health system in the North-West

of Spain – the province of Leon – during the seventeenth and eighteenth centuries”. In a political scenario characterized by the absence of the crown and strengthening the power of the local councils and corporations, it was these local institutions that organized and distributed poor relief and the health care resources, guaranteeing direct positive effects on the populations’ health. On the other side of the frontier, since 1568 that the Portuguese Crown was imposing to several municipalities the financing of the academic training of physicians, surgeons and apothecaries destined to attend the poor from the inner and rural communities. The political actors differed but the assumptions were basically the same in different countries. The direct intervention of the local elites was the key for the implementation of new poor relief and health care structures. This was the case even in Portugal, where the political power was more centralized than in other countries. The 16th century Portuguese monarchs were able to convince the dominant groups to put into practice their ideals and values negotiating with them and granting them several social and political benefits.

However, as Juan Gracia Cárcamo analyses in “Women, families and social welfare in Spain from the 18th century to the present”, the long-lasting presence of the political authorities in the poor relief and health care arena can’t lessen, in analytical terms, the presence of other agents, formal or not². Recuperating the idea of the families, and the role of the women inside the families, as the main social protection resource from poverty, the author contests some recent revisionist interpretations, defending that the 20th century Spanish care model only can be understood taking into account the long-term historical perspective, and doing it, is not possible to deny the importance of families and women as suppliers of well-being.

The question on how the political powers intervene on the public health field and the capacity to impose, or not, their objectives is also the subject of the next four papers. In “State’s medical experts in local practice. Provincial doctors view of themselves as public health promoters: an example from the Swedish countryside, 1880-1920”, Anna Prestjān addresses the emergency of the Swedish welfare state, at the end of the 19th century, analyzing the case of the sparsely populated district of Sveg, in Northern Sweden, through the work developed by the provincial doctors – medical experts nominated by the Swedish state for the countryside communities. And her conclusions are quite clear and easily understandable. The provincial doctors assumed themselves as central government informers and community reformers, rejecting any sort of integration into the places where they were working, were unable to cross over the local logics and to access the very competitive medical marketplace where other health providers dominated and different healing services were offered. This is a situation not very different from the one presented by Alex-

2 For this question see, Dinges, Martin, “Health between Self-Help, Formal and Informal Institutions”, Abreu, Laurinda (ed.), *European Health and Social Welfare Policies*, Santiago de Compostela, 2004, pp. 21–50.

andra Esteves and Maria Marta Lobo de Araújo in “Cholera in the Portuguese region of Alto Minho in the second half of the nineteenth century: Epidemic outbreaks, treatment and behaviours”. In the context of the first International Sanitary Conferences, the hygienist ideology and the medical police principles, the Portuguese state only hardly succeed to implement a more efficient sanitary control and preventive measures against cholera. The authoritarian way the central government tried to impose its policies faced serious resistance from the poor people, refusing to accept orientations that made their daily life even more difficult than it already was.

Using a completely different approach, the Bourbon Crown was able, approximately at the same time studied by Anna Prestjjan, to develop a massive public health vaccination campaign against smallpox in Sicily, “one of the earliest examples of state-sponsored non-compulsory immunisation programmes in history”, to quote John Chircop, in *‘Giusta la benefica intenzione del Re’*: the Bourbon cowpox vaccination campaign in Sicily”. For the success of such a project, the crown established a well organized scheme involving the most important structures of the central and local governments, but also the communities’ actors, as the Church and the health professionals. The result is described by Chircop as a paradox: combining a “deeply entrenched conservatism with a drive for administrative modernisation, particularly in the fiscal system and in public health”, the Bourbon government succeeded to impose new scientific ideas in what concerns public health, capitalizing it according to the most elementary bio-politic principles of health prevention and social surveillance. One of its instruments was the administrative bureaucracy, more and more efficient to report and to produce empirical data.

The importance of the administrative structures as provider and manager of information is also a central point in Elzbieta Kaczynska’ and Panagiotis Eliopoulos papers. In “A Century of Social and Economic Change - Its Impact on Health and Welfare (Poland between 1815 and 1914)”, Kaczynska, discussing the development of health and welfare offered in a very particular political situation, accents the big investment done by the state in terms of hygiene and health care explaining the increase of the number of patients and the criticism against the system, not by the inefficiency of the professionals involved but by the efficiency of the administrative structures, whose development gave more visibility to the data, making possible the entrance of more people into the medical system. For Panagiotis Eliopoulos, studying the Greek maritime city of Patras, in “Matters of Life and Death” in a Mediterranean Port City. Infrastructure, Housing and Infectious Disease in Patras, 1901-1940”, the scarcity of venereal disease and TB among the death records of adults didn’t reflect the absence of such illnesses in the city epidemiologic agenda (for example they were very present in the death records of the foundlings), but the fear of social stigmatization and also due to the political constrains in assuming the real dimension of diseases considered responsible for the creation of generations of degenerate murderers. In Poland, the administrative structures were used to give great

visibility to old problems and it contributed to social panic. In Greece the public administration hid the real data in order to protect the reputation of the population and of the city.

The Multiple Forms of Vulnerability

The second group of papers aggregates different situations of vulnerability³. The first two are referring to vulnerability among young people, in Andrea Fabian's paper, "Juvenile delinquency in Romania: the indirect result of the transition process", and among the minorities in the context of the labor market, in Oscar Fernández's paper, "Wellbeing and Work. Social Inclusion of Vulnerable Groups in Northern Spain". Andrea Fabian discusses the anti-social behavior and delinquency of young people. The big social expectations created after the communist regime in Romania, together with the economic changes that fomented the rural exodus, worsening the living conditions in the cities, and the governments' incapacity to respond to the aspirations of the population, contributed to the increase of the criminality. Rootless, the rural young people became urban delinquents. Direct result from the desocialization processes, so common nowadays in big urban centers, only a more assertive role of the family and of the school can, according to the national public opinion, prevent this type of juvenile criminality. It is precisely the constraints resulting from the educational and social limitations that constitute the most important handicaps presented by Oscar Fernández when he analyzes the difficulties experienced by vulnerable groups in the access to the labour market, in the urban district of Ponferrada, Province of Leon, in Spain. Women at risk (the most represented), disabled, immigrants, addicted (or ex-addicted) people, homeless or ethnic minorities, as the Romany community, are the groups at risk of social exclusion, being urgent to create conditions to help them to find an employment, the most efficient way to avoid anti-social behaviours, such as mentioned by Andrea Fabian. According to the author, the solution can reside in a sort of tailor-made inclusion routes, with financial and social support, organized according to a specific agenda under a flexible methodology, also able to involve the enterprises.

The other papers in this second set deal with the modern demographic behaviours and the enormous challenges that they are creating to the Social Protections Systems and National Health Services. Among the problems studied, the contemporary societies ageing process, and the associated problems, is the most present.

3 For the different concepts of vulnerability and their historical construction see, from Patrice Bourdelais and John Chircop, "Situating and defining vulnerability in historical perspective", in *Vulnerability, Social Inequality and Health*, Patrice Bourdelais and John Chircop (eds.), Edições Colibri, CIDEHUS/UE, PhoenixTN, Lisboa, 2010, pp. 7–14.

Different perspectives and approaches are discussed, covering a vast range of problems and sources.

Crossing national and municipal demographic data with welfare indicators, from 1960 to 2007, Teresa Ferreira Rodrigues explores, in “Regional Dynamics and Social Diversity - Portugal in the 21st Century”, the regional differences and asymmetries reflecting on how the broad demographic and socioeconomic changes occurred in the Portuguese society of the last decades affected such parameters. Concluding that, in spite of the convergence on national demographic behaviours, the homogenization on well-being standards is far from being reached. Rural and interior municipalities are the losers of the development process. Teresa Rodrigues is not far from one of the central ideas of Maria João Guardado Moreira’s paper, “Environmental changes and social vulnerability in an ageing society Portugal in the transition from the 20th to the 21st centuries”. The Portuguese National Health Service is unable to successfully deal with the new economic and social dynamics. When it concerns the extensive demographic ageing course, the new morbidity and mortality patterns and the growing demand in terms of patients, the institutional health and social structures still have a long way to go in order to offer good conditions to the elderly people.

The general reconfiguration of society and the new models and families’ organization, a key point in the ageing societies, as shown in the Portuguese example, is also present in the study of Jolana Rambousková, Eva Křížová, Pavel Dlouhý, Jana Potočková and Michal Anděl, “Nutritional Status in Elderly People Living in Retirement Homes in the Czech Republic”. Evaluating the nutritional status (a crucial determinant of health) of elderly admitted in institutions and comparing it with the ones living alone or with their families, the authors conclude that the institutionalized elderly show higher levels of poor nutritional statuses, accounting for long-term hospitalizations and considerable post-hospitalization care. This means that the institutionalization of the elderly, a recent practice implemented in the Czech Republic, not only increased the financial costs of the health system but also had repercussions in the quality of life of the people involved.

Ageing people, institutionalized care, economic resources and health problems is also the topic of the two last papers of this group: “Health Promotion Programs, for the Elderly in Greece, the “Health Pro Elderly” Project”, by Panayota Sourtzi, Vasiliki Roka, Venetia Velonaki and Athena Kalokerinou, and, by Antigone Lyberaki and Platon Tinios, “The social and economic effects of deterioration in health: ‘Naked-eye’ evidence from a European panel survey”. In the first case, the investigation presents and discusses the Greek experiences of very popular programs in Europe nowadays – the Health Promotion Programs for the Elderly. Aiming to identify the criteria responsible for the success of those programs and practices they conclude that the main part of those projects is developed in Open Care Centres for Elderly, the majority placed in urban areas, which configures an evident situa-

tion of inequality in the access to health resources. In spite of this, the “Health Pro Elderly” projects have produced very positive effects in terms of health promotion for this vulnerable group in Greece as well as in other parts of Europe, the reason why the authors suggest a more intense European cooperation regarding policies and strategies in order to combat the negative consequences resulting from the lack of resources felt by those who works on the field.

The paper of Antigone Lyberaki and Platon Tinios also deals with the role of social solidarity and cohesion for disadvantaged elderly people. Being recognized as one of the most important features of the European Welfare model, the authors wanted to evaluate its level of effectiveness through the amount and quality of social reserves mobilized to help individuals between 50 and 80 years old, with approximate socioeconomic patterns, that had experienced a situation of a suddenly and serious health deterioration. The study, carried out in different European contexts between 2004 and 2006/7, according to the organization of the social protection systems proposed by Esping-Andersen, uncovered different responses according to the social protection system analyzed but presents similar conclusions. On the one hand, the importance of an early response from the social systems to a social and family emergency; on the other hand, that is not the amount of money allocated to the National Health Service that determined their efficiency but how it is used.

To conclude this brief introduction, a separate reference to the text of Clara Oberle, a comprehensive studied, based on a vast range of primary documental sources, entitled, “From Warfare to Welfare, Postwar Homelessness, Dislocation, and the Birth of the Welfare State in Europe: The Case of Berlin 1945-1949”. If the necessity of reinvention of the European social welfare model in order to reconstruct the social cohesion is a topic in the main part of the papers presented in this volume, it is Clara Oberle that affirms it in the most assertive way. Analyzing the particular case of Berlin in a moment of housing and health crisis, she highlights the remarkable consensus created in the postwar period regarding the importance of “public planning, spending, and state involvement in the health and welfare sector”. Making welfare and public health important questions of governability, it was that interventionist consensus, in Germany like in many other European countries, that made it possible to consolidate the European social model. Like other historians, Clara Oberle suggests that the present crisis can be the moment to re-invent the health and welfare policy of Europe, based on shared values and convergent constraints. The scholars of PhoenixTN have contributed to this discussion. I’d like to thank all of them to have been so participative in tackling the multiple challenges that arose in this project context. Allow me to address a special compliment to the PhoenixTN scientific council for having invested part of their time, knowledge and energy to make it work.

Patterns of Hospitality: Aspects of Institutionalisation in 15th & 16th Centuries Nuremberg Healthcare

Fritz Dross

Introduction

Beginning in the late 14th and accelerating in the mid-15th century, health care relief underwent far-reaching changes in German imperial cities.¹ With regard to the organisational framework of relief they have been analysed and described as processes of institutionalisation, hospitalisation, specialisation, and communalisation. With respect to the healing personnel in charge of applying health care relief schemes initiated by the city councils and hospital administrations, this development has been characterised as professionalisation.² Altogether, these transformations could be looked at as a premodern stage of “medicalisation”. But of course, one risks anachronism when applying this term to earlier developments.³

This paper concentrates on institutional welfare⁴ provided by hospitals and aims to give a concise overview of the developments in the imperial city of Nuremberg in southern Germany. Information available on each individual institution is relatively

1 Robert Jütte, *Obrigkeitsliche Armenfürsorge in deutschen Reichsstädten der frühen Neuzeit. Städtisches Armenwesen in Frankfurt am Main und Köln* (Cologne 1984); Annemarie Kinzelbach, *Gesundbleiben, Krankwerden, Armsein in der frühneuzeitlichen Gesellschaft: Gesunde und Kranke in den Reichsstädten Überlingen und Ulm, 1500–1700* (Stuttgart 1995); Annemarie Kinzelbach: “Infection, Contagion, and Public Health in Late Medieval and Early Modern German Imperial Towns”, *Journal of the History of Medicine and Allied Sciences* 61 (2006), p. 369–389.

2 As general overview see Martin Dinges: “A History of Poverty and Poor Relief: Contributions from Research on the Early Modern Period and the Late Middle Ages and Examples from More Recent History”, in Laurinda Abreu ed., *European health and social welfare policies*, [Santiago de Compostela] (2004), p. 23–50.

3 Cf. John Henderson: “Medizin für den Körper und Medizin für die Seele – Hospitäler im Florenz der Renaissance”, in Michael Matheus ed., *Funktions- und Strukturwandel spätmittelalterlicher Hospitäler im europäischen Vergleich* (Stuttgart 2005), p. 33.

4 Concerning the concept of “institution” and “institutional welfare” see Martin Dinges: Introduction to the Volume: Situating Health Care: An Historical Perspective, in: *Hygiea Internationalis* 5 (2006), p. 7–13; Fritz Dross: “The Invention of a Medical Institution? A Discussion of Hospitals around 1800”, in: *Hygiea Internationalis* 5 (2006), p. 91–106.

poor and mostly extracted from the historical literature. The primary goal of this paper is thus not to enlarge our knowledge of particular Nuremberg relief institutions but to deepen our understanding of their interplay.

As an “imperial city”, Nuremberg was directly subordinated to the Emperor and not – like for instance Berlin, Munich or Vienna – to one of the authorities of a territory. As the Emperor’s residence was distant, the authorities of the imperial cities were especially powerful and can be presented as forerunners of modernisation in nearly every respect of public administration. Thus, “imperial city” is a juridical concept characterising the status of a particular city within the Holy Roman Empire; it does not mean “big town” at all –most of them were small in size but conserved the same legal status within the framework of the Empire. Nuremberg was one of a handful of large imperial cities in the 15th and 16th centuries. With some 36.000 inhabitants around 1500, Nuremberg was the second largest city in the Holy Roman Empire in that period, following Cologne (45.000), but bigger than Lübeck (24.000), Regensburg (22.000), Strasbourg (20.000), and Augsburg (30.000).⁵

Till Eulenspiegel in Nuremberg

Till Eulenspiegel is a very popular figure of 16th century folkloristic literature not only in the German-speaking part of Europe. The book (“Ein kurtzweilig lesen von Dyl Ulenspiegel geboren uß dem land zu Brunßwick. Wie er sein leben volbracht hatt. xcvi seiner geschichten.”)⁶ tells the story of a prankster and trickster named *Till Eulenspiegel* (engl. “Master Tyll Owlglass”) in 95 episodes.⁷ The book is structured by the course of life of *Eulenspiegel*, beginning with his birth and ending with his death. The story takes place in northern Germany. The fool *Eulenspiegel* plays jokes on his contemporaries and tricks mainly craftsmen, but also noblemen and clergymen. The stories of *Eulenspiegel* are mentioned for the first time in letters exchanged by two German clerks of the papal court in Bologna and Padua,

5 Ulrich Rosseaux: *Städte in der Frühen Neuzeit* (Darmstadt 2006), pp. 9–11; Augsburg: Wolfram Baer, “Einwohnerzahlen”, in G. Grünsteudel, ed, *Augsburger Stadtlexikon*, Augsburg 2nd ed. 1998 <<http://www.augsburger-stadtlexikon.de/index.php>> 15/07/2010. Of course, one has to be cautious with this numbers with regard to the sources and the difficult procedures in demographic research concerning the early modern period.

6 Wolfgang Lindow, ed., *Ein kurtzweilig Lesen von Dil Ulenspiegel, geboren uß dem Land zu Brunßwick. Wie er sein Leben volbracht hatt. 96 seiner Geschichten. Nach dem Druck von 1515* (Stuttgart 1978). The authorship is dubious. The quoted edition is accessible via internet at <<http://www.zeno.org/Literatur/M/Bote,+Hermann/Schwanksammlung/Dil+Ulenspiegel>> 15/07/2010

7 The 42nd of the 96 episodes is missing already in the 1515 edition.

Dietrich von Niem und Johannes Schele in 1411.⁸ In a chronicle written by Hermann Bote between 1493 and 1502 the author mentioned the death of „Ulen-speygel“ in Mölln (between Hamburg and Lübeck) in the course of the great epidemic in 1350.⁹ The folkloristic stories were printed for the first time in Strasbourg 1510/11 and at least 22 more German-speaking editions were printed in the 16th century. Assuredly, more editions and several translations in other European languages were printed,¹⁰ and a countless number of adaptations, quotations and imitations made *Eulenspiegel* proverbial already in 16th century.

The book was written in Northern Germany (Brunswick/Hanover area) where most of the stories took place. One time (Historie 17)¹¹ *Eulenspiegel* also came to Nuremberg, announcing to be a great doctor.¹² The hospital administrator immediately called for him and asked him to cure as many as possible of his 200 inmates. *Eulenspiegel* promised to enable them to leave their beds for 200 fl., and the hospital master accepted. *Eulenspiegel* talked to every single inmate telling everyone, that he could cure all of them but one whom he would have to burn in favour of preparing the medicine healing the others. Thus he proposed to choose the patient who was closest to death. Next morning he came to the hospital and cried out that every one who felt healthy should leave the hospital. Every one fled the hospital as fast and as far as she or he could – among these also people, who had not been able to leave their beds for weeks. *Eulenspiegel* took the money for his “cure” and left Nuremberg. Predictably, all former inmates came back in the following days.

8 Reinhard Tenberg, *Die deutsche Till-Eulenspiegel-Rezeption bis zum Ende des 16. Jahrhunderts* (Würzburg 1996), pp. 30–37.

9 Tenberg, *Till-Eulenspiegel-Rezeption*, p. 38.

10 E.g: Dutch: “Tijl Uilenspiegel”, Polish: “Dyl Sowizdrzał”, French: “Till l’espègle” or “Ulespiègle”, from where are derived an adjective “espègle” (i.e. mischievous, roguish) and “espèglerie” (i.e. mischievousness, impishness, roguishness). *Eulenspiegel* did not enter English literature before 19th century; English translation: Kenneth R. H. Mackenzie, *Master Tyll Owlglass: His Marvellous Adventures and Rare Conceits* (London 1859) <<http://ufdcweb1.uflib.ufl.edu/ufdc/?b=UF00003232&v=00001>> 15/07/2010 (1860 edition). It seems like a new story of Eulenspiegel that today the oldest printed edition which passed on completely (Strasbourg 1515) resides in the British National Museum in London. See Julia Buchloh, *Hans Baldung Grien und Dyl Ulenspiegel. Studien zu den Illustrationen und zur Text-Bild-Struktur des Straßburger Eulenspiegeldruckes S 1515* (Diss. phil. TU Berlin 2005) <<http://deposit.ddb.de/cgi-bin/dokserv?idn=976609576>> 15/07/2010; Katharina Dücker, *Literarische Bösewichte des (Spät)mittelalters und ihre mögliche Vorbildfunktion für das Eulenspiegelbuch*. (Pro Gradu-Arbeit, Institut für Sprach- und Translationswissenschaften, Deutsche Sprache und Kultur, Universität Tampere 2007) <<http://tutkielmat.uta.fi/pdf/gradu01649.pdf>> 15/07/2010.

11 <<http://www.zeno.org/Literatur/M/Bote,+Hermann/Schwanksammlung/Dil+Ulenspiegel/Die+17.+Historie>> 15/07/2010.

12 See Dücker, *Literarische Bösewichte*, p. 11 english translation: <<http://ufdcweb1.uflib.ufl.edu/ufdc/?m=hd54J&i=56821>> 15/07/2010.

Of course, all the *Eulenspiegel* stories are fiction – there is no historical proof that a person called *Eulenspiegel* ever lived and entered Nuremberg. At the same time, nobody would have had found these stories funny, had they not been conceivable.

An effect of widespread reception of the *Eulenspiegel* stories in 16th century must have been to make Nuremberg famous as a city with a huge hospital offering 200 beds and enshrining the holy relics of the Empire, which are mentioned in the story. Obviously the author had correct information on the size and the circumstances of the Nuremberg's hospital of the Holy Spirit, which is not mentioned by name. Furthermore, the inmates of the hospital are without doubt distinguished as sick people, which was common, or at least not a totally exceptional perception of people living in hospitals.¹³ Even more concrete, sickness is described as being an inability to get up and to move.¹⁴ *Eulenspiegel* whose jokes in general are based on taking common metaphorical expressions literally, tricks the hospital master by making the hospital inmates get out of bed and away from hospital without “curing” them. This means that hospital administration in 16th century obviously took care of inmates by paying “professionals” to cure them. Apparently, if one is to believe the story, expertise in terms of academic studies or an apprenticeship as barber-surgeon was not necessary to be admitted as a career or as a healer. Unfortunately, to decide whether a person was able to keep his or her promise to cure was not easy to ascertain prior to the cure.

Hospitals in Medieval Nuremberg

The imperial city of Nuremberg developed its hospital system in medieval times. A quick appraisal of the establishment of Nuremberg hospitals in medieval times is necessary before analysing the transition to the patterns of the early modern era. The first hospital in town was founded in the first third of the 13th century, manned by the Teutonic Order and dedicated to Saint Elisabeth of Hungary. Both the commandery of the Teutonic Order and their hospital were located just outside the

13 Already in 1340 the founder of the Nuremberg Hospital of the Holy Spirit, Konrad Groß, warned the hospital administration of selling hospital places to healthy people. Ulrich Knefelkamp: *Das Heilig-Geist-Spital in Nürnberg vom 14–17. Jahrhundert. Geschichte, Struktur, Alltag* (Nürnberg 1989), p. 192f.

14 Which seems to be a characterisation of English hospital inmates already in 12th century, “tresdecim pauperes inbecilles et ita viribus attenuati ut vix aut numquam sine alterius adminiculo se valeant sustenare.” Brigitte Resl: “Hospitals in Mediaeval England”, in M. Scheutz, A. Sommerlechner, H. Weigl, A. S. Weiß, eds., *Europäisches Spitalwesen – Institutionelle Fürsorge in Mittelalter und Früher Neuzeit* (Wien 2008), pp. 41–52, quotation p. 47; Ortrun Riha: “krank und siech' Zur Geschichte des Krankheitsbegriffs”, in A. Friedrich, F. Heinrich, C. Vanja, eds., *Das Hospital am Beginn der Neuzeit. Soziale Reform in Hessen im Spiegel europäischer Kulturgeschichte* (Petersberg 2004), pp. 191–201.

medieval city wall. Hospital and commandery remained extra-territorial ground after the enlargement of the city in 14th and 15th centuries when the hospital was enclosed in a new city wall. After the Reformation (in Nuremberg 1522-1533) the hospital chapel of the hospital of Saint Elisabeth was the only church where catholic worship was perpetuated. As a consequence of not being tied to the city's authorities or to the town's inhabitants confession, the hospital hosting about 50 people since late 14th century hardly was subject to the changes in urban health care relief in 15th and 16th centuries.

In 1339 the rich merchant Konrad Groß founded the hospital of the Holy Spirit, which became the central institution of the city's health care and poor relief system. Being one of the most important hospitals in medieval Germany whose records have been kept until today, the Nuremberg hospital of the Holy Spirit played an initial role in German historiography considering the social history of hospitals.¹⁵ The founding charter¹⁶ of the hospital was considered to be a prototype document of what has been called the “budget for the beyond”.¹⁷

Considering the particular status of a hospital capable of hosting about 200 inmates and quadrupling its property within half a century after its foundation,¹⁸ one must not underestimate its function in hosting the relics of the Holy Roman Empire since 1423. Once a year in the second week after Easter the relics were presented to the public (“Heiltumsweisung”). On this occasion the city opened its gates to foreigners. To get an impression of the visiting crowd, one could mention that e.g. in 1487 the City Council had armed about 1,000 men to control the event.¹⁹ Whenever the Emperor came to the imperial city he came to the hospital chapel to look at the relics, including e.g. the crown of Charles the Great.

Being more than an adequate place for civic foundations with respect to the “budget for the beyond” aiming to save the founders and the founders family

15 Knefelkamp: *Das Heilig-Geist-Spital in Nürnberg*.

16 Georg Löhlein, “Die Gründungsurkunde des Nürnberger Heilig-Geistspitals von 1339” *Mitteilungen des Vereins für die Geschichte der Stadt Nürnberg* 52 (1963/64), 65–79.

17 Ulrich Knefelkamp, “Stadt und Spital im späten Mittelalter. Ein struktureller Überblick zu Bürgerspitälern süddeutscher Städte”, in P. Johanek, ed., *Städtisches Gesundheits- und Fürsorgewesen vor 1800* (Köln 2000), pp. 19–40; Brigitte Pohl-Resl, *Rechnen mit der Ewigkeit. Das Wiener Bürgerspital im Mittelalter* (Wien 1996); Resl: *Hospitals in Medieval England*, p. 48

18 Michael Diefenbacher, *Sechshundertfünfzig 650 Jahre Hospital zum Heiligen Geist in Nürnberg: 1339–1989* (Nürnberg 1989); Michael Diefenbacher, ed., *Das älteste Urbar des Nürnberger Heilig-Geist-Spitals* (Nürnberg 1991).

19 “Man hat aus den acht Vierteln der Statt aus jedem sechzig bewehrter Mann genumen, auch aus den erbarn jungen Gesellen ainhundertundzwaitzig pferdt zusammengebracht, Unruh und Auffruhr zu verhüeten, und sein dartzu alle Thürn und Thor wol besetzt worden, sein ab aintausent Man in der Rüstung gewest.” Johannes Müllner: *Die Annalen der Reichsstadt Nürnberg von 1623*. Vol. III: 1470 bis 1544 (Nürnberg 2003), p. 83.

members' soul and their public commemoration,²⁰ the Nuremberg hospital of the Holy Spirit was a holy place within the imperial city and throughout the Holy Empire. Commemorative worship in the hospital and by the inmates closest to the relics of the Empire must have been highly desirable. As a consequence, the hospital went on collecting huge extra foundations and became the owner of around 700 farmyards covering the whole region in the 18th century. Since 15th century the hospital administration was under control of the town aldermen.

As the hospital of the Holy Spirit has monopolised social historian's attention, several other institutions have not been subject to deeper investigation regarding their position within urban poor relief and health care support in medieval and early modern times. Four of the town's leprosaria are relatively well known, they were founded consecutively in the 13th and 14th centuries. As usual they were located outside the city walls on the main roads connecting the imperial city with its commercial partners of Prague, Regensburg, Augsburg, and Frankfurt (Main).²¹ Two of them admitted women and the other two men, although there seem to have been changes in gender allocations in the 15th and 16th centuries.²²

Generally leprosaria differ from more general hospitals, as only people suffering leprosy were entitled to be admitted. Furthermore every leprous person was obliged to enter a leprosarium. The combination of the idea of a hospital dedicated to one distinct disease with a mandatory isolation directive seems quite modern and the modern idea of isolation obviously is a successor of the medieval treatment of lepers in general.²³ At the same time one should be cautious not to confuse both. Admission into one of the leprosaria was not free of charge as one finds elsewhere. Furthermore, the four leprosaria took different admission fees.²⁴ They had cooperative

20 Dietrich W. Poeck, "Wohltat und Legitimation", P. Johanek, ed., *Städtisches Gesundheits- und Fürsorgewesen vor 1800*. p. 1–17; Carole Rawcliffe: "A Word from Our Sponsor: Advertising the Patron in the Medieval Hospital", in J. Henderson, P. Horden, A. Pastore, eds., *The Impact of Hospitals: 300–2000* (Oxford 2007), p. 167–194.

21 Christine Seidel, *Die Siechköbel vor den Mauern Nürnbergs* (MA-Thesis Erlangen-Nürnberg 1984); Georg Gerneth, *Beitrag zur Geschichte der Lepra und Leprosorien in der alten Reichsstadt Nürnberg und in Fürth* (Diss. med. Erlangen 1949); Walter Steinmaier, *St. Jobst: Das Aussätzigenhospital am Empfangsweg des Kaisers. Herrscherkult und Siechenhaus, ein Beitrag zum Stadtausbau unter Karl IV. und zum Spitalwesen der freien Reichsstadt Nürnberg* (Nürnberg 2006).

22 Ernst Mummenhoff, *Die öffentliche Gesundheits- und Krankenpflege im alten Nürnberg* (Nürnberg 1898, Reprint Neustadt/Aisch 1986), p. 89.

23 In an European perspective see: Luke E. Demaitre, *Leprosy in premodern medicine. A malady of the whole body* (Baltimore 2007); Carole Rawcliffe, *Leprosy in Medieval England* (Woodbridge 2006); Bruno Tabuteau: "Historical Research Developments on Leprosy in France and Western Europe", in B. S. Bowers ed., *The medieval hospital and medical practice* (Aldershot 2007), p. 41–58; Kay Peter Jankrift, "Hospitäler und Leprosorien im Nordwesten des mittelalterlichen Regnum Teutonicum unter besonderer Berücksichtigung rheinisch-westfälischer Städte", in Scheutz et al., eds., *Europäisches Spitalwesen* (Wien, München 2008), p. 295–306.

24 Steinmaier, *St. Jobst*, p. 49.

constitutions so that the inmates themselves elected their masters who actually could be dropped by the inmates; if the master and congregation of the respective leprosarium did not agree with the administrator appointed by the City Council, they were entitled to require the nomination of another person.²⁵ At the same time, sometimes people left the leprosarium after several years because they became “clean”; we also know of people not suffering leprosy but living in leprosaria.

Statistics on inmates are only available sporadically for 16th and 17th centuries and change very much; adding the respective maximum number of inmates of each leprosarium results in a total of 80 inhabitants, which certainly never was achieved.²⁶ One can assume that all the four leprosaria accommodated for about 40 men and women in 15th and about 60 in 16th century. The four leprosaria as well as the two hospitals already mentioned exclusively admitted Nuremberg citizens. On the other hand the respective paragraphs concerning the leprosaria usually allowed admitting foreigners for one or two nights. Accommodation and nourishment appear to have been slightly better than given in “ordinary” hospitals. Certainly, the standard was better than one could assume the average standard of living of the lower middle-classes. Foremost it was regularly and predictable which was perhaps a cardinal particularity in premodern times.

The inhabitants were allowed to enter the city in favour of begging only when complying to strictly determined schedules with respect to places, date and time. The officers of the communal authorities were instructed to strictly separate the ordinary beggars from the leprous. Any person detected as “unclean” lost her or his benefits in other charities within the city of Nuremberg and had to move to one of the four leprosaria. This is stated e.g. in the founding charter of an almshouse accommodating old craftsmen of 1388.²⁷ Consequently, the accounts of persons accommodated in the two Nuremberg “houses of 12 brothers” (*Zwölfbrüderhäuser*) mention several “brothers” who had been found “unclean” after some years and finally died in one of the leprosaria.²⁸

To host foreigners, the imperial city had two hospitals dedicated to pilgrims, both of them located outside the city wall at the moment of their foundation in the

25 Willi Rüger, *Mittelalterliches Almosenwesen: Die Almosenordnungen der Reichsstadt Nürnberg* (Nürnberg 1932), p. 22f.

26 Mummenhoff, *Die öffentliche Gesundheits- und Krankenpflege*, p. 96–98; the main sources of the two almshouses are accessible via internet <<http://www.nuernberger-hausbuecher.de/>> 15/07/2010.

27 Georg Wolfgang Karl Lochner, “Die Sondersiechen in Nürnberg, ihr Almosen und ihre Schau”, in *Deutsche Zeitschrift für die Staatsarzneikunde* NF 17 (1861), Nr. IV, 177–252, p. 181 and 189f.

28 Like in England „a significant number of fifteenth-century almshouses ... instituted measures for the prompt removal of lepers and anyone else who posed a risk to health.“ Rawcliffe, *Leprosy in Medieval England*, p. 277.

1350ies and 1360ies: St. Martha and Holy-Cross.²⁹ Like the leprosaria they hosted foreigners for one or two nights unless age, tiredness, sickness or cold and rainy weather hindered the departure of the pilgrims.³⁰ Holy-Cross had 40 beds all in all, including those of the personnel. Numbers of hosted foreigners changed between 850 and 1,600 in 1470ies, between 1,100 and 2,300 in the 1480ies,³¹ so one can assume that most inmates only stayed there for one or two nights.

On this background, shortly after the foundation of the two pilgrim's hospitals, the City Council tried to restrict access to foreigners already in its first regulation concerning begging in 1370.³² This is the first German regulation committing beggars to wear badges passed out after examination by a special municipal officer. As it was impossible to hermetically close the city only foreigners who stayed longer than three days were forbidden to enter the city again for one year.

Within that framework the foundation for the foreign lepers ("Sondersiechenalmosen") *prima facie* seems remarkable.³³ Beginning in 1394 the city opened its gates for three days in the Holy Week before Easter to give clerical attendance, food and shelter to foreign lepers. This meant to take temporary care of people, who should not have been admitted for two reasons: for being foreigners and for being leprous. Whereas foreign beggars should have been refused at the city's gates according to municipal ordinances, citizens, who had been diagnosed as "unclean" should have been set out to one of the city's leprosaria. Consequently, in 1401 the City Council forbade this charity, which is said to have accommodated six persons in its first year. But reacting to an epidemic in the Holy Week 1405 the town aldermen had been accused of having attracted God's anger by banning the charity for the foreign lepers. Even more remarkable is the fact that the municipal authorities conceded

29 Kurt Pilz, *Die Evangelisch-Reformierte St.-Marthakirche und das Pilgrim-Spital St. Martha. Die reformierte Gemeinde in Nürnberg* (Nürnberg 1979); Helmut Haller von Hallerstein, Ernst Eichhorn, *Das Pilgrimspital zum Heiligen Kreuz vor Nürnberg. Geschichte und Kunstdenkmäler* (Nürnberg 1969).

30 "Auch kainen bilgram lenger dan ain nacht zu beherbergen on erlaubnis des pflegers; es deucht sich dan ainer ain wenig swach sein oder regenweter wer", quoted at Haller von Hallerstein, Eichhorn, *Das Pilgrimspital zum Heiligen Kreuz vor Nürnberg*, p. 40; Pilz, *Die Evangelisch-Reformierte St.-Marthakirche*, p. 10.

31 Haller von Hallerstein, Eichhorn, *Das Pilgrimspital zum Heiligen Kreuz vor Nürnberg*, p. 42/43.

32 Edited in Rüger, *Mittelalterliches Almosenwesen*, p. 68; for the Portuguese example see Laurinda Abreu: "Beggars, Vagrants and Romanies: Repression and Persecution in Portuguese Society (14th–18th Centuries)", in *Hygiea Internationalis* 6 (2007), p. 41–66.

33 Stadtarchiv Nürnberg (StAN) (Municipal Archive of Nuremberg) A 21–31 Sondersiechen-Stiftung St. Sebald auf dem Kirchhof; Johannes Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. II: 1351 bis 1469 (Nürnberg 1984), pp. 135–137. The division of care for the Nuremberg foreign lepers reflects the categories of "The wild and the tame" mentioned by Rawcliffe, *Leprosy in Medieval England*, p. 291.

this accusation by readmitting the charity which – following the history of the charity written in 1462 – immediately stopped the epidemic.³⁴

Hospitals in Nuremberg Since mid-15th Century

When discussing historical developments beginning in the second half of the 15th century, one has to bear in mind that the base of doing so, the records, changed considerably in quantity and quality.³⁵ At the same time, the properties, rents, and revenues of the hospitals grew enormously. Consequently, the efforts of financial management had to be refined.³⁶ This is a well-known development of modern administration. Obviously, historians of this era are at risk to take for a dramatic change something that was simply not mentioned earlier, before interesting an administration producing records. The major change, thus, is the need for a modern administration to regulate whatever it meant to give an authoritative order – which does not mean as an imperative that the things to get under authoritative regulation changed themselves. On the other hand, it should be mentioned that health affairs, at least their financial impact, came into the focus of the regulating authority.

This could be shown by means of the history of the charity dispensed to foreign lepers. The earliest documentation of the “Sondersiechenalmosen” dates back to 1462, when the charity came under administration of the municipal authorities.³⁷ First of all, the new administrator appointed by the City Council wrote down the history of the charity and listed its funds. Doing so he secured administrative power and produced the oldest source giving us information on what had happened since 1394. What we know of the late medieval history of the charity of the foreign lepers is already an effect of administrative modernisation.

In the following pages I am going to explore the development of a Nuremberg hospital and relief scheme in late 15th and 16th centuries by starting with the foreign lepers’ charity. Looking for a supposedly weak institution can contribute to draw a more reasonable picture than the describing further growth of the Holy Spirit, one of the biggest (and richest) hospitals of that era. At the same time, the aim of the charity to host and feed foreign lepers seems incompatible with the authoritative

34 “Als pald das geschah. da horet der sterb vnd der portzel auf.” StAN A 21–31 Sondersiechen-Stiftung St. Sebald auf dem Kirchhof.

35 Kinzelbach: *Infection, Contagion and Public Health*, pp. 379–381.

36 As Italian examples see: Matthew Thomas Sneider: “The Treasury of the Poor: Hospital Finance in Sixteenth and Eighteenth Century Bologna”, in Henderson et al., eds., *The Impact of hospitals: 300–2000* (Oxford 2007), p. 93–116; Marina Garbelloti: “Assets of the Poor, Assets of the City: The Management of Hospital Resources in Verona between the Sixteenth and Eighteenth Century”, in *ibid.* p. 117–134.

37 StAN A 21–31 Sondersiechen-Stiftung St. Sebald auf dem Kirchhof.

aim to cleanse the city of begging foreigners and of citizens suffering infectious diseases (in the contemporary conception) and especially lepers. But banning the charity had already failed in early 15th century. Consequently, focusing on the foreign lepers' charity enables to detect more subtle strategies as well as their failure and thus helps to construe a more complex view on the general process.

After readmission in 1405 clerical and physical attendance to the foreign lepers was given on the churchyard of St. Sebald, one of the two big parish churches of the town. In the years 1446 to 1448 a new house had been built by the foundation for the foreign lepers with support of the municipal authorities to shelter them for three days and three nights from Tuesday afternoon until Friday afternoon in the Holy week. This could be regarded as a first isolation house that opened its doors only when needed, like the pest houses of the early 16th century. But contrary to the latter, the house for the foreign lepers was to open and to close on fixed days of the year in the Holy Week. In the statutes of the foreign lepers' charity it is unmistakably stipulated that it should not open earlier and that everyone must leave the hospital on Good Friday. If there should be lepers who had fallen ill and were not been able to leave, they should be moved to one of the city's leprosaria. But predictably the hospital building was used for other purposes in the meantime when no foreign lepers were cared for.³⁸ The leper-inspection was operated in another house, whose owner was asked moreover to host the horses of the foreign lepers, which were fed twice a day. Obviously one must be cautious with the notion of poverty of the foreign poor.

The part-time hospital was a big building as the charity had been a big event. The number of people coming to Nuremberg to benefit from the charity vary between several hundreds and more than 3,000: In 1462, 600 foreign lepers and several more diagnosed not to be leprous entered the city in the Holy Week, in 1574 it had been more than 3,000, 2,450 of those had been diagnosed lepers.³⁹ This means that the number of foreign lepers in this year came close to 10 % of the Nuremberg population. But already lower numbers must have caused serious fears: A Nuremberg poor law of 1478 (repeated in 1518) made coverage obligatory for every beggar afflicted by "miserable damage" in order not to horrify the urban public, especially pregnant women, by the beggar's ugly deformation.⁴⁰ Not before 1575 the City Council succeeded in relocating the event outside the city walls, to one of

38 Lochner, *Die Sondersiechen in Nürnberg*, p. 229f.

39 Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. II, pp. 135–137.

40 "Item das auch ein yeder petler, er sey burger oder gast, dem zu petteln vergonnt wirdet, und einen offenbaren erbmlichen schaden au seinem leibe oder glidern hat, davon die swangern frawen durch gesicht schaden empfahen mochten, denselben schaden verdecken und nit offenberlich noch sichtiglich tragen noch zaigen sol, bey der puss ein jar von der stat." Almosenordnung 1478, Joseph Baader, *Nürnberger Polizeiornungen aus dem XIII. bis XV. Jahrhundert* (Stuttgart 1861) p. 318. Repeated in Almosenordnung vom 22. Juni 1518, edited in Rüger, *Mittelalterliches Almosenwesen*, p. 72.

the city's leprosaria. But quite clearly the charity had become very famous, so that the authorities had to publish the ordinance again in the following years shortly before the Holy Week.⁴¹

Foreign lepers probably camped outside the city walls before the gate was opened for them on Tuesday afternoon. They would then form a procession to the churchyard of St. Sebald where they were fed. On Wednesday they were inspected to ascertain that they were “unclean” and not simply simulating leprosy in order to benefit from the charity.⁴² An official letter signed by the examining doctor documented this examination. Those who had been found “clean” (“*immundus*“, in the German sources “*schön*”) were to leave the hospital but were fed the following days on the churchyard of St. Sebald. After regular confession the priest shriving the leprous handed out a distinctive sign to avoid others creeping in among the crowd of foreigners. On Thursday morning the lepers attended an open-air sermon in the churchyard on how to take the Holy Communion worthily, before taking communion inside the church. On the morning of Holy Friday, the lepers were again inspected and all were checked for written confirmation of their leprosy and proof of having been confessed before hearing a sermon on the sufferings of Christ and then eating and drinking started. Finally the lepers received clothing and some money, which was handed to them after they had given back the signs they had been given by the priest. Before leaving Nuremberg they had to promise not to come back before the following year.

This short sketch of the procedure sheds a light on the authorities’ ambition to gain control. It seems that the foreign lepers were considered to be especially dangerous. Obviously, controlling the dangerous most of all meant separating them, most suitable in proper houses dedicated to that special purpose. As this was expensive, as an additional strategy the City Council tried to modify the permeability of the city gates and even special places inside the city. Changes did not simply aim at refusing the entrance of foreign beggars, but also admitting thousands of foreigners on the occasion of the presentation of the relics of the empire (“*Heiltumsweisung*”) on the second Friday after Easter. In an ordinance of 1478 aiming to lock out foreign beggars the authorities explicitly state the exception of three days before and after this event as well as All Saints’ Day and All Souls’ Day in early November.⁴³ In the same way the foreign leper’s charity may be understood as an exceptional allowance, which also legitimates strict regulations.

41 Gerneth, *Beitrag zur Geschichte der Lepra*, pp. 74–75; Robert Herrlinger, *Volcher Coiter 1534–1576* (Nürnberg 1952), p. 35.

42 Concerning the “*iudicium leprosum*” cf. Demaitre, *Leprosy in Premodern Medicine*, p. 34–74; Rawcliffe, *Leprosy in Medieval England*, p. 184–190; Fritz Dross: “Vom zuverlässigen Urteilen. Ärztliche Autorität, reichsstädtische Ordnung und der Verlust armer Glieder Christi in der Nürnberger Sondersiechenschau”, in *Medizin, Gesellschaft und Geschichte* 29 (2010);

43 Baader, *Nürnberger Polizeiordnungen*, p. 318.

In the following century the imperial city's hospital policy could be understood as a process of managing exceptions owing to exceptional circumstances. This becomes clear through the history of two foundations created by legacies of the 1480ies.⁴⁴ First of all, the point that both testaments completely change the logic of the “budget for the beyond” attracts attention. Both testaments were atypical as they did not voice the desire to save their founder's souls by giving detailed and concrete instructions on how to proceed. The founders simply gave instructions to sell their property and to spent the money in God's glory⁴⁵ or to serve the poor⁴⁶. Both entirely relied on their executors' capability to find adequate schemes. The same person, Sebald Schreyer, executed both testaments.

Schreyer invested the assets of Georg Keipper in a foundation financing a physician, a barber-surgeon and an apothecary serving the hospital of the Holy Spirit. In the late 1480ies the hospital of the Holy Spirit became one of the first hospitals of the Empire employing and paying it's own academically trained physician.⁴⁷ At the same time the City Council began planning the enlargement of the hospital of the Holy Spirit. As its location was immediately adjacent to the river Pegnitz this incurred severe technical problems. In 1488 the City Council nominated Sebald Schreyer, the executor of Keipper's last will, to be the master builder of the project which included building a bridge over the river Pegnitz.

The property of Konrad Topler, the second testator, was used by Schreyer to build a pesthouse in 1490. Bringing the victims of pestilential epidemics into a pesthouse placed immediately outside the city walls avoided crowding the hospital of the Holy Spirit and infecting it's inmates in times of pestilence which, according to the founding charter, usually occurred every ten to twelve years in Nuremberg.⁴⁸

44 Cf. Dinges, *A History of Poverty and Poor Relief*, p. 35f.

45 “was ich uber diese vorgeschribne mein verschickte hab und gut hiner mir lasse, ... soll man zu gelt machen, so man allererst mag und solichs gelt in Gottes ere wenden und keren...” Elisabeth Caesar, “Sebald Schreyer, ein Lebensbild aus dem vorreformatorischen Nürnberg”, in *Mitteilungen des Vereins für die Geschichte der Stadt Nürnberg* 56 (1969), 1–213, p. 69.

46 “was ich laß [...] nichtzit hindan gesetzt, das alles sollen mein vormundt verkaufen und die kaufsumma oder dasselb gelt durch Got geben hawßarmen und andern armen leuten oder ains teils zu gotshewsern, armen clostern oder anderswo, do es notturfteiglich und woll angelegt wirdet, nach iren trewen und pester verstantnus, wie si dann alle versamentlich oder durch ein merers aus in zu rat werden.” Caesar, Sebald Schreyer, p. 65.

47 In southern Germany there had been no distinct hospital physicians prior to the 1480ies. See Wolfgang F. Reddig, *Bürgerspital und Bischofsstadt. Das St. Katherinen- und das St. Elisabethenspital in Bamberg vom 13–18. Jahrhundert. Vergleichende Studie zu Struktur, Besitz und Wirtschaft* (Bamberg 1998), p. 262. Generally, the hospitals had been served by the town physicians until early 19th century. See Fritz Dross, *Krankenhaus und lokale Politik 1770–1850. Das Beispiel Düsseldorf* (Essen 2004).

48 “das zu den zeiten, so auß der verhencknuß des allmechtigen Gottes durch die wurckung der körper des himmels sich in disen landen vergiftung des luftes und regirung der pestilenz begeben, als sich dann gemainklich in zehen oder zwelf jaren ungeverlich einmal erewget in diser loblichen stat Nurmberg.” Caesar, Sebald Schreyer, p. 73; Charlotte Bühl, “Die

In the periods between pestilential epidemics, the fund's interest should be used by the Keipper-foundation for financing medical services for the hospital of the Holy Spirit. In case of plague the Keipper foundation in return was to provide medical services for the pesthouse. But already in 1493, before the foundation stone of the pesthouse had been laid down, the City Council disapproved the plan to build a separate pesthouse while enlarging the hospital of the Holy Spirit. After quitting his job as the master-builder of the enlargement of the hospital in 1491, Schreyer proceeded as protagonist of a separate pesthouse against the will of the City council. He favoured a bigger two-storeyed building while the authorities later, having decided to support the plan in the interval, wanted to build two smaller but distinguished buildings. In 1516 Schreyer finally gave up the project.⁴⁹

Facing the plague

As already feared by the town authorities both projects encountered severe difficulties: The laying of the foundation stone of the pesthouse did not happen before 1497 and the wooden parts of the enlargement of the hospital of the Holy Spirit had to be demolished in 1506. More than ten years after beginning the building of the pesthouse the founding stone of its chapel was laid in 1509. The chapel grew faster than the pesthouse itself and was consecrated in 1513. The pesthouse opened before completion in 1520 but was only finished eight years later, in 1528. The following year work started again to enlarge the new pesthouse. The enlargement of the hospital of the Holy Spirit was finished by 1525. In 1552 the pesthouse was demolished for military reasons but rebuilt in the same year and again enlarged in 1592.

In a plague epidemic in 1494/5 the victims had been cared for in the pilgrims' hospital of Holy Cross as well as in the hospital of the Holy Spirit. In the next year, when the so-called French Disease first struck the imperial city, the City Council accommodated its victims in the pilgrim's hospital.⁵⁰ Meanwhile the City Council

Pestepidemien des ausgehenden Mittelalters und der Frühen Neuzeit in Nürnberg (1483/84 bis 1533/34)", in R. Endres, ed., *Nürnberg und Bern. Zwei Reichsstädte und ihre Landgebiete* (Erlangen 1990), 121–168, p. 123; Mummenhoff, *Die öffentliche Gesundheits- und Krankenpflege*, pp. 98–99; Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 112f.

⁴⁹ Caesar, Sebald Schreyer, p. 75.

⁵⁰ Mummenhoff, *Die öffentliche Gesundheits- und Krankenpflege*, p. 104; European reactions to the French Disease: Jon Arrizabalaga, John Henderson, Roger French: *The Great Pox. The French Disease in Renaissance Europe* (New Haven 1997); Annemarie Kinzelbach: "Böse Blattern" oder "Franzosenkrankheit": Syphiliskonzept, Kranke und die Genese des Krankenhauses in oberdeutschen Reichsstädten in der frühen Neuzeit", in M. Dinges, Th. Schlich, eds., *Neue Wege in der Seuchengeschichte* (Stuttgart 1995), p. 43–70; Claudia Stein: "The

tried to isolate people suffering from French Disease in tiny barracks and in 1507 opened a small pox-house; in 1523 he decided to build a new and bigger one. In the years 1514, 1515 and 1517 the new buildings of the hospital were near completion but still not in regular use, when at the same time 250 people were reported in the hospital which was clearly overcrowded. Moreover, during the Holy Week the hospital of the Holy Spirit was reported to shelter up to 700 lepers.⁵¹ If this is not a mistake by the chronicler Sebastian Müllner of the 17th century, which is possible but not most likely, this means that when the hospital of the foreign lepers was overcrowded by approximately 600 – 800 people, everyone beyond that number was hosted in the hospital of the Holy Spirit. While the big hospital of the Holy Spirit and the pilgrims' hospitals are frequently mentioned as provisional accommodation for the sick in case of need, there is no evidence that the hospital of the foreign lepers ever was used that way although it was filled only three days a year. In 1525 yet the scales for flour were moved from the “Sondersiechenhaus” to a chapel near the hospital of the Holy Spirit for their location had been deemed inconvenient.⁵²

Already when opened before completion in 1520 the pesthouse broke the instructions of its foundation charter. This document intended the pesthouse to host the convalescent for three more weeks and to accommodate both for Nuremberg citizens and the inhabitants of surrounding villages, but the City Council instructed the hospital master to discharge everyone no longer seriously ill and not to admit foreigners.⁵³ According to its dedication the pesthouse was opened in times of plague. But there were several exceptions like in 1523 when the City Council decided to erect a new pox-house and brought the people suffering from French Disease from the older pox-house, which was described as overcrowded, into the pesthouse still under construction.⁵⁴

The opening of the pesthouse was a widely recognised indication that the situation was out of control and in the later 16th century the City Council usually opened the pesthouse when the reality of the plague epidemic could no longer be kept from the inhabitants and the town's commercial partners elsewhere.⁵⁵ At the same time only a smaller part of the infected were forced to move into the pesthouse. In the epidemic of 1533, for example, according to some sources quoted by the chronicler Müllner, 1,100 people died in the pesthouse while 5,830 died in

Meaning of Signs: Diagnosing the French Pox in Early Modern Augsburg”, in *Bulletin of the History of Medicine* 80 (2006), p. 617–648.

51 Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 437.

52 “weil sie daselbs etwas ungelegen gewest” Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 564.

53 Bühl, *Die Pestepidemien des ausgehenden Mittelalters*, p. 150.

54 Mummenhoff, *Die öffentliche Gesundheits- und Krankenpflege*, p. 105

55 Carolin Porzelt, *Die Pest in Nürnberg. Leben und Herrschen in Pestzeiten in der Reichsstadt Nürnberg (1562–1713)* (St. Ottilien 2000).

town.⁵⁶ In early September that year there were 250 people inside the pesthouse increasing to 490 within nearly three weeks. When in 1542 an epidemic was declared among thousands of mercenaries around Nuremberg and led to many soldiers dying on the streets⁵⁷ the City Council opened the hospital of the Holy Spirit. After the hospital had been overcrowded he also opened the pesthouse to the sick soldiers.⁵⁸ In the following year the pesthouse was opened because of plague but in 1544 it did not open during an epidemic because “only the poor have died”.⁵⁹ This could possibly be linked to different states of contagiousness. Physicians in the imperial town of Nördlingen (about 100 kilometres south-western from Nuremberg) in 1571 distinguished two different classes of pestilence.⁶⁰ Secondary to the very contagious and dangerous form they described another one caused namely by malnutrition. The latter hardly affected the wealthier.

Beyond the plague

Confronted with plague and epidemics early modern hospital policies do not appear to have been very successful. The detailed picture of founding new hospitals, enlarging the older ones, re-building and re-dedicating several others is confusing, indeed. But one has to realise that what has been looked at in the last paragraph mostly have been bustling activities in times of a social, economical and political catastrophe. In modern times when activities of administrative units on nearly every level produce documents and records, as historians one has to be cautious not to overestimate the sheer number of sources produced on such very special occasions. Not to have that amount of sources in between epidemics must be interpreted by the assumption that the main concepts were not challenged and worked in a way satisfying the persons in charge.

At the same time a new paradigm emerges. Reacting to special needs in public health affairs usually meant some kind of building activity or, more precisely, the preparation of building activity. The authorities began confronted to a special sanitary necessity, at least since mid-15th century, preparing the erection of a special building. This sounds banal and insignificant as it is the very condition for any

56 Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 642.

57 “die arme Knecht hin und her an den Strassen gestorben”, Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 708f.

58 Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 708f; Ulrich Knefelkamp: “Über die Pflege und medizinische Behandlung von Kranken in Spitälern vom 14. bis 16. Jahrhundert”, in M. Matheus, ed., *Funktions- und Strukturwandel spätmittelalterlicher Hospitäler im europäischen Vergleich* (Stuttgart 2005), p186.

59 “Sein aber nur viel arme Leut gestorben” Müllner, *Die Annalen der Reichsstadt Nürnberg von 1623*, vol. III, p. 740.

60 Kinzelbach, *Infection, Contagion, and Public Health*, p. 383.

hospital policy. Furthermore the hospitals and hospital-like buildings considered here were dedicated to distinguished types of care, of different groups of people to be cared for and different caregivers. Concerning the sources one must conclude that they themselves were destined to help gaining control in case of panic. They do not tell the every-day standard of caregiving but report the exceptional case, e.g. when hundreds of foreign lepers were sheltered in the hospital of the Holy Spirit and people suffering the French Disease were sent to the pilgrims' hospital of Holy Cross. Within these exceptions in times of epidemics one could detect that the biggest of the Nuremberg hospitals, the hospital of the Holy Spirit, most of all was used in an exceptional way. If a bigger group of people unexpectedly needed to be hosted, the City Council first of all tried to accommodate them in the hospital of the Holy Spirit. Secondary the authorities sought to shelter them in the two pilgrim's hospitals. Thirdly they opened the pesthouse. At the same time, there was a big (and empty) building, the foreign lepers' charity, which could hold up to 800 individuals in the Holy Week ("Sondersiechenhaus"). Both the "Sondersiechenhaus" and the four leprosaria outside the city walls were not used to shelter others than (foreign) lepers in the period under discussion.

Within this subsidiary structure the hospital of the Holy Spirit acted as a container in cases of urgent needs. But this was definitely not what it was meant to be its place within the Nuremberg landscape of hospitals. In fact, it was quite the opposite: having a fully equipped medical branch of its own, it was to become the city's medical care centre. Hospital statutes of 1565 do not only very clearly describe the admission procedure, but also the way in which and when the inmates should be released from hospital.⁶¹ In case of need an ill person should send his spouse or someone to the hospital and announce his misery and sickness. By the way within this formulation once again we find the notion of sickness as an inability to get up and move mentioned above. The hospital master then should assign the probing-women ("Schauerin") to visit the person announced and to examine if she or he was entitled to be admitted within the hospital. The sick person should only be kept until her or his recovery. With respect to discharging the inmates the probing-woman ought to visit the wards routinely once a week in order to explore which of the inmates had recovered and could be released. When discharged, patients would receive some bread and some money to help them on their way home. No one should be discharged because of favour or by accepting a gift.

Remarkably, although employing a physician, a barber-surgeon as well as an apothecary, the decision to admit and to discharge persons was made by a female professional.⁶² For my purpose here, I would like to highlight the detailed regulations concerning the discharge of recovered hospital inmates. Relying on detailed

61 Knefelkamp, *Das Heilig-Geist-Spital in Nürnberg*, p. 197f.

62 The official oath of the "Schauerin" in Knefelkamp, *Das Heilig-Geist-Spital in Nürnberg*, p. 386.

data concerning late 16th and early 17th century Ulrich Knefelkamp has already shown that most of the inmates of the hospital of the Holy Spirit left the hospital after a stay of three or four weeks and that nearly a third left the hospital even earlier.⁶³ The general patterns resemble those found by Uta Lindgren when working on Barcelona's hospitals between 1480-1500.⁶⁴ This could only be achieved by an already highly differentiated landscape of hospitals, structured in a subsidiary way in 16th century Nuremberg.

Conclusion

It may be the case that historians of the early modern hospitals are too partial in focusing on the admission rules and the entrance barriers of hospitals. These serve as indicators of a certain degree of specialisation already in the Renaissance and early modern hospital. But specialisation in the Renaissance hospital must not be interpreted as a specialisation based upon our modern criteria. At the same time one could search for the complementary regulations of dismissal in a subsidiary structure of hospitals distinguishing different groups of people to be cared for and applying different ways of taking care. Not focusing on the success or failure of medical therapy alone would widen the perspective to several kinds of in-house care given temporarily. The inmates' condition to be released could be achieved by several ways among which medical therapy is only one – although growing in the following centuries. Finally discharging people from hospitals radically changed the logic of charitable hospitalisation. Caring for others started to become a commercial branch, when neighbours of a Nuremberg woman in 1544 accused her of accommodating sick persons and the City Council granted her engagement because no one could be forced to send her or his kin members into hospital.⁶⁵ By getting rid of their inmates as fast as possible hospitals could care for more people actually in need. Thus at least the figure of the hospital master in the 17th story of *Till Eulenspiegel* finds a clearer explanation.

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63 Knefelkamp, *Das Heilig-Geist-Spital in Nürnberg*, p. 276–331. Likewise, John Henderson stated facing the Florentine hospitals in 14th and 15th centuries, that people came into the hospitals not in order to die but to leave the hospital cured and living as fast as possible. Henderson, *Medizin für den Körper und Medizin für die Seele*, p. 32.

64 Uta Lindgren, *Bedürftigkeit, Armut, Not. Studien zur spätmittelalterlichen Sozialgeschichte Barcelonas* (Münster 1980).

65 Knefelkamp, *Das Heilig-Geist-Spital in Nürnberg*, p. 197.

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Healing the Body and Saving the Soul in the Portuguese Hospitals of the Early Modern Age

Maria Marta Lobo de Araújo and Alexandra Esteves

Healing the sick is the second corporal work of mercy and expresses the care provided by the *Santas Casas* to the poor who were in need of medical assistance. The overwhelming majority of Portuguese hospitals in the Modern Age were under the administration of the *Misericórdias*¹.

From early days, the *Misericórdias*' work in the health sector took the form of hospital assistance, helping to treat the ailments of the body. However, the work of these brotherhoods in the area of health was more extensive than this and included all those who did not wish to or could not be admitted to hospital. They helped them by tending to the sick at home, sending health professionals or by giving money, food and even clothing.

In this study, we aim to analyse and discuss the charity services that the Portuguese *Misericórdias* provided for patients throughout the Modern Age, both through the hospitals they administered and the home assistance they provided. We will also find out how the hospitals operated during that period.

At the beginning of the Modern Age, faced with the welfare institutions' incapacity to respond effectively to the needs of the poor, it was clear that a reform was needed that would involve joining hospitals, keeping a record of their assets, appointing new administrators and creating income and expenses records. In Portugal, this change took place during the 15th and 16th centuries, underwent various levels of reform and began with the hospitals. The process was autonomous and preceded the appearance of the *Misericórdias*.

The welfare establishments were in a very poor state and did not meet the needs of a poor and growing population. The hospitals were not only very small but also badly run. Their income was used for purposes for which it had not been intended and the institutions lacked supervision. Some of the brotherhoods that ran hospitals

1 The *Misericórdias* are lay brotherhoods, with royal protection and began in 1498 with the setting up of the Lisbon *Misericórdia*. They practise the 14 works of mercy, include the local elites and play an unequalled role in fighting poverty in Portugal during the Modern Age.

had too few members and found themselves unable to fulfil the duties to which they were bound. On the other hand, the assets that supported these welfare institutions financially also lacked adequate supervision². However, it is possible, in general terms, to understand the disorder in which the welfare institutions found themselves at the end of the Middle Ages and realise their incapacity to cope with the existing problems. Reform of the existing system was therefore imperative.

On the other hand, a solution that would diminish poverty was also urgently required. The number of poor had increased for several reasons: a change in the structure of farming production, years of poor harvests and a consequent increase in the price of products, particularly of food (resulting from greater demand that began with demographic growth and led to lack of work in plague years)³. The precarious situation brought about a sharp increase in the number of beggars who put pressure on the cities by asking for alms, frightening their inhabitants and pressurising the political powers to change the existing situation.

The study of the welfare reform in Portugal must be included in the wider context of this sector's restructuring throughout Europe.

In Portugal, the reform began during the 15th century, as we said, and lasted until the following century. It was an extensive period of time in which the welfare system underwent a gradual transformation.

One of the measures taken was to merge hospitals, creating larger and better-run treatment units aimed at meeting the demands of a growing number of poor and sick.

The hospitals were created by means of pious bequests and required papal authorisation to merge and establish new places of health care. This process took place in Santarém, Coimbra, Évora, Lisbon, Tomar and in other places in the kingdom.

It was during the Avis dynasty that the process took place, from the reign of Dom Duarte to John II. It was the latter monarch who joined the Lisbon hospitals and created the hospital of Todos-os-Santos (All Saints). Throughout the kingdom hospitals merged and larger hospital centres were created in several Portuguese towns⁴.

This effort towards modernisation, carried out by the Portuguese Crown was, as Laurinda Abreu says, worthy of papal support⁵.

2 Braga, Paulo Drumond, "A crise dos estabelecimentos de assistência aos pobres nos finais da Idade Média", in *Revista Portuguesa de História*, volume XXVI (1991), pp. 175–190.

3 Jutte, Robert, *Poverty and Deviance in Early Modern Europe* (London, Cambridge University Press, 1994), pp. 21–24.

4 Braga, Paulo Brumond, "1" "A crise dos estabelecimentos de assistência aos pobres nos finais da Idade Média", pp. 75–190.

5 Read Abreu, Laurinda, "As crianças abandonadas no contexto da institucionalização das práticas de caridade e assistência em Portugal, no século XVI", in Araújo, Maria Marta Lobo

It was within this framework of reform that the Lisbon Misericórdia was set up in 1498, the *Regimento das capelas, hospitais e albergarias e confrarias da cidade de Lisboa* (Regulations of the chapels, hospitals and inns and brotherhoods of the city of Lisbon) in 1504 and the *Regimento de como os contadores das comarcas hão-de prover sobre as capelas, hospitais, albergarias, confrarias, gafarias, obras, terças e residós* (Regulations of how the district controllers should provide for chapels, hospitals, inns, brotherhoods, leper hospitals, works, orders and residences) in 1514.

The publication of the 1514 *Regimento* spreads a new attitude across the kingdom with regard to the welfare institutions. Concern is shown for getting to know the state of the pious bequests and implementing a stricter policy in managing the institutions set up with them⁶.

In addition to this purpose, this legislative body would undeniably have had parallel effects on strengthening of the monarch's power. By giving orders for the hospitals' goods to be recorded, promoting the preservation and improvement of property management, Dom Manuel was strengthening his own power. The same occurs when, by royal order, hospitals were withdrawn from municipal administration and passed into the hands of the Misericórdias.

New health units were formed from the merging of the hospitals, which were better prepared to take in patients: the general hospitals, including that of Todos-os-Santos, in Lisbon. The Caldas da Rainha (thermal hospital) was set up at the same time. While the former brought together the assets of 43 hospitals in the city, the latter was founded by Dona Leonor, opened only between April and September and was supported by the rent paid from the neighbouring lands belonging to the queen, namely Aldeia Galega and Óbidos. It had 60 beds for the poor, 20 for pilgrims and another 20 for "honoured"⁷ persons.

The Todos-os-Santos hospital had 200 beds, a clinical staff, head chaplain and regulations.

Another thing that was new about these treatment units was the separation of the sick from pilgrims, a situation that was very different from that of medieval hospitals, in which these two categories of the poor shared the same space.

They were large units compared to the hospitals in the previous period.

de; Ferreira, Fátima Moura (Orgs.), *A infância no universo assistencial da Península Ibérica (sécs. XVI–XIX)* (Braga, ICS, 2008), p. 36.

6 Rosa, Maria de Lurdes, "O Estado manuelino: a reforma das capelas, hospitais, albergarias e confrarias", in Curto, Diogo Ramada (dir.), *O tempo de Vasco da Gama* (Lisbon, Difel, 1998), pp. 205–206.

7 For a broader study of the hospital of Caldas da Rainha, see Rodrigues, Isabel Maria Pereira, "Doença e Cura: Virtude do Hospital Real das Caldas (1706–1777). Elementos Sociais e Económicos" (Lisbon, Faculdade de Letras da Universidade de Lisboa, 2008, multi-copied Master's dissertation).

Set up by royal decree, the Misericórdias were brotherhoods that were always well protected by the Royal House. Kings and queens were enrolled among their ranks and they were widely favoured by different monarchs. Apart from founding hospitals through bequests received or from their own revenue, the Santas Casas also incorporated many medieval hospitals, especially from the second half of the 16th century, and therefore ran most of the hospitals in Portugal in the Modern Period.

As we have already said, the steps taken by the Portuguese Crown made it an important element in the entire reform process. Apart from the points already described, the Royal House ordered records to be drawn up of properties and rents, with a view to improving the management of the welfare institutions through better supervision and by preserving assets. At the same time, it ordered income and expenses books to be kept, imposing stricter control, and determined the existence of rules by drawing up regulations. It also appointed new administrators in the charity establishments⁸.

The Portuguese hospital network thus continued to respond to existing health problems. However, at plague times, everything changed and the existing hospital structure was neither ready nor could it respond to the requirements of the time. The needs of a sick and starving population required other measures.

In April 1598, the councillors of the Lisbon City Council wrote to the monarch telling of “large groups of men, women and children” who arrived at the city undernourished and sick, from all over the country. Since the Todos-os-Santos hospital, already under the administration of the Lisbon Misericórdia, was unable to take them all, the council asked the king to authorise a tax on the sale of meat and wine (one real⁹ per pound¹⁰) for three months, to raise money to build a new hospital where sick beggars could be treated. The councillors feared that the arrival of more people from outside “who as they are very poor and badly fed, walk around this city in droves asking for alms, entering all the houses in the city, it is feared, and we have almost seen, that it will be contagious”¹¹. Not only was there general hunger but there was also the plague that spread to many parts of the kingdom and the fear that the poor aroused¹².

8 Sá, Isabel dos Guimarães, *Quando o rico se faz pobre: Misericórdias, caridade e poder no império português 1500–1800*, Lisbon, Commission for the Commemoration of the Portuguese Discoveries, (1997), pp. 42–50.

9 Old Portuguese currency.

10 Old unit of weight measurement corresponding to 459 grams.

11 Oliveira, Eduardo Freire, *Elementos para a História do Município de Lisboa*, volume II (Lisbon, Typographia Universal, 1887), pp.103–104.

12 Rodrigues, Teresa *Crises de mortalidade em Lisboa, séculos XVI e XVII* (Lisbon, Livros Horizonte. 1990), p. 117.

The feeling of danger and of contamination was strong and felt throughout the population. The poor were a discomfort because of their sheer numbers, because they went around “in droves”, because they went from door to door asking for alms and because they carried disease. Despite the fears, the Lisbon councillors decided not to expulse them. There were many of them, they said, but when these left, others would come in their place. That is why they agreed to shelter them, but forbade them to beg at private homes. In other words, the Council would help them, but door-to-door begging was over.

The rate of growth in the European population at the beginning of the Modern Era led to the concentration of a considerable number of people in urban centres, obliging a regular supply of food to satisfy the needs of a hungry and growing population. Levels of consumption changed, as did the pressure placed on products by the population. These products were unable to keep up with the required amounts, forcing their prices to rise and therefore becoming prohibitive for the poor population.

The hospitals of the Modern Age fulfilled two main functions: to heal the body and to heal the soul. When the poor sought the hospital, they were suffering from ailments of the body, but the institution provided these two services. They had a clinical staff and a chaplain¹³. There was generally an altar on the wards where the religious man would celebrate mass and patients would receive the sacraments.

The clinical staff normally consisted of doctors, surgeons and bleeders, and the large treatment units could also include a highly variable number of apprentices, according to the hospital’s needs. The institutions could also include nurses or orderlies. The latter provided nursing services, made meals and served them to the patients. In the large and medium-sized hospitals, the nurses’ work was coordinated by the head nurse, a post that did not exist and was unnecessary in smaller institutions.

The clinical staff was a new phenomenon in the hospitals of the Modern Age.

It was up to the doctor(s), physician(s) or surgeon(s) to visit the patients regularly. At the Todos-os-Santos hospital in Lisbon, the physician had to visit the patients twice a day: early in the morning and at the beginning of the afternoon, and his visit had to be accompanied by the head nurse and by the pharmacists, by the head of the institution, by the overseer and by the orderly¹⁴. In other words, specialised staff, providers of medical care and staff related to the hospital administration. The number of people involved and the posts that some occupied

13 Santos, Eugénio dos, “O homem português perante a doença no século XVIII: atitudes e receituário”, in *Revista da Faculdade de Letras, História*, II series, vol. 1, (1984), pp. 190–197.

14 Salgado, Abílio José; Salgado, Anastácia Mestrinho, (introduction, transcription, glossary, notes and index), *Registos dos reinados de D. João II e de D. Manuel I* (Lisbon, s. e., 1996), p. 472.

made the act a rather solemn one, showing how important the moment was considered to be.

In accordance with their regulations, many hospitals had an established schedule for these visits. In Portel, the visits that the doctor and the surgeon made to patients also took place in the morning and the afternoon, and in the 18th century were at a fixed time. In the morning and in the winter, they would take place at eight o'clock, while in the summer they would be at seven. In the afternoon, they would be held at 16.00 and in the summer at 17.00¹⁵. Rituals took place at hospitals that obliged the patients and health professionals to be subjected to standards and make their daily lives fit in with the institution's rules.

Nevertheless, there were hospitals at which the health professionals were not bound by any schedule. The flexibility of the institution did not relieve them of responsibility, however, as they had to visit the patients regularly and be available for attending to them. This freer schedule was associated with other tasks that they undertook. They also had private practices and many of them were army and city council doctors.

The doctors took care of ailments related to matters of Medicine, while the surgeons devoted themselves to the field of Surgery. The bleeders were responsible for placing leeches and bleeding the patients¹⁶.

The functions of each group of health care providers were established in each hospital's regulations or, in the absence of these, in the commitment of the Misericórdias and in the decisions of the Board. Consequently, each group knew exactly what tasks they were expected to perform and, if they failed to do so or did not do so wholeheartedly, they would be cautioned and ran the risk of being fired.

In contrast to the situation in the Middle Ages in which the sick and travellers shared the same space, the hospital in the Modern Age separated the afflicted from travellers and created areas for each of them¹⁷. The sick were now housed in wards for fevers or wounds and were normally separated by sex, according, in fact, to the

15 Araújo, Maria Marta Lobo de, "O hospital do Espírito Santo de Portel na Época Moderna", in *Cadernos do Noroeste*, no. 20 (1-2), (2003) (a), p. 336.

16 Lourenço, António Gomes, *Breve exame de sangradores* (Lisboa, Oficina de Simão Thaddeo Ferreira, 1791), pp. 14-16.

17 Sá, Isabel dos Guimarães, "Os hospitais portugueses entre a assistência medieval e a intensificação dos cuidados médicos no período moderno", in *Actas do Congresso Comemorativo do V Centenário da Fundação do Hospital Real do Espírito Santo de Évora. Actas* (Évora, Hospital do Espírito Santo de Évora, 1996), p. 97.

clinical symptoms they had¹⁸. There were, however, smaller hospitals where men and women cohabited on the same ward.¹⁹

Hospitals were of varying sizes. The larger ones had several wards, while the smaller ones normally had only one or two areas for admitting patients. When they had the right conditions, they could take in people other than the poor. In Vila Viçosa, the Santa Casa hospital had six wards at the beginning of the 18th century: one for fevers, one for wounds, one for honoured people, one for convalescents and two for the cure of “boubas”, or syphilis²⁰. In other words, apart from treating people suffering from illnesses of a medical and surgical nature, the hospital also had areas for other treatments, such as syphilis. It also had a separate area for honoured and religious people and a ward for those who were in recovery.

The sick occupied beds separated by curtains, they used hospital clothing and footwear during their stay at the hospital and, although hospital furniture was precarious and insufficient, the institutions offered those that went there a place of comfort to which they were not normally accustomed.

Although health concerns in the Modern Age were not the same as those of contemporary societies, people were afraid of losing their health and becoming ill. When the ailment set in and the body gave way to illness, the poor sought out the hospitals to be treated free of charge. The hospitals were therefore always full.

The permanent occupation of the wards obliged constant spending in the health sector: food, crockery, pharmaceutical medicines, clothing and health professionals' salaries were certain expenses.

The hospital also provided transport for the sick: it would pick them up from home and carry them in a chair and, when absolutely necessary, would provide them with transport when they were discharged, sending the patient on a beast to the closest town and giving them a letter of passage. A letter of passage was a named document that attested to the holder's poverty. In Mora, it was the council gatekeeper that proclaimed “the coming of the poor”. All those that left the hospital and needed to be transported were taken by whoever made the best offer to the Santa Casa. The contract was annual and included all patients that left the hospital with a letter of passage.

With this document attesting to their poverty and need, the sick could have their letter of passage renewed by the welfare institution in the town to which they were travelling and, if necessary, a beast would be provided to carry them.

18 Barreira, José de Barros, *A assistência hospitalar no Porto 1750–1850* (Oporto, Faculdade de Letras, multi-copied Master's dissertation, 2002), pp. 350–353.

19 Araújo, Maria Marta Lobo de, *Dar aos pobres e emprestar a Deus: as Misericórdias de Vila Viçosa e Ponte de Lima (séculos XVI–XVIII)* (Barcelos, Santa Casa da Misericórdia de Vila Viçosa; Santa Casa da Misericórdia de Ponte de Lima, 2000), p. 84.

20 Araújo, Maria Marta Lobo de, *Dar aos pobres e emprestar a Deus: as Misericórdias de Vila Viçosa e Ponte de Lima (séculos XVI–XVIII)*, p. 176.

The poor were undernourished, not all of them had a home, nor did they have rules of hygiene and often had no one to take care of them if they were ill. The hospital therefore provided these services, a fact that helped keep mortality rates down. As soon as they showed signs of recovery, they were authorised to leave, since the beds were needed for other patients. Without undergoing convalescence, many of the poor returned to the hospital to be taken care of again. Medical care was obviously important, but attention was also paid to the patients' well-being, which could be seen in the hygiene that was required in these institutions, normally associated with "good smells". Products were bought to make the environment more pleasant and, in the 18th century, concerns over the comfort of the environment also included heating hospital areas and the use of sweet-smelling herbs: rosemary and lavender. These efforts made concerning the sick reflect the interest in improving health conditions and were manifested by doctors and philosophers²¹. The concerns over hygiene and the well-being of the sick increased throughout the Modern Age because these issues were understood to be an essential part of the treatment²².

In the hospitals it was the doctor and the surgeon that prescribed the treatment and the medicines to be prepared for the patient. In most of these institutions, the prescription would be given to the orderly or nurse, who then passed it on to the pharmacist. Once the medicine had been prepared and if the institution did not have its own pharmacy, the pharmacist would send it to the hospital to be administered to the patient. When hospitals had their own pharmacy, everything was quicker and easier. In Portugal, however, not all hospitals were equipped with a pharmacy.

In the case of home visits, the prescription would be given to the patient or to a family member, although it would be addressed to the pharmacist. Some of these probably had to be deciphered by the man at the pharmacy, although at the end of the 18th century and in the "large production centre of medicaments in Portugal" – the Pharmaceutical Dispensary of the University of Coimbra – the entire medical prescription book was already written in Portuguese²³. This was different from the situation in Spain or in France during the same period, where prescriptions included terms in Latin²⁴.

21 Ackerknecht, Erwin H., *La médecine hospitalière à Paris (1794–1848)* (Paris, Poyot, 1986), pp. 190–206.

22 Park, Katharine, "Healing the poor: hospital and medical assistance in Renaissance Florence", in Barry, Jonathan; Colin, Jones eds., *Medicine and charity before the welfare state* (London, Routledge, 1991), pp. 26–45.

23 Pita, João Rui, "O arsenal terapêutico no Hospital da Universidade de Coimbra (1792–1836)", in *Actas do Congresso Comemorativo do V Centenário da Fundação do Hospital Real do Espírito Santo de Évora. Actas* (Évora, Hospital do Espírito Santo de Évora, 1996), p. 229.

24 Kibleur-Gramain, Pascale, "Le rôle des prescriptions médicamenteuses dans la société française du XVIIIe siècle", in *Histoire, Economie, Société*, no. 3, (2001), pp. 327–330.

But what other treatments were patients subjected to? According to their pathology, medicines were prescribed. Pharmacopoeia was not particularly well developed and despite the efforts made throughout the 18th century, treatment continued to be based on bleedings, on the placing of leeches and on a few medicines. However, treatment was given according to the illness in question.

When hospitals did not have their own pharmacies, they had contracts with one or more pharmacies in the neighbourhood to prepare and send remedies for the patients. The large hospitals usually had pharmacies, but the smaller units did not have the capacity to support the expenses of a pharmacy or the payment of a salary. It was therefore more convenient to negotiate with a pharmacist and have this service provided.

Pharmacy expenses were a great concern for these institutions, not only because of the sums they reached, but also because they were certain costs. In the 18th century, when the hospital population grew, the welfare institutions were confronted with greater expenses in the health sector and often complained of pharmacy expenses; they would therefore ask pharmacists for bigger discounts²⁵. It was also a time for the smaller hospitals to assess the advantages of having a pharmacy and of having these services provided²⁶. Having their own pharmacy meant an end to complaints over the quality of the products supplied, and it was also a way of saving money.

Although hospitals reflected the concerns in this sector, these were, in fact, more of a financial nature than a medical one. Even so, in the large hospitals, the presence of the pharmacist was required during the doctors' and surgeons' rounds, so that they would be responsible for preparing and delivering the prescribed medicine.

In order to promote the services they provided, pharmacy owners focused on the quality of their products, highlighted the cleanliness of their houses and stressed how well stocked they were. When there were several competitors to supply medicines to a hospital, self-preservation was of the utmost importance. Those who worked in the pharmacies of institutions that provided health care had to take great care over their instruments and the medicinal substances, otherwise their salaries could be cut when periodic visits were made by the administration²⁷.

25 Braga, Isabel M. R. Mendes Drumond, *Assistência, saúde pública e prática médica em Portugal, séculos XV–XIX* (Lisbon, Universidade Editora., 2001), pp. 46–47.

26 In Mértola, the hospital was given a pharmacy in 1792. Read Ferreira, Manuel Gomes Duarte, *A Santa casa da Misericórdia de Mértola (1674–1834)* (Coimbra, Universidade de Coimbra, 2008), Multi-copied Master's dissertation, p. 110.

27 López Dias, M^a Teresa, “La botica del Hospital del Amor de Dios de Sevilla”, in *Boletín de la Sociedad Española de Historia de Farmacia*, year XXXVII, no. 147, (1986), p. 182.

Hygiene and diet were also on the support programme for patients²⁸. It is known that the poor person's diet was low in calories and lacking in proteins, vitamins, calcium and phosphorous. This poor diet brought consequences for everyone and resulted in health problems for both young and old, making them frequently dependent on health and charity services²⁹. The hospitals concerned themselves with providing a careful diet, following the doctors' indications.

Since bread was a part of all meals, the poor were dependent on cereals. These goods were cheap compared to others that made up their diet. Until now, it has been studies on welfare institutions that have provided information on assistance for the sick.

In the Vila Viçosa Misericórdia, patients at the Real do Espírito Santo hospital had varied meals as well as a range of desserts. Their diet was based upon bread, chicken and mutton, pork and pigeon, the latter being served when the sick had little appetite.

Meals could also include rice and salt cod³⁰ and were accompanied by a wide range of vegetables: turnips, lentils, broad beans, spinach, purslane, cucumber, lettuce, etc. They also included milk and eggs. Dessert was varied and included seasonal fruit: plums, pears, apples, oranges, cherries and melons, but was also alternated with the distribution of cakes: slices of preserves bought in Lisbon and sponge cake; or even other delicacies made at the hospital: quince jam and sweet vermicelli. Dessert also included raisins, Edam cheese and almonds³¹.

It was a very rich and diverse diet, capable of contributing to the patients' physical stamina.

At the Convalescence Hospital in Coimbra, meals included bread, chicken and mutton at the end of the 18th century. Fish was consumed in small quantities, but milk, eggs and fruit were also eaten. At the beginning of the 19th century, at the Hospital Real in the same city, beef and mutton, rice and salt cod were eaten. During Lent, the sick were served fish³².

Although meals varied in these hospitals, the common denominators were bread and chicken. The reason for this was that they were readily accessible and very

28 Wilson, Renate, "Pietist Universal Reform and Care of the Sick and the Poor. The Medical Institutions of the Francke Foundations and Their Social Context", in Finzsch, Norbert; Jutte, Robert (ed.), *Institutions of Confinement. Hospitals, Asylums, and Prisons in Western Europe and North America, 1500–1950* (London, Cambridge University Press, 1996), pp. 144–147.

29 Soubeyroux, Jacques, "Pauperismo y relaciones sociales en el Madrid del siglo XVIII", in *Estudios de Historia Moderna*, nos. 12, 13 (1980), pp. 100–101.

30 Braga, Isabel M. R. Mendes Drumond, *Do primeiro almoço à ceia. Estudos de História da Alimentação* (Lisbon, Colares editora, 2004), pp. 53–54.

31 Araújo, Maria Marta Lobo de, *Dar aos pobres e emprestar a Deus; as Misericórdias de Vila Viçosa e Ponte de Lima (séculos XVI–XVIII)*, pp., 215, 657.

32 Lopes, Maria Antónia, *Pobreza, Assistência e Controlo Social. Coimbra (1750–1850)*, vol. 1 (Viseu, Palimage Editores, 2000), pp. 655–664.

probably because of the existing bequests for the healing of the sick. The bequests that hospitals had for the treatment of patients obviously had an impact on the services that they were provided with and in particular the food they were served. What was included in the meals also reflected the local diet and therefore led to certain differences in the various hospital menus.

The composition of the meals and the fact that they were better and more varied in terms of vitamins and proteins contributed to the patients' physical recovery and made the hospital, at least in terms of cuisine, an exceptional place in their lives³³.

Since diet was considered to be part of the treatment, great care was taken over it.

In specialised hospitals, such as those for syphilis, care was more specific and aimed at the disease. The sick were subjected to sweatings, bleedings and fumes, syrups and ointments. Some products were combined to obtain the required medicines: sarsaparilla, pock wood, China root³⁴ among others and mercurial ointments were used³⁵. Treatment was accompanied by a careful diet adapted to the patient's condition. A change in clothing was also very important for the cure. In these hospitals, clothing was subject to great wear and tear and, consequently, investment in this area was greater and more frequent than in other hospitals.

In order to economise on these products, the ointments that were left over from the spring were saved for the autumn cure. Little is known, however, on how these hospitals functioned in Portugal. There are few studies that analyse them, though they did operate in different ways from the common hospitals.

The same can be said in relation to the *hospitais reais* (royal hospitals). We know that the Portuguese crown set up hospitals to treat the military, the so-called *hospitais reais*, *hospitais d'el rei* or *de campanha*, normally dismantled after the war in which they served, but there are few studies that analyse them. This is an open field for study, which awaits researchers to analyse and divulge the hospitals, especially for some regions of the country.

33 Vega Rojo, Anastasio, *Enfermos e Sanadores en la Castilla del siglo XVI* (Valladolid, Universidade de Valladolid, 1993), pp. 78–82; Ramos Martínez, Jesus, *La Salud Pública y el Hospital General de la Ciudad de Pamplona en el Antiguo Régimen (1700 a 1815)* (Pamplona, Gobierno de Navarra, 1989), p. 112; Codima, Jaume, “L'alimentación humana a L'Hospitalet de Llabregat durant el segle XVII”, in *Estudios históricos y documentos de los archivos de protocolos*, IV, (1974), pp. 271–296.

34 Arrais, Duarte Madeira, *Do methodo de conhecer e curar o morbo gallico: propoemse diffinitivamente a essencia, specias, causas, sinais, pronostico e cura de todos os affectos gallicos e largamente se trata do azougue, salsa parrilha, guaycão, pao santo, raiz da China e todos os mais remedios della e enfermidades*, Lisbon, Antonio Crasesbeeck de Mello, Impressor de S. A., (1663), p. 69.

35 Sánchez Téllez, María Carmen, “La medicación antivenérea en los hospitales meadrileños durante la Ilustración”, in *Boletín de la Sociedad Española de Historia de la Farmacia*, year XXXV, no. 140, (1984), p. 221.

With the War of Restoration (1640–1668), the Portuguese Crown concluded contracts with the Misericórdias to heal the military in their hospitals. However, the parties involved did not always reach an agreement and in certain places the small size of the treatment units meant that *hospitais reais* had to be set up. These were placed in the hands of the religious order of São João de Deus, which had experience in this field.

The hospitals remained much the same until the second half of the 18th century, when criticism of their operation became more vocal. The attacks made focused on everything from the organisation to the administration as they were considered poor health care providers for the sick population.

But the treatment of the sick was also carried out at home. Not all the Misericórdias had hospitals. To give but a few examples, Ponte da Barca only received a hospital in 1748 and Monção in 1803. Even the Santas Casas that had hospitals provided home treatment, fulfilling, in fact, the commitment of 1618. The two areas of assistance were always in operation in the Santas Casas that had hospitals, all the more so because the treatment units did not always have room to admit the patients, and particularly women, when they refused to be admitted. In some places, such as in the Alentejo (southern Portugal), hospital patients were mostly men, many of whom were seasonal workers from the North or Centre of the country who went to this region to work at certain times of the year³⁶. The women were tended to at home, remaining in the more secluded environment of their houses.

Why would women in some regions refuse to be hospitalised? The reasons were probably associated with the defence of female honour. Cohabiting with men, in some cases on the same ward, or in very confined areas, was not something that would add respect or contribute towards the defence of honour. That is why many women preferred to be treated at home and helped by the Misericórdias. The opposite situation is found in the North of Portugal. In Ponte de Lima, women represented 62.8% of hospital patients between 1690 and 1799, which reveals a very different reality to that of the south of the country³⁷. Ponte de Lima was a region with a high emigration rate, particularly in the 18th century when many men went to Brazil, Lisbon and Castile, leaving the women as the main family support. With a more exposed life, carrying out tasks that were traditionally done by men, the

36 For the region of Setúbal, see Abreu, Laurinda, *Memórias da alma e do corpo. A Misericórdia de Setúbal na Modernidade* (Viseu, Palimage Editores, 1999), p. 406.

37 Records of the Santa Casa da Misericórdia of Ponte de Lima, *Livro dos cabidos particulares 1678–1717*, no. 5; *Livro dos asentos que a Meza faz por cabidos particulares 1717–1740*, no. 6; *Livro para os ascentos (sic) da meza 1740–1751*, no. 7; *Livro que a (sic) de servir para os asentos da meza desta Caza da Santa Mizericordia da villa de Ponte de Lima 1763–1787*, no. 8; *Livro de entrada de doentes 1780–1799*, no. 655.

women in this region had a different view of the hospital and, when necessary, they used its services.

In the border *Misericórdias*, it was common for hospitals to fill up with soldiers during war times. This was a result of agreements made with the Crown and which obliged the poor to be treated at home.

The *Santas Casas* would send the doctor and/or surgeon to the house of the sick, would pay for the medicines and might even send chicken or other meat or give some money for food. In some cases of extreme poverty, the institutions might even send bedding.

In some cases, help could accompany convalescence. The patients' condition was conveyed to the Board by the health professionals³⁸, but they were also supervised by a member of the board who went to their home to attest to their need and check on their state of health.

Modern Age hospitals fulfilled another function: that of healing the soul. For this purpose, in addition to the clinical staff, they also had a chaplain who was responsible for taking care of the soul. He had to give the sick the sacraments, say prayers for the dead for whom the institution was responsible, give spiritual comfort to the dying and bury those that died. In some Spanish hospitals, the chaplain also had to indoctrinate those who were admitted³⁹. Generally, the poor did not meet moral standards, did not live by religious precept and did not follow the Catholic doctrine, because in many cases they were unaware of it. It was therefore understood that their time spent in hospital also served to put them on the road to salvation, giving them the opportunity to be redeemed from sin and to change their behaviour.

All patients went to mass at least once a week, celebrated by the head chaplain in the wards. These areas had an altar, as we have already said, where the divine offices took place⁴⁰. This was positioned so that it would be visible to men and women.

In many hospitals, the chaplain was obliged to live in the institution, which showed the importance given to saving the soul, at the same time as revealing its primacy in relation to the body. This paid member of staff had to provide permanent assistance to the sick, both by day and night. So as not to have to take the viaticum outside the facilities, the church was normally connected to the hospital via a door, thus facilitating the chaplain's access and preventing time loss.

When patients arrived at the hospital, they would be obliged to confess and at the hospital of *Todos-os-Santos* in Lisbon, they also had to make a will. They

38 Governing body of the brotherhood.

39 Carmona García, Juan I, *El sistema de la hospitalidad pública en la Sevilla del Antiguo Régimen* (Sevilla, Diputación Provincial de Sevilla, 1979), pp. 143–148.

40 Araújo, Maria Marta Lobo de, "A Santa Casa da Misericórdia de Monção (séculos XVI–XVIII)", in Capela, José Viriato (coord), *Monção nas Memórias Paroquiais de 1758* (Braga, Casa Museu de Monção, 2003), pp. 72–93.

would not be admitted without these formalities. While they were in hospital, they were given spiritual assistance and, if death occurred, they were also accompanied to the grave by the priest and their soul was prayed for with mass.

The 1504 regulations of the Todos-os-Santos hospital determined the existence of two chaplains living in the institution to celebrate daily mass and give confession, communion and holy unction to the patients, as well as other “things” for the “health of the soul”⁴¹. It was also the chaplains’ job to speak to the sick, console them and help them spiritually. This hospital also had a papal bull that absolved the sins of those who died there.

Similar concerns with the soul are expressed in the 1516 commitment of the Lisbon Misericórdia, when the brother that visits the sick is given the task of providing them with “spiritual medicines”, since, as it says, they “are provided with corporal things much more than they are for those of the soul”⁴².

The importance of spiritual matters is maintained in the commitment of 1618, but this time there is a new aspect: in this text, the bodily health of the sick is dependent on the spiritual comfort offered to those in hospital. In order for temporal matters to obtain better effects, the head of the pharmacy should, at the hospital of Santa Ana, take “particular care with the spiritual good” of the sick, advising them to make frequent confessions and, when their life is in danger, to call a priest to deliver the last rites, accompany them to death and pray for the salvation of their souls⁴³.

It was during these last moments that they were most in need of spiritual assistance and steps for a good death were ritualised. At hospital and at home, it was the priest that remained at the bedside of the sick, offering pardon for their sins, a good death and a cure for their soul.

Mainly under the administration of the Santas Casas, the Portuguese hospitals in the Modern Age were constantly overcrowded as a result of the great demand for them. At a time when man’s main concern was that of salvation, the hospitals offered services to heal the wounds of the body, but at the same time they took care of the soul, preparing it for the moment of passage. Not knowing what the future held, and at a time when the cares of the soul were more important than the cares of the body, men prepared to die because they knew that there was no fixed date, but that it was certain and would come to everyone.

Nevertheless, in the 18th century, concerns with well-being increased, which shaped a new status for the body. The soul took second place and the body became the focus of renewed attentions. Demand for hospitals increased considerably and

41 Salgado, Abílio José; Salgado, Anastácia Mestrinho, *Registos dos reinados de D. João II e de D. Manuel*, pp. 456–457.

42 *Do Compromisso da confraria da Sancta Caza da Misericordia de Lisboa fundada pela rainha D. Leonor de Lencastre* (caldas da Rainha, Tipografia Caldense, 1929), p. 23.

43 *Compromisso da Misericórdia de Lisboa*, Lisbon, Pedro Craesbeeck, 1619, p. 34.

health sector expenses rose dramatically, revealing the investment that was being made in the well-being of the body.

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Disease and Health Care in the North-West of Spain in the Early Modern Period. The Bierzo Region

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The Bierzo is one of the natural districts of the Spanish Province of Leon. Situated in the western part of this province, it borders the Galician Provinces of Lugo and Orense to the west; to the south lies another natural region of Leon, the Cabrera; to the east stand the Mounts of Leon; while to the northwest there is the former administrative district of Ribas del Sil de Arriba. This is a territory with considerable geographic diversity, in which it is possible to distinguish mountainous zones, occupying somewhat more than half of the district, the so-called Upper Bierzo; plains or depressions, forming the Lower Bierzo; and transitional areas, linking these two.

The chief administrative centre of the Bierzo was and is the town of Ponferrada, although other places such as Villafranca del Bierzo or Cacabelos also were of importance during the early modern period. In the case of the first of these, this was because of its religious standing, which developed under the auspices of the marquises of Villafranca, while in the case of the second it was thanks to the major fairs held there.

The Hospital Network of the Bierzo

The Bierzo was crossed by the Pilgrim's Way to Santiago de Compostela, which ran into it from the city of Astorga in three branches that join up at Ponferrada. One crossed the Mounts of Leon by the Manzanal pass, another via the pass of Foncebadón and the third was termed the Cerezal route¹. The branch with the greatest traffic was the second. For this reason, during the Middle Ages it had a greater concentration of activities aimed at assisting pilgrims. Thus, at several places along this

1 Caveró Domínguez, G. (1987), *Peregrinos e indigentes en el Bierzo Medieval (siglos XI–XVI). Hospitales en el Camino de Santiago*, Ponferrada: Basílica de la Encina y Asociación de Amigos del Camino de Santiago, pp. 43–52.

route, such as Manjarín, El Acebo or Molinaseca, hospitals or hostels were set up, intended to help travellers. This does not imply that centres of this kind were not in existence on the other routes, of course. Once the three branches united, pilgrims could find places to stay or be treated for ailments at Ponferrada, Camponaraya, Cacabelos, Villafranca or Pereje. The life of some of these establishments was ephemeral. However, a few of them did remain open throughout the Early Modern Period.

In those centuries, although the Pilgrim's Way had already lost the exclusively religious character with which it had originated, it continued to be a heavily used route². At that time the main flow of travellers were no longer pilgrims but voyagers of every social class and with very varied purposes for their journeys³. Nonetheless, not all were potential clients of these establishments lying along the Way. Only those who had no money were accepted, since anybody who could afford to stay the night in more comfortable lodgings was not allowed to have recourse to the charity offered by these foundations. However, all travellers were exposed to the risk of catching an illness, so that many of the hostels, which had a hospital section, included in their regulations the possibility of helping wealthier patients, as long as they paid for the costs of treatment and convalescence.

According to the general responses to the survey by the Marquis de la Ensenada, undertaken during the 1750s, there were already no more than four such centres offering aid and assistance. In Bembibre there was the Saint John Hospital, which took in sick pilgrims and travellers, having for this purpose an annual income of 242 reals [the "real" was a small silver coin, worth somewhat less than the contemporary English shilling]. There was a more modest institution at Columbianos, maintained with the cash that came from two ground rents (38 reals) and the income in kind from lands it owned (26.5 *cuartales* [about five bushels] of wheat). Larger establishments were to be found in Villafranca del Bierzo and Ponferrada, these having a hospital section. The Saint James Hospital in Villafranca had 10 beds to care for the sick and for pilgrims. It was maintained from an income of 3,000 reals derived from various estates and ground rents. Here, 10 *cuartos* a day were spent on the food ration for each sick person admitted [the *cuarto* was a copper coin, worth rather less than a contemporary English halfpenny]. Pilgrims, on the other hand, were given only a bed, fuel and salt. The Ponferrada establishment was stated to have a more modest income, 600 reals. Nonetheless, the expenditure on food was more generous, a whole real per patient per day. The respondents to the

2 On the true function of the Pilgrim's Way in the Middle Ages and Modern Period, see Ofelia Rey Castelao, O. (2006), *Los mitos del apóstol Santiago*, Vigo: Nigratea.

3 In early modern times this route lost in part its religious status, to become a route for beggars, as it became to some extent a "poor man's way", travelled by people who lived off the alms distributed by the hostels. See Carasa Soto, P. (1991), *Historia de la beneficencia en Castilla y León. Poder y pobreza en la sociedad castellana*, Valladolid: University of Valladolid, p. 31.

survey declared that this income was not sufficient to cover the costs arising. However, the income recorded for this hospital must have been either considerably understated or the outcome of some short-term cash flow difficulty. This impression is confirmed by looking at the outlays on food during the 1760s, which totalled 2,500 reals. In fact, one century earlier the hospital had had annual receipts of an amount similar to this.

Hostels and Hospitals in Ponferrada

Of the eight establishments that were active during the Middle Ages in the town of Ponferrada, only the one known as the Queen's Hospital was still operational in the eighteenth century. Alongside this welfare institution there was one other with very specific functions: the foundlings' home that cared for abandoned children.

The establishment run by the Pomboeza guild had disappeared because this religious brotherhood had been broken up in the sixteenth century. For the same reason, and at about the same time, the Saint Nicholas Hospital had ceased operations. It is unsure at what exact point the Old Saint Lazarus Hospital went out of existence, but there is a record of New Saint Lazarus being merged with the Queen's Hospital in 1661⁴. Before the end of the Middle Ages, this latter had also absorbed the Pedro Didaci Hospital. For its part, after a brief lifespan, the establishment that had been founded by the Lords of Priaranza as an annexe to the Convent of the Conception was closed down in the last quarter of the sixteenth century. Little can be said about Saint John's, founded in the thirteenth century, or Saint Martin's, which in the mid-sixteenth century was run by the hermits who were dedicated to the Saint in question⁵.

For its part, at the end of the 1820s, at the urging of the Bishop of Astorga, Don Leonardo Santander y Villavicencio, the Queen's Hospital had annexed to it the Ponferrada religious guilds of Our Lady of the Oak, Saint Joseph, Saint Barbara, the Angel, Saint Nicholas and Saint Crispin. The motive for this amalgamation must be seen, on the one hand, as influenced by the policy of limiting this type of religious association that had been adopted by the Crown and, on the other, as the result of the declining number of members and the shrinkage in their resources. Their income was necessary to maintain the Queen's Hospital, especially after the early nineteenth century. In 1805 the hospital lost a lawsuit against the Monastery of Carracedo concerning lands that constituted one of its main sources of revenue. From that moment onwards, its income was reduced to around 1,300 reals a year⁶.

4 A.H.M.P. (Ponferrada Municipal Historical Archive), Folder No. 27.

5 For more information, see Cavero Domínguez, G. (1987), *Peregrinos e indigentes en el Bierzo Medieval (siglos XI–XVI)*, pp. 71–78.

6 A.H.M.P. Folder No. 25, File 11.

During the Middle Ages in Spain, the term hospital was used to designate all establishments that had been set up with a clear charitable purpose of aiding the needy, whether or not they offered medical care. This usage continued into the Modern Period⁷. For example, Don Andrés Pérez de Capillas called the establishment he founded at Puente Villarente in 1537 a hospital, while in reality it was no more than a hostel for pilgrims and travellers. In the case of the Queen's Hospital, this hostel function was paralleled by medical and health assistance, besides another purpose fundamental in those days: spiritual aid, valued by the sick as highly as physical assistance⁸. Likewise, during the whole period the centre did not lose sight of the mediaeval ideal that considered aid to the poor as a way of gaining spiritual salvation for all those involved in hospital work. Indeed, the Bishops of Astorga, during all their visits to the institution of which records have survived, reminded the administrators that they should keep in mind that the poor represent the figure of Christ⁹.

The Queen's Hospital was founded by the Catholic Monarchs in 1498, or more accurately re-founded, since, although new installations were set up in the Parish of Saint Andrew, it appears that they arose from the merging of other centres of this kind. Hence, it fell within the framework of the policy put forward by the Monarchs, who were seeking to create a network of hospitals characterized by effi-

7 Although some humanist thinkers, like Luis Vives, reminded monarchs of the responsibility that the Civil Power had to take on when secularizing these centres, in practice they remained strongly linked to the Church, as had been the case in the mediaeval period. In any case, these projects of the humanists faded away during the seventeenth century. This change in attitude arose from the financial troubles affecting the State's revenues and the atmosphere of the Counter-Reformation, in which aid to the needy once again became a crucial part of the exercise of charity. Once again in the eighteenth century civil responsibility came to prevail over religious charity when it was a question of offering assistance to those in need. Despite the disagreements arising in the eighteenth century between conservatives, who preferred traditional charity, and innovators, and in spite of the efforts of Charles III to secularize welfare, neither at this period nor in those immediately following were there any major advances in this direction. See García Guerra, D. (1983), *El hospital Real de Santiago (1499–1804)*, Corunna: Barrie de la Maza Foundation, pp. 48–49 and 138; Callahan, W. (1978), "Caridad, sociedad y economía en el siglo XVIII", *Moneda y Crédito*, 146, pp. 65–77; Schubert, A. (1984), "Nuevos enfoques sobre la beneficencia en España en el siglo XIX", *Studia Zamorensia*, 19, pp. 325–336. Carasa Soto, P. (1991), *Historia de la beneficencia en Castilla y León*, pp. 9–16.

8 Religious consolation at this time was valued as much as medical treatments, which were often subordinate to it. See Henderson, J. (2001) "Healing the Body and Saving the Soul: Hospitals in Renaissance Florence. Renaissance Studies", *Journal of the Society for Renaissance Studies*, 15 (2), pp. 188–216. Valenzuela Candelario, J. (2002), "Hospitales y Beneficencia. Historias de hospitales". *Revista de Trabajo Social y Salud*, 43, pp.39–66.

9 Even in establishments that were not dependent on the Church, bishops had the right to carry out inspection visits. See Carmona García, J.I. (1979), *El sistema de la hospitalidad pública en la Sevilla del Antiguo Régimen*, Seville: Seville Provincial Council, p. 19.

ciency and not by a plethora of small and poorly endowed centres¹⁰. From its earliest moments, it was managed by the Town Council, although it seems that there may also have been a guild linked to the centre¹¹. Such a group is mentioned in the document by which the Monarchs Isabella and Ferdinand conceded *a juro* [a perpetual annuity from the public purse] to the hospital. However, there was no longer any mention of it in the regulations drawn up at the end of the eighteenth century. Be that as it may, the most significant fact is that the Queen's Hospital was the only charitable centre of any size operating in the Province of Leon that was not directly managed by the Church¹².

The work of the hospital was not limited to medical and health care for patients admitted to it. It also gave alms to the poor, generally in the form of a dole of food, provided beds for pilgrims and travellers, and carried out transfers. These involved transporting by horse to the next stage in their journey those patients who had now recovered, or who showed signs of being on the mend, sometimes giving them in addition a small sum of money so that they could buy food for themselves for the next few days¹³. The number of charitable actions of this kind was not very large, since the years for which data are available show a variation between 4 in 1661 and 15 in the previous year. Alongside these more normal sorts of aid, the hospital could also offer extraordinary assistance, as in the instance arising in 1686 when the centre paid for a wet-nurse for a baby girl abandoned there¹⁴.

Very little information is available about the building that housed the Queen's Hospital. It is known only that it had at least two wards for the sick, one for each sex, with various other sections, among them a kitchen, a chapel and rooms for the

10 This process of unification of hospitals initiated by the Catholic Monarchs was continued by the Hapsburg kings who followed them on the throne of Spain. The consequences are seen not only in the Province of Leon, but from the dawn of the Modern Period can be noted throughout Spain. For example, for Pamplona, see Ramos Martínez, J. (1989), *La salud pública y el Hospital General de la ciudad de Pamplona en el Antiguo Régimen* (1700 a 1815), Pamplona: Regional Government of Navarre, p. 191.

11 The Monarchs ordered the council, magistrates, councillors, officials and good citizens of the town of Ponferrada, and the guild members who were or might be associated with the said hospital to take care to visit and inspect the hospital. "El hospital de Nuestra señora de Santa María de la Villa de Ponferrada", *Estudios Bercianos*, 13, 1990, p. 44.

12 On the network of hostels and hospitals in the Province of Leon, see Martín García, A. and Pérez Álvarez, M. J., (2007), "Hospitalidad y asistencia en la provincia de León a finales del Antiguo Régimen (1728–1896)", *Dynamis*, 27, pp. 157–185.

13 An entry records an outlay of 3 reals to discharge a poor man from the hospital, plus two day's food for the journey, in total 4.5 reals. A.H.M.P.

14 Thus, it was fulfilling the mission that had been entrusted to it by the Catholic Monarchs when they assigned to it an income drawn from the land called "Cabañas de Fabero", so that the poor pilgrims who passed through the town would have a place to stay and a bed to sleep in and so that food might be purchased for any patients who might be admitted to the hospital. "El hospital de Nuestra señora de Santa María de la Villa de Ponferrada", *Estudios Bercianos*, 13, 1990, p. 43.

staff. It also had an entrance hall, access to which was through a door in a stone façade on which a religious image was set. Immediately next to the building there was a cemetery, reserved exclusively for the centre, and inaugurated in 1564¹⁵.

At the end of the eighteenth century, the building underwent some renovation work, which continued in the following century. Specifically, in 1798 a cistern was constructed underneath the room of the senior nursing officer, being intended to hold collected rainwater. Such a tank was very necessary for hygiene in the hospital, as the centre was a long way from the river and it had proved impossible to dig a well. However, this repair work does not seem to have been all that was needed, since in the minute book for 1799 it was noted that the women's ward was close to collapse and that the kitchen was poorly ventilated. To right these problems, the authorities controlling the centre decided to commission a renovation project from a builder. Although the work could have been paid for from the hospital's existing funds, they agreed to nominate a person to go and seek contributions from the surrounding villages. The argument they put forward for this decision was that the inhabitants of all these places would be those who benefited most from the aid provided by the centre.

Despite these projects, deficiencies continued over the next few years. In 1801 sources record the problems relating to the women's ward, because of its limited capacity, inappropriate orientation and the unpleasant odours that were noticeable in it, leading to more than a few infections. This unacceptable situation led the board of the centre to hasten a petition for permission to build, sent to the Council of Castile. Once again, these projects came to nothing, with the defects already pointed out remaining unremedied. In any case, it is not strange that these plans for restoration work could not be put into effect, if it is taken into account that the crisis of the beginning of the eighteenth century more or less ran on into the Peninsular War. In fact, between 1808 and 1816, the establishment stayed closed because of the damage that had been done to it by the occupying French troops.

Governance and Internal Organization of the Hospital.

As has already been noted, the Queen's Hospital was managed by the Town Council. During the seventeenth century and most of the eighteenth, it exercised its direction through one or two councillors. The financial side of management fell to the steward or administrator, to whom all the other workers at the hospital reported. The hospital had a fairly small staff to attend to the sick¹⁶: physician¹⁷,

15 González García, M. "Notas para la historia de Ponferrada", *Bierzo*, 1977, pp. 98–104, pp. 98–99.

16 The composition of the hospital's staff is very similar to what was in place in the hospital at Loja, even though this had a larger capacity for patients, specifically 24 beds. See

blood-letter (later replaced by a surgeon), chaplain and “attendant”. This latter post, as has been observed elsewhere in the Province, seems in fact to have been held by a married couple, even though the accounts record only a single salary, as for instance in the contract drawn up in 1655¹⁸. This couple shared the domestic, maintenance and basic nursing tasks in accordance with their sex. This simple organizational arrangement became considerably more complex at the end of the eighteenth century¹⁹. From this point onwards, after the establishment of new regulations, it is possible not merely to know the composition of the board of management of the hospital, but even the specific tasks entrusted to each of the members composing it.

The new rules set down that the Queen’s Hospital was to be managed by a board made up of nine members, who gave their services free. This group comprised the *Corregidor* [Royal Alderman, an official appointed by the Crown to preside over the town council] of the town, who held the chair, and another eight lay and ecclesiastical members who had the right to speak and vote: the longest-serving town councillor, the priests of the Parishes of Our Lady of the Oak and of Saint Andrew, the hospital chaplain, the *contador principal* [head finance officer], the *procurador síndico general* [town ombudsman] and a gentleman of the town who was to be somebody well known for his virtue and charity towards the poor. The term of office is not specified in the regulations, and so would appear to have depended on the civil or ecclesiastical post held outside the hospital. The frequency of meetings was set down in the rules, however. Once a month there was to be an ordinary meeting, while extraordinary meetings were to be called whenever any member requested one. Both were to be held at the Town Hall. This board of management was to be responsible for taking all decisions affecting the centre. It was only when problems arose which needed an immediate solution that the chair-holder had the power to act alone.

Once the board had been constituted, holders were nominated for thirteen posts. Of these, five (the secretary and four commissioners) were chosen from among the

Coronas Tejada, L. (1990), *El hospital Real de Nuestra Señora de la Misericordia de Loja*, Granada: University of Granada, pp. 46 et seqq.

17 The fact that in one way or another medical cover was provided for all social classes implied a certain socialization of medicine. It should be remembered that only the wealthiest could afford to have private treatment from a university-qualified practitioner. See García Guerra, D. (1983), *El hospital Real de Santiago...* p. 58–59, and (1978), “La asistencia hospitalaria en la España Moderna: el Hospital Real de Santiago”, *Estudios de Historia Social*, 7, pp. 289–327.

18 González García, M. “Notas para la historia de Ponferrada, p. 99.

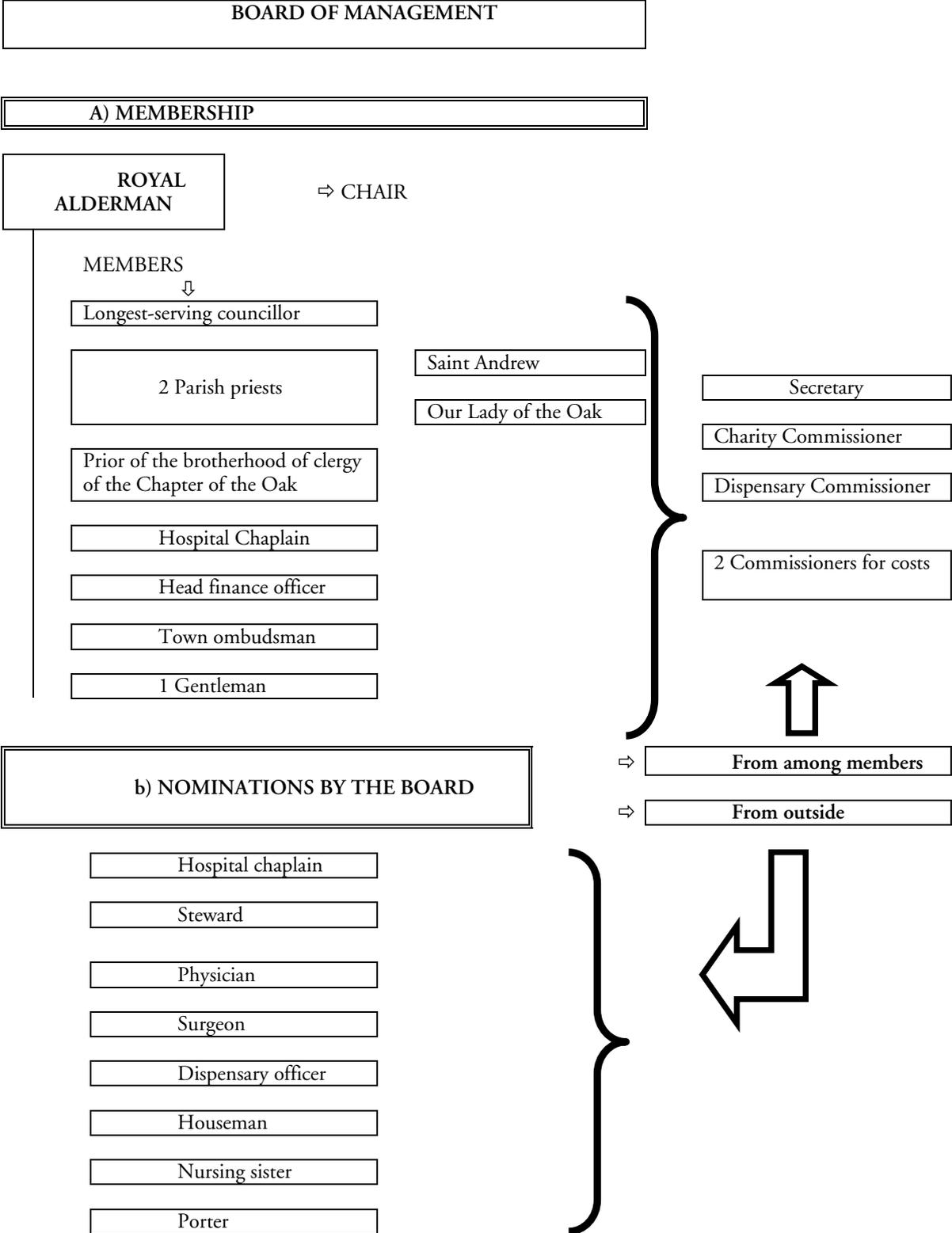
19 The process of drawing up the new regulations was approved in 1788, but had begun in the previous year. They were produced by Don Jerónimo Francisco de Acevedo, who used as a model a set that had been provided by the Council of Castile, with the intention that the deplorable state and poor administration of income of the centre in Ponferrada should be remedied. A.H.M.P. Folder 26, Vol. 3.

board members. Two of these commissioners were charged with the management of the pasture land belonging to the centre, one oversaw the dispensary and the fourth was responsible for charity. The remaining eight positions were more directly related to the hospital: chaplain, steward, physician, surgeon, dispensary officer, the *praticante* [roughly equivalent to a houseman or senior nursing officer, being a man with basic medical and surgical training], nursing sister and porter. The 1788 regulations in fact implied an increase in the hospital's staff with respect to the previous situation. Up till then, attention to the physical needs of patients had been provided by a much smaller staff, composed of two practitioners (physician and surgeon) and an attendant, while the chaplain had taken care of spiritual needs. Above this small group was the steward, responsible for managing the centre's property.

The secretary had to keep the hospital's minute book up to date, issue, with the chair-holder's approval, the orders for payment of salaries and bills for supplies and give notice of meetings. For their part, the commissioners for charity and for the dispensary acted as supervisors. The dispensary officer had to report to the second of these, who was responsible for inspecting the dispensary so as to ensure that it was supplied with all the preparations necessary to cover the needs of the hospital and meet demands from outpatients. At the moment when the new rules were drawn up, it would appear that the dispensary had been much neglected, so that great stress was laid on the necessity for it to be restored in order for it to regain its former good reputation throughout the Province. The dispensary officer could be aided by an assistant who was to be trained so as to cover for any absence of the officer himself. The commissioner for charity was to keep an eye on the conduct of those employees directly linked to hospital assistance. He was required for this purpose to visit the centre three times a week, so as to ensure for himself that the patients were being properly looked after.

The chaplain was responsible as much for physical assistance to patients, in collaboration with other employees, as for their spiritual care. Hence, this post was considered to have the greatest and most continuous workload. Among the work assigned were the tasks of visiting the patients frequently, consoling them, administering the sacraments to them, helping them to die well if their ailment took a fatal turn, and of burying the dead in the graveyard. Moreover, the chaplain was required to celebrate mass on days of obligation and holidays. The important part played by this employee in the establishment is reflected in the prominence of his post in the regulations. These stipulate that he should not be permitted to leave the town for more than a week at a time. Similarly, to ensure that the post was filled, the Bishop of Astorga was requested to allot it a Church income of 2,200 reals, which implied a doubling of the pay hitherto received. Such an interest in laying down the pay and obligations of the chaplain is all the more significant when the

Figure 1. Governance and Internal Organization of the Hospital.



For their part, the two “commissioners for costs” had the obligation of ensuring that the maximum financial benefit was obtained from the pasture land owned by the hospital.

same is not done for the physician. That is to say, even in the Age of Enlightenment it would appear that spiritual interests of mediaeval origin predominated over

medical and health services. This state of affairs is even more striking if it is kept in mind how closely the establishment was linked with the civil authorities.

The regulations allotted the porter a very minor role. Initially, he was required merely to let members know when meetings were being held, to light the brazier warming the room where they were to take place, and stay at the door while the discussions lasted. As time went by, the post was assigned more tasks, and the number of such workers was even increased to two. In 1801, when the centre was overwhelmed with requests for help because of the difficult circumstances the country was going through in that decade, one porter was given the specific job of providing food to travellers, while preventing them from taking refuge in the hospital.

Finally, one crucial position was that of steward. It was not for nothing that the responsibilities that this person took on were recompensed with the largest salary among the lay staff: 2,200 reals per year. This was considerably higher than the physician (550) or the surgeon (300)²⁰. The steward managed all the hospital's financial resources, under the direct supervision of the head finance officer. He was also charged with implementing all the decisions taken by the board of management in this area. The post was involved with the most varied matters, from representing the centre in lawsuits, defending the hospital's interests, to checking on what kind of firewood was being used, from purchasing food for the larder to selling the clothes of inmates who died. The fact that all the finances of the hospital were in his hands was the reason that the regulations stipulated clearly a monetary guarantee that would avoid possible fraud and aid in selecting in all cases an individual with ample financial resources. Thus, those aspiring to this post were required to deposit caution money of 1,000 ducats [equivalent to some five times the yearly pay or more].

Although the norms approved in 1788 appeared to regulate adequately the internal organization of the hospital, it was not long at all before they began to be disobeyed. Just a few years after the new regulations came into force, the minute book began to be kept, and this has scattered throughout it notes referring to failures to obey the rules. For example, the physicians and surgeons kept patients in the hospital longer than necessary; the priest was not fulfilling his temporal and spiritual obligations; or the dispensary officer was not attending to the store of drugs in a professional way. The reaction of the board to such irregularities was quite prompt, except in the case of the priest, since he was under the jurisdiction of the bishop, who was the only person who had the capacity to dismiss him.

Hospital treatment was available only to the clearly destitute who did not have chronic diseases, as the long process of medical attention such cases required would

²⁰ Nonetheless, this information should be nuanced, as the practitioners were the same men as were appointed to similar posts for the town. This means they were not full-time.

restrict the number of other patients who could be handled²¹. On this point, in 1791 the board agreed that if this rule was broken, besides expelling such patients, it would require the outlays involved by their convalescence to be borne by the physician and surgeon²². If these prior requisites were met, the centre's practitioners (the physician and surgeon) were responsible for deciding if patients should be admitted. If they felt they should be, they submitted a report to the board for approval so that the sick person could be brought into the hospital. Once this had happened, a full operating procedure was brought into play, in which all the hospital's employees were direct participants, all with their own specific competences. The first thing to be done by patients was to hand over their clothing to the chaplain, who would take care of it while they remained in the hospital. If any patients died, their clothes were given to the steward, who with the board's agreement would use them as seemed most appropriate or sell them²³.

The sick were visited twice a day by the physician and surgeon, accompanied by the chaplain, the nursing sister and the houseman. These last two had the mission of correctly applying all the prescriptions of the doctors with regard to diet and medicine. The nursing sister did so in the women's ward, while the houseman looked after the men's ward, both of them providing a continuous presence. They also had to take care of the daily chores in the hospital, such as keeping the wards and equipment clean, or ensuring that the food for patients was properly prepared and in good condition. In addition, the nursing sister had charge of the kitchen and of the laundry service, for which she could call on the help of another person. For his part, the houseman was responsible for the care of all the hospital's equipment, whether it was bedding, furniture or other items, which were issued to him against an inventory. He was also expected to have some knowledge of surgery so as to be able to offer initial treatments in the case of any emergency. So as to ensure that these staff were completely dedicated to caring for the patients, they were required to live in the hospital, where they were given a daily food ration identical to that served to the patients.

21 This sort of limitation on the admission of patients was also to be found in other hospitals, for example at Saint James of Compostella. See García Guerra, D. (1983), *El hospital Real de Santiago...* p.52.

22 In April 1799, after the monthly visit carried out by the commissioner, he informed the board that there were in the hospital two sick people whose ailments had become chronic. In consequence, it was agreed that the commissioner should seek the best way of getting rid of them, even at some cost to the centre, although in such a way that this discharge would be consistent with the patients' right to charity and brotherly treatment. A.H.M.P., Folder 26.

23 This was a common practice in establishments of this kind. In this instance it is not known what weight this sort of income had in the revenues of the centre as a whole. See González Díaz, A. M. (1997), *Poder urbano y asistencia social: el hospital de San Hermenegildo de Sevilla (1453–1837)*, Seville: Seville Provincial Council, p. 212.

The chaplain's participation in visits was motivated by his double task of being an intermediary between the nursing personnel and the doctors and of supervising the well-being of the patients. He was supposed to guarantee that the people most directly involved in their treatment were scrupulous in fulfilling their duties.

Treatment for the poor was free. Nevertheless, if any of them had some property and died in the hospital, the steward was responsible for taking the necessary steps to offset the costs that such patients had made necessary during their sickness against the value of the property in question²⁴.

The Financial Support for the Hospital

The Queen's Hospital was a small centre with a modest endowment, and this naturally had an influence over its beneficent actions, limiting the amount of assistance it could offer. During the second half of the seventeenth century there were few years in which its income reached as much as 3,000 reals (Table 1). This precarious state of affairs was not just a result of the harsh negative climate of that century, but was also due to the sparse resources with which the centre had been endowed.

At the end of the sixteenth century its revenue came fundamentally from two sources: a perpetual annuity and the donations made weekly by the richer and chief citizens of the town. In 1661, the Town Council of Ponferrada, conscious of the limitations and difficulties faced by the Queen's Hospital in treating the sick, added to this the income of the inactive Hospital of Saint Lazarus²⁵. This new endowment had the effect of increasing revenue by some 12% to 13%, as can be seen from a breakdown of the accounts for the period 1662 to 1664. To this small financial boost donations and charitable offerings were gradually added, as was the interest derived from loans made. In this way, little by little a small financial holding was built up that allowed the hospital to cover its needs.

24 Such practices led Ramos Martínez to feel that the deaths of patients were more profitable for the hospital than their restoration to health. Ramos Martínez, J. (1989), *La salud pública y el Hospital General*, p. 234.

25 The magistrates and councillors of Ponferrada, as patrons of the Hospital of Saint Lazarus in this town, recognizing the restricted income of the Queen's Hospital of Ponferrada, which led to a lack of aid for the poor who came to it, and recognizing that there were no longer any patients at the Hospital of Saint Lazarus, added the revenues of this latter hospital to those of the infirmary of this town. A.H.M.P., Folder 26.

Table 1. Income and Expenditure of Queen’s Hospital (1662–1721).

| Year | Income in reals | Average Yearly Income | Expenditure | Out-turn |
|--------------|-----------------|-----------------------|-------------|----------|
| 1662 | 2,054.4 | 2,054.4 | 1,578.6 | 475.8 |
| 1663 | 2,054.4 | 2,054.4 | 2,447.7 | -393.3 |
| 1664 | 2,062.0 | 2,062.0 | 2,220.3 | -158.3 |
| 1676 to 1679 | 10,843.5 | 2,710.9 | 10,906.0 | -62.5 |
| 1687 to 1689 | 9,569.0 | 3,189.7 | 9,016.0 | 553.0 |
| 1693 to 1698 | 17,253.0 | 2,875.5 | 16,724.0 | 529.0 |
| 1699 | 3,401.0 | 3,401.0 | 2,874.0 | 527.0 |
| 1700 | 2,271.0 | 2,271.0 | 2,159.0 | 112.0 |
| 1701 | 2,341.0 | 2,341.0 | 1,970.0 | 371.0 |
| 1702 | 2,935.0 | 2,935.0 | 2,461.0 | 474.0 |
| 1721 | 1,667.0 | 1,667.0 | 1,524.0 | 143.0 |

Source: Account ledgers

The way in which the Queen’s Hospital’s accounts were kept, sometimes in a very summary form and sometimes grouped by the period in office of a steward, it is hard to undertake any detailed survey of the sources of income. Nonetheless, consideration of a small sample for which a year-on-year breakdown was carried out with some precision makes it possible to get a feel for where revenues were drawn from by the centre (Table 2). Of these, those derived from investment in *censos* [a form of ground rent or interest on a real estate loan] were the most prominent. Thereafter came the income from rural properties, with in third place the revenue from the *juro* or perpetual annuity, at this time paid out of the *alcabalas*²⁶ of the town of Ponferrada and its surrounding district, which had been a donation from Isabella the Catholic Monarch in 1499, drawn from the property known as the preserved lands of Cabañas de Fabero²⁷.

In the second category, that is, revenue coming from rural properties, one striking item is the forty *fanegas*²⁸ of grain [around sixty bushels] paid to the hospital by the nearby Monastery of Carracedo. The contribution in question represented between 50% and 60% of the total amount received under this heading²⁹. The extensive property of the Cabañas de Fabero led the hospital into a long lawsuit, lasting more than three centuries, against this monastery. The final judgement,

26 These *alcabalas* were a form of purchase or consumption tax.

27 This perpetual annuity was initially intended to be charged to the pastures and haymeadows of the preserved lands of Cabañas de Fabero. However, by 1566 it was already being drawn from the rates of the town of Ponferrada, and throughout the seventeenth and early eighteenth century it was derived from the *alcabalas* of the town and its district. A.H.M.P. Folder 27.

28 The *fanega* was a measure of capacity used at this time, and it amounted to between 40 and 45 kilograms of grain.

29 The payment of this amount of grain was subject to an agreement concluded in 1569 between the Monastery of Carracedo and the Hospital. See Balboa, J. A. “El hospital de la Reina de Ponferrada”, *Bierzo*, 1977, pp.45–55, p. 49.

delivered in the first few years of the nineteenth century, went against the hospital³⁰. With respect to charitable donations or alms, it was only in 1702 that they were of any significance in percentage terms. This was when the substantial sum of 440 *reals* was received, coming from a legacy bequeathed by Doña Antonia Gamarra, a resident of Ponferrada. Similar bequests were made at other times, but involved much more modest amounts that seldom made any impact on the total income received.

Table 2. Breakdown of the Income of the Queen's Hospital in Reals.

| | Ground Rents | Dividends & Interest | Annuity | Charitable Donations | Total |
|------|--------------|----------------------|---------|----------------------|-------|
| 1676 | 1.418 | 955 | 206 | 30 | 2.609 |
| % | 54.4 | 36.6 | 7.9 | 1.1 | 100 |
| 1686 | 1.092 | 563 | 206 | - | 1.861 |
| % | 58.7 | 30.3 | 11.1 | - | 100 |
| 1702 | 1.261 | 1028 | 206 | 440 | 2.935 |
| % | 43.0 | 35.0 | 7.0 | 15.0 | 100 |
| 1721 | 792 | 785 | 90 | - | 1.667 |
| % | 47.5 | 47.1 | 5.4 | - | 100 |

Source: Account Ledgers.

Some knowledge of the main financial blunders made by the administrators and health personnel can be gleaned from the information derived from inspection visits that is included in the account books. Details of one such visit are available for the sixteenth century, relating to 1566, and of two in the seventeenth century, one inspection being held in 1682 and another in 1687. While the first was carried out by the town's *Corregidor* or Royal Alderman, for the remaining two it was the chief religious authority in the diocese, the Bishop of Astorga, who made the inspection. This change in the activity of supervision of the hospital to ecclesiastical overseers, in place of civil, is clearly related to the provisions of the Council of Trent, which granted bishops the right of visitation for all such centres³¹.

In 1682, no reference of any sort was made to financial matters, which leads to the assumption that the stewards had been fulfilling their duties meticulously. The same was not true of 1687, when the bishop criticized those responsible for finances

30 On 7 May 1805 the minute book recorded the loss of this suit, stating that the sentence would bring extreme ruin to the town and its surroundings, as troops that were continually moving between Castile and Galicia, pilgrims going to Saint James of Compostella and Galicians travelling to work on the harvest all relied on the aid of this hospital to treat their ailments. It also noted that the private gentleman Don Antonio Rueda (a member of the board) moved by charity and zeal, volunteered to go to the capital at his own expense to beg the King to overthrow the verdict, or, if this were not feasible, to assign to the hospital income from funds intended for pious works or hospitals, of which there were many unused in the villages and religious guilds of the Province. A.H.M.P., Folder 26.

31 See González Dáz, A. M. (1997), *Poder urbano y asistencia social: el hospital de San Hermenegildo de Sevilla* (1453–1837), Seville: Seville Provincial Council, p. 61.

for not keeping proper accounts over the previous few years. In consequence, they were given a month in which to sort out this unacceptable situation, failing which they would be excommunicated. Poor management would seem to have been a frequent problem in the centre. However, it was in the 1560s and at the end of the eighteenth century that it reached its greatest proportions.

On 13 January 1566 the *Corregidor* of Ponferrada, Master Fernando de Robles, recorded that the centre's limited funds were being eaten away because of the poor administration of resources. Don Fernando noted that the amount of 7,000 *maravedis* [when initially awarded, equivalent to some 2,300 *reals*] with which the centre had been endowed by Queen Isabella for the use and profit of the hospital and the poor admitted to it, and which constituted the principal source of income at that time, was not being collected. Similarly, the negligence of the stewards had led to the loss of some properties of the hospital and the income from a legacy bequeathed by one Francisco Arias, a resident in the town. Furthermore, the necessary care was not being given to the noting down of the donations made each week by the richer individuals in the town, which led to a fear that this custom might be discontinued. Such unforgivable negligence not only had a negative effect on the hospital's finances; it also had a clear impact on the treatment available for the sick poor. To put an end to this calamitous situation, orders were given during the visit that henceforward an inventory should be kept of all property and goods and caution money required from the stewards to guarantee against losses through bad management. Somewhat more than two centuries after these incidents, in 1787, a similar situation arose, since one of the chief reasons justifying the need to draw up new regulations was the deplorable state and poor administration of the revenues of the hospital.

With regard to the distribution of costs for the hospital, similar information is available to that already noted for income. From this, it becomes evident that the two largest expenditures were those on food for patients³² and on pay for staff. Together, these accounted for somewhat more than 50% of all outlays and in 1662, 1663 and 1664 represented more than 75% of costs (Table 3). The percentage spent on food was very variable, being dependent on the number of people treated. Thus, for instance, during the last quarter of 1677 the hospital had no admissions. In contrast, with regard to pay a certain stability is observable, since between 1676 and 1702 variations in it were minimal.

32 The high percentage of outlays represented by food for patients would appear to be common in other centres, too. See García Hourcade, J. J. (1996), *Beneficencia y sanidad en el S. XVIII. El hospital de San Juan de Dios de Murcia, Murcia: University of Murcia*, p. 117.

Table 3. Expenditure of the Queen's Hospital (1662–1721).

| Year | Outgoings | Food | Pay | % Food | % Pay | Total % Food plus Pay |
|--------------------|-----------|---------|-------|--------|-------|-----------------------|
| 1662 | 1,578.6 | 800.7 | 610 | 50.7 | 38.6 | 89.4 |
| 1663 | 2,447.7 | 1,398.8 | 596 | 57.1 | 24.3 | 81.5 |
| 1664 | 2,220.3 | 1,166.1 | 596 | 52.5 | 26.8 | 79.4 |
| 1676–1679 | 10,906.0 | 2,836.0 | 2,780 | 26.0 | 25.5 | 51.5 |
| 1687–1689 | 9,016.0 | 2,831.0 | 2,145 | 31.4 | 23.8 | 55.2 |
| 1693–698 | 16,724.0 | 4,935.0 | 4,302 | 29.5 | 25.7 | 55.2 |
| 1699 ³³ | 2,874.0 | 1,566.0 | - | 54.5 | - | - |
| 1700 | 2,159.0 | 1,027.0 | - | 47.6 | - | - |
| 1701 | 1,970.0 | 638.0 | - | 32.4 | - | - |
| 1702 | 2,461.0 | 697.0 | 750 | 28.3 | 30.5 | 58.8 |
| 1721 | 1,667.0 | 317.0 | 739 | 19.0 | 44.3 | 63.3 |

Source: Account Ledgers.

The remaining headings under which money was spent are highly varied: firewood, soap, candles, medicines, transferring patients, religious celebrations, equipment for the hospital, repairs, and the like. It was precisely these last two, the replacement of furniture, linens and other items to accommodate the sick and repairs to the hospital and the chapel of Saint Lazarus, that became more prominent in the last quarter of the seventeenth century and in 1702. So, for instance, between 1687 and 1689 what are termed new works in the hospital were undertaken. They must have consisted fundamentally of renovations to the wards, the reinforcement of a wall and repairs to the entrance, involving an outlay of 2,044.7 reals. At this same time purchases were made, to the value of 263.7 reals, of blankets, sheets and bedspreads. A few years later, in 1697, work was carried out on the façade of the hospital. Then again, in 1702, repairs were effected to the roof of Saint Lazarus, at a cost of 340 reals, while a further 198 went on replacing bed linen. All this was possible thanks to the slight increase in revenue.

With respect to the buying of medicines, another of the main expenditures, it is only in a very few years that this is distinguished from general costs. However, data referring to a series of years permit it to be calculated that such purchases must have amounted to between 2% and 3.5% of annual outlays³⁴. It is unknown what kind of drugs were in use, since entries are very general, normally appearing in the books as simply payments for medicine for the dispensary.

³³ In 1699, 1700 and 1701, the entries for expenditures are divided into just two: food and other.

³⁴ The calculations refer to 1687, 1688 and from 1693 to 1698.

Buildings and Food

As has already been pointed out, the Ponferrada hospital was a modest establishment, this being reflected in its installations. At the end of the seventeenth century, it had just eight beds for the sick poor of both sexes. It was only in the case of particular urgency, such as an epidemic of some contagious disease or a natural catastrophe, that the board of management might agree to an expansion in the hospital's capacity for patients. In any case, such an increase was always limited, generally amounting to no more than a couple of extra beds³⁵.

This situation of penury noted at the end of the eighteenth century was inherited from previous periods, despite the efforts made throughout that time to improve installations. According to the 1566 inventory³⁶, the furnishings of the centre comprised a bench, a chair, a large chest, two trestles, an iron lamp and eleven wooden beds. In the kitchen there was a large pot or cauldron and a fire crane³⁷. With regard to bed linen, there were fourteen sheets, four mattresses, two pillows (one old, one new) and twenty-four blankets made of frieze. This, plus one hoe, constituted all the equipment the centre had. Three years later, bar slight changes in the number of sheets and blankets, everything was the same.

At the end of the 1670s, thanks to the modest funds which had gradually been built up, and the merger with the Hospital of Saint Lazarus, the installations were somewhat better equipped. The largest purchase of material took place between 1676 and 1678. At that time the centre owned two chests, three benches, a writing desk and ten wooden beds (five of them new), besides a modest amount of kitchenware. The supply of linen had also been considerably expanded, and two pictures with religious motifs had even been hung on the walls, one showing the Apostle Saint James, the other an *Ecce Homo*. These improvements did not last long. In fact, ten years later, in 1687, the Bishop of Astorga during a visitation put on record the parlous state in which the bed linen was, this causing the sick poor to be untidy and unprotected against the cold. For this reason he ordered these problems to be solved by the purchase of new items.

Inspection visitors were quite strict (if the mentality of the period is taken into account) in respect of everything relating to the cleanliness of the installations and the way the sick were treated. There are repeated recommendations in respect of

35 In November 1803 the minute book recorded a decision that not more than eight patients should be in the hospital at any one time, unless it was a grave emergency, such as had occurred in previous months as a consequence of the large number of tertian and quartan agues that had been suffered by the inhabitants of the town and its district. In a situation of that kind, it was agreed that the number of beds could be raised to ten, this measure being communicated to the physician and surgeon by the secretary to the board of management. A.H.M.P., Folder 26.

36 The inventories are included in the account books. A.H.M.P. *Libros de cuentas del Hospital de la Reina* [Accounts of the Queen's Hospital].

37 A fire crane is a device used to hang a pot over a fire.

keeping the patients, the bedding and the wards clean. The documents also put some stress on recalling that a destitute person represents Christ. For this reason, the staff were to be kind to the patients. Beside this humane treatment, it was absolutely necessary to respect the timetable for meals and for medication, as also, in the case of the practitioners, to make the appropriate visits to examine the patients.

A major feature of hospitals like the Queen's, dealing primarily with the indigent, was the food provided for the sick, since for many of them it represented a therapeutic item of considerable importance for their recovery. It should not be forgotten that quite often the ailment itself was not the trigger for the parlous physical state of patients. It was rather the case that other factors, such as hunger or exhaustion from travelling, that led to their admittance.

The data found in the sources with regard to patients' diets are mostly concentrated in the last few years of the eighteenth century. Even so, there are some very interesting references relating to earlier centuries. It is known that in the late seventeenth and early eighteenth centuries the hospital kitchen prepared a "poor man's stew", a dish composed primarily of chickpeas and belly pork, flavoured with a little saffron and other spices. The greater part of these basic products was purchased by the institution at the start of the year. Thus, during the 1690s, it was usually in January that the administrators bought a small quantity of belly pork, likely to have been salted, weighing between nine and twelve kilograms, together with a similar quantity of chickpeas. The remaining products were replaced as and when they ran out.

Besides basic foodstuffs, the institution's books from the late seventeenth and early eighteenth centuries also mention the purchase of mutton, honey, sugar, eggs, milk, cake, bread, wine and spirits. Apart from the first of these, such purchases were mostly occasional³⁸ and in response to very specific needs. All the same, with regard to bread and wine, the fact that no large amounts were spent on buying them was a consequence of the fact that it was more or less self-sufficient, thanks to the income in kind that it enjoyed.

By the middle of the eighteenth century, the documentation is rather more detailed with respect to the diet fed to the sick. Between 1765 and 1769 it is known that the daily ration provided to patients included about 400 grams of bread, accompanied by beef or mutton, and wine. Alongside these foodstuffs, the consumption of eggs became more general. At this period, patients consumed an egg

38 For instance, in the case of honey, just a half litre was bought in 1694, in the month of December, and in 1699 a single litre was purchased. In March 1696 the outlay on cake, sugar, eggs and spices amounted to only 5 reals.

every two or three days. The purchase of cake, sugar and chocolate³⁹ became more usual, although it must be surmised that, as in other establishments, these products were intended for special diets.

There is more detail in the monthly summaries of the food consumed in the year 1800. The daily allowances for the sick (which would appear to have included the “poor man’s stew”) consisted of approximately 362 grams of meat, 453 of bread, 45 of belly pork, 68 grams of chickpeas and 0.8 of a gram of lard, topped off with a daily quarter-litre of wine. This basic allocation was complemented with the products already noted in the documentation from the previous century (cake, chocolate, chestnuts, milk or sugar⁴⁰) or with other new foods, such as rice. In contrast, the consumption of eggs, frequent in earlier years, became only occasional⁴¹. In this list, fish is missing, this being an essential food in Lent and on fast days, which is mentioned in the documentation from other hospital foundations in Leon. This surprising absence may perhaps be due to its being acquired in other ways than by direct purchase, such as gifts, exchanges and the like.

The months when the largest numbers of purchases were made were towards the end of the year. This strategy was logical, since by following such a policy the administrators were trying, on the one hand, to stock up the foodstuffs necessary to be in a position to face with some confidence the harsh winter season, and, on the

39 At this period, chocolate should not be seen so much as a foodstuff, but rather as a medicinal product. See Coronas Tejada, L. (1990), *El hospital Real de Nuestra Señora de la Misericordia*, p. 85.

40 It can be shown, on the basis of products purchased, that the diet provided for patients in the Ponferrada hospital was very similar to what was given to those at Loja and Pamplona. See Coronas Tejada, L. (1990), *El hospital Real de Nuestra Señora de la Misericordia*,... pp. 83–87. Ramos Martínez, J. (1989), *La salud pública y el Hospital General*,... pp. 324 et seqq. The commentaries by Eiras Roel and Enríquez Morales upon the feeding of the sick in the Royal Hospital at Saint James of Compostella are of considerable interest. See EIRAS ROEL, A. and Enríquez Morales, M. I. (1975), “El consumo alimentario en los Colegios Mayores de la Universidad de Santiago y otras colectividades del Antiguo Régimen”, *Liceo Franciscano*, 82–84, pp. 243–261.

41 So, for example, in May 1796 or June 1800, just two eggs were purchased. In the first instance the administrators specified that they were for use in gargling, in the second that they were for a patient with a digestive ailment. The fact that eggs virtually disappeared from the hospital diet was a reflection of the crisis that the Province of Leon went through from the end of the eighteenth century onwards. This, logically, affected the institution, whose income declined because its tenants could not pay their rents. In the minute book entry for 26 July 1800, it is noted that because of the failure of the crop the tenants are not in a position to pay what is due. A.H.M.P. Folder 26. With respect to what eggs represented in economic fluctuations, see Braudel, F. (1984), *Civilización material, economía y capitalismo (s. XV–XVIII)*, Madrid: Alianza. Vol. 1, p. 174. With regard to the impact of economic conditions on beneficent actions, see Carasa Soto, P. (1987), *Pauperismo y revolución liberal en Burgos (1750–1900)*, Valladolid: University of Valladolid, p. 378.

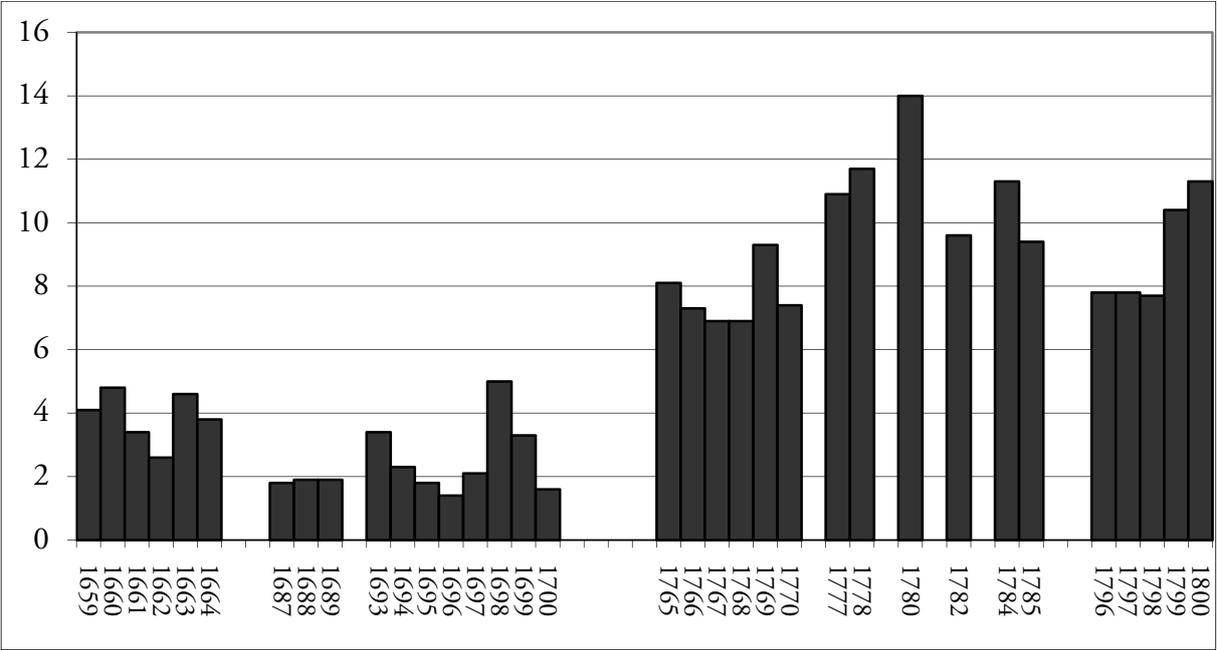
other, to take advantage of seasonal price movements, since at this time many products tended to be cheaper.

Hospital Admissions: Evolution and Seasonal Variation

To gain an awareness of the variations in occupation levels in the Queen’s Hospital, an indirect source must be made use of, the quantities of food served, since neither the register of admissions, nor, failing that, the register of deaths, are available. It is known that the administrators were under an obligation to record such events in the relevant two books, at least from the introduction of the 1788 regulations. However, for the moment it has not proved possible to locate them, despite a careful search through all the documentation generated by the hospital that is to be found in the Ponferrada Municipal Historical Archive.

The problem with using lists of food provided as an alternative indicator lies in the inflation of results. It would seem that in these records all patients remaining in the centre for more than one day, as was quite common, were counted as many

Figure 2. Probable average daily number of patients undergoing treatment in the Queen’s Hospital, 1659–1800.



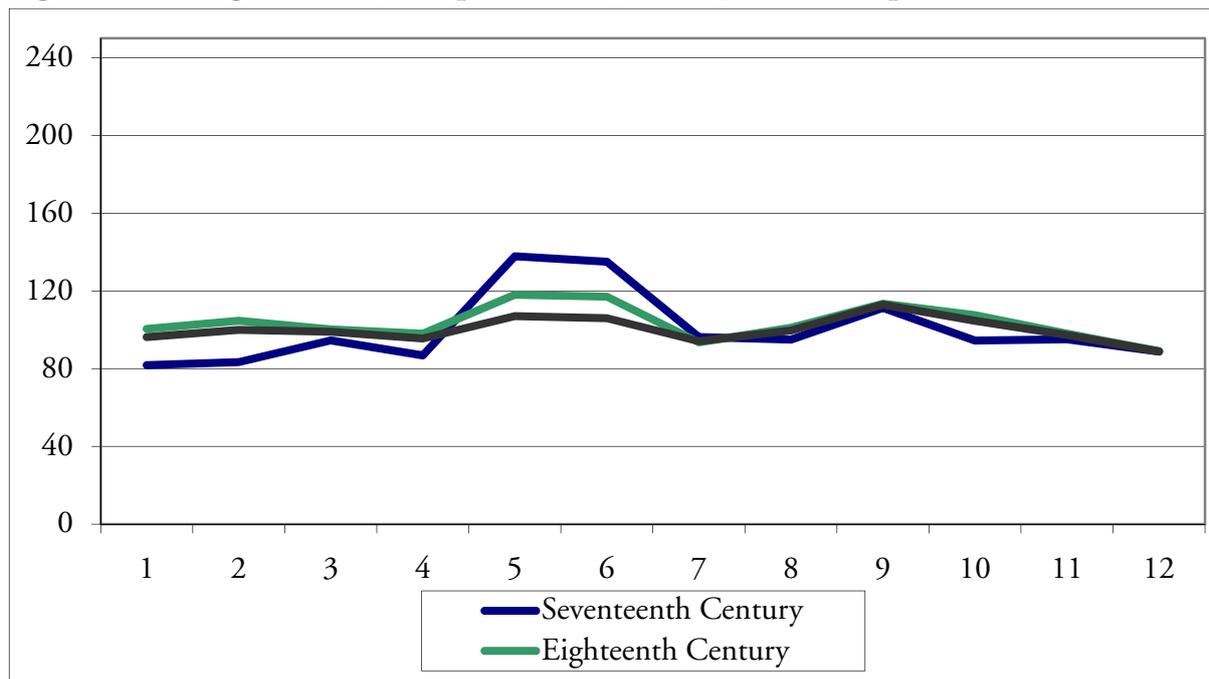
times as the number of days their sicknesses lasted⁴². To correct as far as possible this deficiency in the source, the approach taken here is to calculate the average number of portions served per day, since this indicator comes closer to the likely average of patients in the hospital. So, for instance, in the year 1661, the 1,248 rations provided imply an average daily presence of 3.4 patients.

Taking this index as a basis, it is possible to find evidence, firstly, of the considerable growth in the number of patients treated towards the end of the eighteenth century, in comparison with the previous century (Graph 1). In fact, this figure eventually doubled, going from between two and four rations per day to more than seven. This trend was strongly accentuated during the final quarter of the eighteenth century, a time when there was an acute crisis at a provincial level. It is highly likely, although the sources provide no further data, that this increase in aid continued during the early years of the nineteenth century, as it has proved possible to observe in the neighbouring cities of Astorga and Leon. It should not be forgotten that this growth in assistance provided must have been contributed to significantly by patients not originating in the town. This is a reference not so much to the travellers and pilgrims who were in transit along the Pilgrim's Way, as to inhabitants of nearby rural areas. In times of economic difficulty these latter would make for Ponferrada to seek help from its charitable institutions, as it was the chief town of the district.

The last aspect to be studied is the monthly demand for assistance over the course of the year. For this purpose a time series has been produced, making the appropriate distinction between seventeenth and eighteenth century data (Graph 2). The behaviour patterns observed for the two centuries are very similar, showing a noteworthy rise in aid provided during the months of April, May and June. This peak, more marked in the seventeenth century, is the consequence of the impact on the registers of the movements of seasonal agricultural workers who followed the "French Way" to reach the internal plateau of Spain. Although there are no data on this point, it is likely that among this group there was a considerable representation of people originating in Galicia, a region bordering on the Bierzo district and having a long-established tradition of this sort of transhumance. A second, less pro

42 In the Hospital of Saint Antony the Abbott in the city of Leon and Saint John's Hospital in the city of Astorga, both located in the same Province as the Queen's Hospital, the average hospital stay varied between twenty and thirty days. Martín García, A. and Pérez Álvarez, M. J., (2007), "Hospitalidad y asistencia en la provincia de León a finales del Antiguo Régimen (1728-1896)", *Dynamis*, 27, pp. 157-185, p. 179; Martín García, A. (2009), "Pobres y enfermos en el León de la Edad Moderna: la asistencia hospitalaria en la ciudad de Astorga", in Rubio Pérez, L. M. (ed.), *Pobreza, marginación y asistencia en la Península Ibérica (siglos XVI-XIX)*, Leon, University of Leon.

Figure 3. Average monthly aid provided by the Queen's Hospital, 1659–1800.



nounced, peak occurred in the month of September, corresponding to the return journeys of such temporary workers to their places of origin.

Apart from these well-defined cycles, the graph shows striking stability in the amount of aid provided. These results correspond to the characteristics of a centre of the modest nature and limited size that is being studied. These characteristics led to a very limited radius of action, practically restricted to the immediate neighbourhood. It should also be remembered that the installations could hold only a very limited number of patients, as the regulations reflect.

Final Conclusions

A study of the Queen's Hospital in Ponferrada serves to understand the functioning of a typical beneficent centre in the Province of Leon during the Modern Period. Its small dimensions and limited funding put considerable restrictions on its social actions. However, this was far from meaning that it was of no importance in a region rather isolated by its geographical circumstances and having very little urban development.

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Barbers, Doctors and Healers: Community Welfare and the Health System in the North-West of Spain – The Province of Leon – During the Seventeenth and Eighteenth Centuries

Laureano M. Rubio Pérez

Introduction

Public health systems, in the strict sense, from a present-day perspective and within the framework of European industrial societies, are a matter that relates to recent history or times not long since. This is when progress and the welfare state affecting the whole of society seem to triumph, in terms both of their progressive implantation and development, and of the structures upon which these are founded. However, they have a historical backcloth and supporting bases that in some sense may shape their present and future development. Hence, an awareness of their background and in particular of their underlying structures may aid both historical knowledge and planning for the future in times of major changes in demographic patterns, with a type of technological and scientific development which is far from that enjoyed by current European societies.

Nevertheless, despite these great advances, despite the forceful development of the capitalist system itself, not a few societies retain traditional features. These in some way constrain the future in certain territories or regions where the industrial and scientific revolutions have made less of a mark and traditional farming patterns still sustain a social grouping governed and sheltered by many traditional and long-standing approaches, attitudes and behaviours. The current tendency for some individuals or social groups, faced with pain or illness, to turn to healers, shamans or visionaries when they cannot find an answer in medical science forms a part both of the human condition itself and of a traditionalism deeply rooted in pre-industrial societies. Although today's is a fully scientific era and a point in time witnessing major medical advances, humans still to this day feel weak, and sometimes even helpless, when faced with the threat of death.

The chief aim of this work is to investigate through a historical analysis one of the questions that, owing to the lack of documentary evidence, is among both the simplest and the most complex affecting peasant societies under the pre-Constitutional monarchy of Spain. This is the question of health and the various different responses, mostly rather limited, that society and its local institutions set in train in the context of some helplessness and a total absence of State intervention. The lands and farming communities administratively and culturally within the former Kingdom of Leon, both because of their situation in the north-western part of the Iberian Peninsula and thanks to their peculiar system of population and forms of organization tightly linked to the institution of Local Councils and a rigid system of agricultural collectivism and community structure, constitute a good instance for in-depth study. Here, using the interrelation of various parameters, a deeper knowledge can be gained of the problems of health and the capacities and ways of responding of two fundamental social agents: the community of inhabitants itself and the Council that directed, controlled and protected it.

Taking as a starting point the homogeneity still retained by the population centres or communities forming such traditional societies, especially when assessing certain parameters related to disease, health, life and death (demographic patterns), it will be a question of defining and evaluating a potential model on the basis of the predominant organizational system. This centres on the mechanisms for control and intervention in the context of a weak health system that in practice leaves the whole problem of health and the fight against disease in the hands of the communities themselves and clearly dependent on their own financial resources. From this point of view, and in the light of the long period involved, allowing possible changes and survivals to be analysed, once the spatial, human and social context under study has been outlined, an attempt will be made to investigate several questions or problems in this primarily rural world. These are: society and disease, their conditions and shaping factors; forms of action and mechanisms for self-defence: regulations or laws, preventive measures, legal or penal approaches; practical measures and features shaping them: doctors, medicine, healers; results and achievements against disease and death.

On this point, and within the structural framework of economic, demographic, social and cultural revolutions, the context in which the development of medicine and of the agents that succeeded in definitively controlling the old pandemics occurred, three long phases or stages can be established. The first would run from the sixteenth century through to the end of the eighteenth century, or the first few decades of the nineteenth. It was from the eighteenth century onwards that the Enlightenment and the actions of communities themselves put in place policies of prevention that to some extent contributed to putting a brake on the effects of the great pandemics like the plague. However, it was in the nineteenth century that it became true to talk of major advances typified by preventive measures and by pre-

ventative or environmental health, as also by the prevention of diseases like smallpox through vaccination. In these circumstances, communities gradually realized that dirt and the presence of disease, or at least infectious and parasitic illnesses, were closely related. Thus, increased Council legislation on the topic opened up a new major line of attack, prevention based on a knowledge of the relation of cause to effect, a relationship that was typified by vaccination and other preventive measures once the causes of certain endemic diseases became known. Health services, hygiene and checks on foodstuffs and on the agents causing diseases, based on a slow, steady growth of knowledge, were the factors that laid the foundations for a new revolutionary phase. Nonetheless, what is termed the Modern Era was marked by society's helplessness against illnesses and the total lack of practical involvement by the State in the fight against disease, together with the continuation of highly traditional demographic patterns.

For its part, the second phase would cover the second half of the nineteenth century and the early decades of the twentieth. It was moulded by limited technical and medical advances, great dependence upon a subsistence farming economy and the incidence of traditional diseases which slowed any change in demographic patterns. Thereafter, well into the twentieth century, the third phase clearly took over, once the effects of the Spanish Civil War were overcome. This was in a new European context and benefited from fresh economic and industrial development and the new tools and advances available to applied medicine, as well as a demographic pattern striking for its sharp reduction in death rates.

To find an answer to these questions, with all the difficulties noted above, there are available legal documents, and particularly Council decisions, together with tax and accounting records, whether of the Councils or of religious institutions such as church guilds. In addition, Council by-laws governing the rural communities of Leon and a whole set of qualitative serial documentation covering everything from contracts with physicians, through inventories of dispensaries and apothecaries' shops, to other individual official orders and by-laws, holds a response to a good few queries. However, to get at this it is necessary to go very deep into social structures strongly dependent upon economic patterns and to a lesser extent upon political and administrative frameworks.

It is true that there is a certain homogeneity across the whole of Spain with respect to the set of communities living in and forming what is called the rural environment, when it comes to matters relating to health and medical practices. Nevertheless, structural factors, both population patterns and the type of rural settlement shaped by the physical or spatial surroundings, permit the establishment of models, even in such a complicated matter. These models in some sense, and within a general trend affecting Spain as a whole, are the consequence or outcome of a complex web of individual and collective actions that are largely moulded by local external factors and those inherent in each community. In this case, the spatial

context chosen for the study of the problem in question is the heartland of the old Kingdom of Leon. This is a region situated in the North-West of Spain, from which administrative measures were to form what is today the Province of Leon. While certain circumstances and contexts to some degree affected all pre-industrial societies alike, here the structural setting, together with community action and the collectivist spirit that for centuries pervaded these communities did have positive, even if very limited, effects. These arose not so much from any direct action on health and disease, as from a better social balance and a redistribution of wealth and poverty.

Crises, disease, remedies and limited responses

On these structural foundations that to some extent remained stable well into the twentieth century, the communities governed by Local Councils in Leon retained a considerable capacity to manage their own financial resources and the means of production which not merely guaranteed greater social balance and less polarization, but to a certain degree also reduced the incidence of extreme poverty and ensured that the absolutely destitute poor were few and far between. From this point of view it is possible to understand the policy of total control of specific means or resources and especially Council monopolies particularly aimed at supplying the community and at fighting hunger. Those communities were fully aware that poverty, hunger and disease were tightly linked to one another and so demanded a collective effort going beyond any weak individual actions. With this background, it is understandable that virtually all written Council orders from the sixteenth century on, once the late mediaeval crisis had been overcome, stressed the need to give every community a set of tools and preventive measures which in some ways were two centuries in advance of the State legislative projects that would emerge in the Enlightenment. Fear of the former plague and measures set in the context of a new phase of expansion in the economy that did not merely recover strongly within the Realm of Castile, but even explained an upward trend in population over a large part of the sixteenth century, would appear to lie behind the absence of any major demographic disaster, although it is true that the parameters defining demographic patterns remained stable.

From this point onwards, the territories of the Kingdom of Leon underwent considerable economic and demographic growth during the sixteenth century. They also fell definitively into a demographic pattern of a highly traditional kind, defined by high marriage rates combined with high birth and death rates. In this pattern, mortality, especially infant mortality, became to some degree the element that moulded demographic developments, despite the noteworthy part played by the more sociological parameter, the marriage rate. In this context, the plague of 1599,

particularly widespread in the northern parts of Spain, not merely cut short future growth, but was also the cause and simultaneously the consequence of an economic, social, and even mental collapse. This collapse in some sense spurred the communities governed by Local Councils, to the limited extent that they could, into reacting, faced as they were with the inertia of State institutions. Preventive measures, to combat both hunger and the plague, were brought into force within Local Council areas as they imposed by-laws requiring a certain level of hygiene to be observed and old habits and customs to be eradicated. While strongly urbanized towns concentrated on controlling those travelling along the Pilgrims' Way to Saint James of Compostella, and ensuring adequate separation between humans and animals, reforms in rural Council by-laws aimed at achieving better personal hygiene, keeping a watchful eye on the cleanliness of those public places, such as water sources, that were vital for the community's development. Although it cannot be said that these measures contributed to changes in demographic patterns, they did aid in putting a brake for the greater part of a complicated century on the major epidemic incidents that continued to scourge the Iberian Peninsula.

Indeed, in spite of sixteenth century economic growth, problems reappeared in the shape of a growing economic crisis and the appearance of new population difficulties ensuing from the bubonic plague that affected a good part of the Peninsula. Both northern Castile and the Kingdom of Leon were hit by this fresh pandemic. Although a certain flagging in the upward trends had shown signs of developing slightly beforehand, the arrival of the plague in 1599 hit a helpless population and choked off demographic growth in the short and medium term¹. During the seventeenth century the displacement of the black rat by the grey rat would seem to have lain behind the absence in these areas of any serious epidemic, even though this was a century of economic crises and high death rates triggered by the impact of famine and traditional diseases². However, despite new circumstances, as an outcome of earlier experience Local Councils in Leon seem to be aware of the need to set up preventive measures, using their financial resources and power to govern themselves. Reinforced community links and control of public spaces, together with measures of hygiene that affected the latter, were coupled with a rigorous control of the transient population and of settlement. The Pilgrims' Way led the Corporation of Ponferrada, among others, to prohibit entry to the town to any travellers suspected of carrying diseases. Similarly, the Royal Alderman of Astorga legislated insistently in respect of the prohibition on pigs being allowed to roam loose

1 Plague caused by the bacterium *Pasteurella pestis* was propagated by the black rat (*Rattus rattus*) coming into the country in ships touching at ports in Cantabria. The poor harvests of 1596 and 1597 left the population weakened and unable to fend off the plague when it arrived in March 1599. See: V. Pérez Moreda: *Las crisis de mortalidad en la España interior, siglos XVI–XIX*. Madrid, 1980.

2 L. Rubio Pérez. *La Bañeza y su Tierra, 1650–1850*. Leon, 1986, pp.78–85.

through the city³. Although achievements from this were rather limited and the few urban centres, just like rural settlements, lacked means and resources to combat traditional diseases, preventive measures, particularly hygiene and improvements in the physical conditions of communities in Leon, were once again among the preoccupations of Local Councils. This was especially so from the second half of the eighteenth century onwards, with the new guidelines of Enlightenment reformers concerned both by pandemics and the need to ensure food supplies for the population. However, neither official legislation⁴ nor the setting up by Local Councils and other institutions of *positos* [public grain stores] seemed to give any result in the absence of any modification in the predominant structural conditions and relations of production. Against this background, crises of mortality were recurrent and already at the beginning of the century they became apparent among the infant population in the shape of a disease, smallpox, which was only to be brought under some control in the mid-nineteenth century.

While the eighteenth century is considered the century for fevers, these were already present in the previous hundred years. Both typhus, and tertian and quartan agues, were closely linked to the conditions of life and the presence of swampy zones in which the mosquito or insect vector could reproduce⁵. However, traditional diseases such as diphtheria, murine (or endemic) typhus, and the like, were joined by other causes of death related to hunger, cerebral ailments, and respiratory and digestive illnesses. This not merely slowed population growth, but was to some degree a reflection of how few advances had been achieved despite the efforts of Local Councils and communities. Thus the demographic and economic crisis of the

3 A.H.P.L. *Archivo Histórico Provincial de León* [Leon Provincial Historical Archives], Astorga protocols of 1622.

4 On the topic of State projects and advances in medicine in Spain as a whole, extensive studies have been undertaken, including J. M. López Piñero: *Ciencia y técnica en la sociedad española, siglos XV–XVII*. Barcelona, 1979, J. L. Peset (ed.): *Historia de la ciencia y de la técnica en la Corona de Castilla*. Against a background dominated by Paracelsianism, Spanish medicine, like Spanish chemistry and biology, underwent no real change until the end of the seventeenth century. Contributions by Juanini (*Discurso político y físico*) and the group of *novatores* [innovators] from Valencia and Saragossa, especially Juan de Cabriada, were fundamental for the future of medicine, while showing up Spain's backwardness in science and the great mental and financial limitations that continued throughout the eighteenth century. Although in theory there was some change thanks to these contributions and the process of reform during the Enlightenment, in practice, other than in a few elitist circles neither this new knowledge nor the means available reached the population as a whole, so that the situation lingered on throughout the Modern Era.

5 In 1630 murine (flea-borne) endemic typhus and in 1693 louse-borne epidemic typhus severely affected the population of Leon and some administrations that had the resources to do so, like the City of Leon, attempted to combat them by hiring physicians at periods when there was a major shortage of qualified medical personnel. A.M.L. [Leon Municipal Archives], *Actas* [Minute Books], 1622 and 1693.

early years of the nineteenth century (1804 and 1805) was to be the forerunner for the arrival of diseases old and new that continued to decimate the population. The notorious fevers now had added to them rabies in a fresh context characterized by hunger, war, growing social polarization and increasing poverty. Starvation, pauperization, poor conditions of hygiene and the farming crises of the years 1864, 1869 and 1883 contributed to worsening the situation in an area where the process of industrialization had made no mark and the drain of capital away from the countryside was at a gallop. The influenza that in 1918 decimated the Leonese population was a faithful reflection of this precarious situation and the last great pandemic to make a major contribution to keeping death rates very high.

Table 1. Principal diseases, remedies and treatments involving the population of the province of Leon in the eighteenth and nineteenth centuries.

| TYOPOLOGY | TREATMENT: PLANTS, EXTRACTS AND SUBSTANCES |
|--|--|
| 1.-Infectious diseases | |
| 1.1. Respiratory Tract. | |
| Bronchitis, coughs and colds. | Snails, poppies*, violets*, mallow*, fenugreek*, jujubes*, figs*, raisins*, ground-ivy*, kermes mineral (sulphuretted antimony), coltsfoot*, belladonna*, hemlock, foxglove*. Common sweet flag (<i>Acorus calamus</i>), sea onion (squill). |
| Pneumonia, pleurisy and tuberculosis. | Winged broom (carquesia, <i>Genista tridentata</i>), tartar emetic, belladonna. |
| 1.2. Typhus (typhoid fevers) | Musk, wormwood (absinthe)*, gentian*, ipecac (ipecacuanha), arnica*, rhubarb*, camphor, wine*, spirits of salt (hydrochloric acid), dilute nitric acid, spirits of vitriol (sulphuric acid), sulphuric ether, tartar emetic, cream of tartar. |
| 1.3. Syphilis (pox) | Burdock*, kalawalla fern, balsam of copaiva, guaiacum (lignum vitae), spurge flax (<i>Daphne gnidium</i>)*, quicksilver (mercury) and mercury salts |
| 1.4 Smallpox | Chicory*, lettuce*, dandelion*, borage*, fumitory*, scorzonera (black salsify)*, lunar caustic (silver nitrate), spurge (<i>Mercurialis</i>), vaccine (vaccination began in Spain in the late eighteenth century, in Leon in the first third of the nineteenth). |
| 1.5. Measles | Burdock*, torus herb (<i>Dorstenia contrajerva</i>), scorzonera*, bugloss*, violet*, apothecary's rose (<i>Rosa gallica</i>)*, sassafras, linseed*, marshmallow (<i>Althea officinalis</i>)*, nitre, sorrel salt (potassium oxalate)*, Tabasco pepper. |
| 1.6 Diphtheria | Spirits of salt, gum ammoniac, alum, volatile alkali (ammonia). |
| 1.7. Cholera | Leon barely saw this disease; there was a small outbreak in the Bierzo district at the beginning of the nineteenth century) Ipecac (1672), morphine (1805). |
| 1.8 Diarrhoeas. | Hartshorn (ammonium carbonate), opium, rice*, starch*, torus herb, quinces*, logwood (<i>Haematoxylum campechianum</i>). |
| 1.9. Leprosy | White arsenic, quicksilver, fumitory.* |
| 1.10.Herpes | Borax, manganese, hellebore*, black pepper, pasqueflower (<i>Pulsatilla</i>)*, spurge flax.* |
| 1.11Carbuncle | Dried chloride of lime (calcium chloride) |
| 1.12. Ulcers and sores. | Ivory black (animal charcoal), cantharides, sumac*, benzoin resin, essence of turpentine*, creosote, acetic acid.* |

| TYPOLOGY | TREATMENT: PLANTS, EXTRACTS AND SUBSTANCES |
|--|--|
| 1.13. Hydrophobia (rabies). | Belladonna*, antimony chloride. |
| 2. Parasitic diseases | |
| 2.1. Malaria (tertian and quartan fevers) | Absinthe*, cornflower*, gentian*, willow*, mustard*, rue*, black pepper, milk thistle*, cinchona bark (end of the seventeenth century), Prussian blue (iron cyanide), green vitriol / copperas (iron sulphate), blue vitriol (copper sulphate), verdigris (copper carbonate) |
| 2.2. Amoebic dysentery | Rhubarb, sulphuric acid. |
| 2.3. Ringworm (in 1805 this was called <i>lepra</i> [leprosy] in Leon) | Black pepper, white lead (lead carbonate), manganese. |
| 2.4. Mange (itch) | Sulphur, fumitory*, borage*, rue*, scabious*, hellebore*, verbena*, mustard*, white lead. |
| 2.5. Intestinal worms (helminths). | Tansy*, rue*, wormwood (absinthe)*, lemon pips*, sagewort (<i>Artemisia maritima</i>), gamboge resin, ash tree leaves*, birthwort (<i>Aristolochia</i>)*, castor beans*, pepper. |
| 2.6. Tapeworms | Myrtle*, pomegranate*, male-fern*, rue*, garlic*, false dittany (<i>Dictamnus albus</i>), castor beans*. |
| 3. Other diseases | |
| 3.1. Rheumatism | Arnica*, club moss (lycopodium)*, turpentine*, juniper oil*, phosphorus, incense, deadly nightshade*, essence of rosemary*. |
| 3.2. Epilepsy (in eighteenth-century Leon called <i>gota coral</i> [falling sickness]) | Blue vitriol, black henbane*, stramony, valerian*, orange-tree leaves* |
| 3.3. Digestive ailments. | Fennel*, ginger, chamomile*, mustard*, angelica*, aniseed*, wormwood (<i>Artemisia</i>)*. |
| 3.4. Haemorrhoids | Lesser celandine*, cocoa butter |
| 3.5. Hysteria and neurosis | Castor (beaver musk), musk, poppies*, valerian*. |
| 3.6. Scurvy | Common scurvy grass (<i>Cochlearia officinalis</i>)*, mustard*, sorrel salt*. |
| 3.7. Stroke (apoplexy) | Coloquint* ,sabadilla (<i>Schoenocaulon officinale</i>)*. |
| 3.8. Gout | Birthwort*, burdock*, Spanish broom*, gentian*, guaiacum, torus herb. |
| 3.9. Goitre (endemic in the Cabrera and Bierzo districts). | Powdered sea-sponges |
| 3.10. Oedema (dropsy). | Sea onion*, foxglove*, juniper*, lettuce*. |

* Plants indigenous to Spain or extracts and substances obtained from them.

Sources: Parish Registers: death registers for the districts of La Bañeza and Astorga (1750 to 1850). Inventory of the Astorga Dispensary and yearly inspection reports, eighteenth century. On the range of medicines held by the Dispensary of the Hospital of Saint Anthony the Abbot in Leon, the Leon Cathedral Archives and the doctoral thesis: *La Farmacia en la ciudad de León*, 1800 - 1950. María Luisa Martínez Velasco. University of Leon, July 2008.

Commentaries: In most illnesses bloodletting was routinely undertaken, either by the application of leeches or by phlebotomy (bleeding). The barber-blood-letter, or barber-phlebotomist, was a familiar figure in the Province of Leon. Similarly, by routine almost all ailments were treated with purges: aloe, tamarind, jalap, Spanish broom*, common buckthorn*, antimony, senna*; or emetics: violet root*, blue vitriol, tartar emetic, kermes mineral, ipecac.

Professionals: Physicians, surgeons, barbers and healers.

The situation was thus one of total absence of any State co-ordination and of means and resources likely either to improve living conditions or to solve health problems. Hence, it was communities themselves, that is, rural Councils and urban Corporations, which throughout the Modern Era assumed the responsibility for combating disease and caring for the health of the inhabitants or residents. This self-protection had its roots in the capacity of councils to legislate or issue orders, the chief objective of which was to provide for and guarantee minimum basic resources, such as water, bread and other foodstuffs. Local by-laws on the cleanliness of council-owned water supplies, of bakeries and other public places, such as taverns, appeared and became increasingly common from the seventeenth century onwards. Both Local Councils and town Corporations, together with administrators connected to the central government (Royal Aldermen) seem to have taken an interest in supplies of food and in the availability of remedies and resources in the few private dispensaries and apothecaries' shops existing in the Cities of Leon and Astorga. Thanks to a few inventories from the seventeenth and eighteenth centuries, it is possible to gain knowledge of the limited medical remedies to hand, largely linked to traditional medicine⁶, which would appear to explain the growing efforts of town Corporations in favour of preventive measures. Since treatments were so basic and lacked means and resources, prevention stood out as the only alternative, all the more so within communities that had full powers to manage their own resources and environment. Council-organized food supplies and monopolies in rural communities and even in cities and urban centres, such as Astorga or Leon, became a major line of action that went well beyond merely ensuring there was food. It was from the last few decades of the eighteenth century onwards that considerable ability to pass by-laws and a major effort by Councils is noted with regard both to hygiene and food supplies⁷. Thus, Councils took a close interest in ensuring that there were suppliers obliged to provide meat to butcher's shops or wine to taverns, but simultaneously insisted on proper conditions for slaughtering animals and for

6 During an inspection of the apothecary's store by the authorities of the City of Leon in 1643, it was noted to hold: precious and oriental stones, drugs, amber, agaric, kidney-wood, senna leaves, guaiacum (*lignum vitae*), cinnamon, saffron, cloves, pepper, compounded cordials and tinctures, pills, gums, poultice ingredients, ointments, roots, syrups, oils, flowers, herbs. A.H.P.L. Box 209. In 1702 an inventory of the apothecary's store of the town of La Bañeza recorded the presence of herbs as a basic element in the preparation of ointments, which were made up of animal fats, minerals and herbs. Alongside these items for external application there were pills, tablet ingredients, gums and juices. A.H.P.L. Box.7292.

7 L. Rubio Perez, *Ordenanzas del concejo de Santiago de Millas y su barrio de Penillas, Año 1671*. Leon, 1985. The greater part of the council orders studied in L. Rubio Perez, *El sistema político concejil*, op. cit., are on the same lines.

the distribution of meat or bread⁸. Similarly, while in 1790 the Leon City Corporation organized systematic rubbish collections, they once again stressed something already a constant in the seventeenth century, that is, ensuring a supply of snow, used as a medical treatment against the ever-present fevers⁹.

Together with their greater or lesser preventive and organizational capacities Leonese communities run by Local Councils sought, as far as internal and external limitations permitted, remedies against disease by a two-fold route. On the one hand there was the traditional way linked to beliefs and their own resources, on the other the scientific way, based on medicine and in particular upon exercise of the medical profession, these two ways being intertwined. In view of the limits and lacks already mentioned, and outside scientific medicine, which could hardly reach much of society, especially rural society rural, until well into the nineteenth century cures were sought the traditional way, itself divided into two approaches: practical (or heterodox) and religious. It is hard to quantify or measure the real presence of a whole range of healers and curers, scattered throughout Leon, but particularly in mountainous areas. This is, as might easily be supposed, partly because they were anonymous, and partly because, operating outside the law, they left no written trace of their activities. Only a check on a certain number of trials by the Inquisition reveals their existence and the growth in the activities of healers as the eighteenth century progresses. The exercise of healing was the result of the absence of any response from institutions and the limits of medical means and resources. The well-known example from the district of La Bañeza of María Domínguez, a woman in her eighties from a small community called Santa María de la Isla, is a good reflection of the linking of religion, spiritualism and traditional healing lore in a practice mixing religion and natural knowledge and resources. At the bidding of the Valladolid Inquisitor, the María in question was accused and tried in 1761 as involved in healing and superstition. This was because she cured various diseases using herbs that were mysterious or magical and by making use of a set of charms or invocations of protecting saints that varied in accordance with the type of ailment to be remedied¹⁰. From witness statements made during the trial, it is clear that alongside

8 In 1798 rules were drawn up for slaughtering cattle and supplying the butchery of the district of Astorga. These make plain the preoccupation about both human foodstuffs and public hygiene and health. A.H.P.L. Box 10612.

9 A.H.P.L., Boxes, 55 and 860.

10 In 1761 the Inquisitorial Commissioner, at the request of the Prosecuting Inquisitor of Valladolid, interrogated various witnesses in the case in question. One of them declared that his wife had gone to the house of the accused. The latter, after examining her, stated that she was suffering from an air blockage, but she could cure her. She told her to come to her house the following day, and while the two were alone in her kitchen, she examined the wife's breasts and repeated that it was an air blockage. She heated wine and oil in a small dish, putting in another some glowing embers, throwing onto them rosemary and thyme, together with vine twigs that she said were good for the air, and adding several other herbs. She then put the dish in the wife's

the use of products and herbs known for their healing properties an attempt was made to invoke divine powers, while there was also clearly some basic awareness of the human body and of certain traditional illnesses. Problems arose when these natural remedies were joined by others linked to witchcraft or from the constant mixing of healing items from nature with invocations and religious practices that neither Church nor Inquisition were prepared to accept. This was so, even though people from kings to the clergy had no hesitation in resorting to this sort of person and other natural healers.

On these same lines, Council orders, records of religious guilds and the account books of local treasuries, thanks to their entries and annotations, make it clear there were a number of deeply-rooted traditions, spells, invocations and other acts of worship, the aim of which was to gain the help of a number of saints who were supposed to protect people and animals. Although the greater part of these practices, to which Leonese Councils, not to mention the religious guilds, devoted more than 30% of their income, had their origins in the Middle Ages, it was after the seventeenth century crisis and during the eighteenth century when they were at their height. This is a clear manifestation of how Councils and their communities desperately sought remedies which it was hard to find, in view of the parlous situation of medicine and medical knowledge and the absence of any input of resources by State institutions. Invocations to the holy martyrs Saint Fabian and Saint Sebastian, to Saint Anthony, Saint Roch, Saint Lucy, and others were coupled to a whole scree of religious actions or practices on the part of Councils or communities, some seasonal, some annual. In these, through official pledges and prayers, an attempt was made to win divine protection and favour against disease and economic crises. The fact that even in the reforming nineteenth century this sort of practice continued and flourished shows just how little developed medical science was, and how hard it was for small communities run by Local Councils to gain access to medical professionals. From the sixteenth century onwards, such professionals may be divided into three groups. The first comprised physicians, who undertook university studies and after appropriate examinations were awarded a licence to practice by the central medical authorities, or *Protomedicato*. They were to be found mostly in towns, and their numbers until the eighteenth century were small, which to some extent explains their high salaries. In second place came surgeons of two sorts. There were Latinists or master surgeons, who, while not holding a full medical degree, had completed courses in surgical operating proce-

lap and made the sign of the cross with her hands, at the same time uttering charms and prayers. She swore by the lance with which Longinus stabbed Our Lord on the cross, adding "Amen" and "Jesus". Within nine days the baby girl began to suckle properly and the wife noticed that she had more milk every day. The baby grew up very robust and healthy. Similarly, various witnesses declared they had had eye ailments cured by means of salves and invocations to Saint Lucy. A.H.N. [National Historical Archive] Inquisition Section.

dures and were authorized to prescribe medication for external uses. There were also non-Latinists who had undergone controlled training under a master surgeon for a number of years under the terms of an apprenticeship contract until the *Protomedicato* approved them to practice. Finally, there were barber-blood-letters or barber-phlebotomists, who could bleed patients, extract teeth and so forth, still present in a society that was well used to them, although communities did attempt to engage the services of experienced surgeons recognized by the *Protomedicato*¹¹.

Indeed, both legal documents and the records of Councils and local by-laws stress from the sixteenth century onward the need to engage the services of medical professionals, especially after the establishment in 1477 of the Royal Tribunal called the *Protomedicato*, the function of which was to examine candidates wishing to become physicians once they had completed basic Arts studies and four years of courses in a Medical Faculty¹². However, neither in the sixteenth century nor in the following centuries was access to medicine open to urban communities as a whole, much less to small country communities, whose respective Councils had to counter the deficiencies and total lack of interest on the part of other authorities or State institutions. It is true that, especially from the late seventeenth century onwards, not only were there advances in knowledge and practice, but also a noteworthy proliferation of orders, decrees, regulations and other provisions that tended to bring order to the chaos and in some way favour the exercise of medicine. However, in practice there was total failure, in part because of the lack of personnel, in part because of the scarcity of financial resources. In this situation, neither institutions, nor the Crown, nor other governing or ruling groups seemed to have any involvement in the problem beyond this legislative and preventive framework. The limited number of universities, Salamanca, Valladolid, Alcalá, combined with social and economic factors affecting studies, led to a state of affairs in which, regardless of the developments in medicine, the availability of medically qualified professionals was sparse and large urban centres took the lion's share, more than half, of these trained staff¹³. Thus, it was urban Corporations and local Councils of rural communities that, to the extent their means and resources permitted, fostered and paid for medical services and access to them by those living in their areas. However, both the scarcity of resources and the collective ethos that affected Leonese Local Council

11 Luis S. Granjel: *El ejercicio médico y otros capítulos de la medicina española*. Salamanca, 1974.

12 In 1798, Manuel Rico Merino, a candidate for the post of physician for the City of Leon listed his experience and long periods of training, which mingled Classics with medical practice.(See Table below). A.H.P.L., Box.755.

13 J. M. López Piñero reckons that there were around one thousand physicians, mostly established in the larger cities of Castile, with a major vacuum in the countryside. See J. M. Lopez Piñero. *Ciencia y técnica en la society española de los siglos XVI y XVII*. Barcelona, 1979. See also: D: Goodman. *Poder y penuria. Gobierno, tecnología y ciencia en la España de Felipe II.*, pp.242–243, 1990.

communities meant that for centuries, even beyond the end of the early modern period, questions of medicine and access to it were handled collectively and affected the residents as a whole. This explains why, as is noted in the few surviving records of agreements and of council accounts that can be consulted, contracts for medical professionals were issued by the council organization over time, at no direct cost to individual residents, since it was the council treasury that took on the burden of paying emoluments.

Hence, entries in the accounts and legal contracts between medical professionals and the councils of the various Leonese communities offer access to some specific points that are hard to assess from the perspective of a systematic serial analysis of medical and health practices. There would appear to be two reasons for the scant presence of qualified physicians in the Leonese countryside in the sixteenth and seventeenth centuries. These are the small number of such personnel and, especially in the seventeenth century, the lack of funds to hire them. This led councils that had some resources tended to engage phlebotomists and barber-blood-letters, with surgeons established mostly in towns and small cities that were the seats of jurisdictions¹⁴. These lesser-qualified professionals could let blood, undertake minor surgery, set bones and fix splints, besides working as barbers. It was their guild and the ruling authorities of each town that awarded them their qualifications, after a practical examination, and their medical services were paid for by councils and by individuals. So, for example, in 1635 the town Council of Castroalbón agreed to hire a barber-blood-letter from a nearby village, stipulating certain terms and conditions. He was to come to the town twice weekly to examine any sick, even without specific appointment, and was also to come whenever required by a patient. Any application of cupping-glasses to unbroken skin was to be paid for at the rate of eight *maravedis*, while an application to scarified skin or a blood-letting would earn sixteen [some two or three pence in English money of the period]. He was to treat all residents, their children, nieces and nephews, while if he treated their servants, he was to be paid in accordance with the treatment given. He was to shave or trim the beard of all householders, who each were to give him five *celemines* [about twenty-three litres or somewhat over half a bushel] of wheat a year, apart from any payments for individual treatments.¹⁵ Together with these medical workers, there were often surgeons who up until the mid-nineteenth century undertook minor surgery, splinting and setting bones. In some sense they made up for the absence of physicians, especially in moments of crisis, when the number of surgeons recognized by local authorities and their own guild tended to grow. This was encouraged by the way that the job could be learnt without formal academic study and the low rate of

14 From least to most qualified, medical professionals fell into the categories: barber-blood-letter, phlebotomist, surgeon and physician.

15 A.H.P.L., Box 6953.

pay, which meant services cost little, similar services also being on offer, as has been seen, from an assortment of healers and spell-casters¹⁶.

The contributions both of the *novatores* and of the scientific revolution, together with the new economic conditions prevailing in Leonese communities governed by Local Councils in the first half of the eighteenth century, appear to lie behind the slight changes noted from that time onwards. Thus, the presence of a qualified physician became more frequent, even in rural communities, and in some sense the foundations were laid for a system that was to last until the major transformations that came in the twentieth century thanks to a revolution in science and the current health system. Although the collective, Council-run nature of services continued in respect of the benefits of having a qualified medical practitioner, as also in some sense the right of residents to free medical treatment, paid for from the funds available to each Council, in the mid-eighteenth century certain adjustments are to be noted. These include the introduction by Council-governed communities of medical rates and the possibility that the doctors employed might treat outsiders on the basis of personal payment for their services. This state of affairs indicates a certain alteration in the social situation. While it is true that attempts are made to maintain a free Council service, a lack of resources on the part of Councils or communities leads to access to medicine being sought through personal contributions. This to some extent created social differences, very much on the lines of the growing spirit of individualism that become increasingly present in the nineteenth century¹⁷. In

16 Healers treated the sick by applying saliva, breathing on or touching the patient, while spell-casters effected their cures with prayer and magic words. Curers of these sorts were very abundant in the Leonese communities run by local councils and were even recognized and given contracts by council order in some mountain areas in the eighteenth century. In 1630 a contract for an apprenticeship in the art of surgery was drawn up between a resident of Santa Marina del Rey and a surgeon living in Astorga. The surgeon, Antonio de Luaces, was required by the contract to take into his home Manuel Sánchez to instruct him in the arts of surgery and to keep him there for two years, providing him with clothing, board and lodging, in exchange for which he was to receive two hundred *reals* [equivalent to some seven or eight pounds sterling of the period] A.H.P.L. Box 9497.

17 Santa Marina del Rey was a small but wealthy town, no longer subject to any lord, situated on the fertile lands along the River Órbigo. Its capacities for self-government by its own council were full, although it did have to pay a considerable annual sum to the previous lords of the manor. The buying out by the council of their rights, which did not extend to the extinction of the yearly tribute due to the Cathedral Chapter of Astorga, did give it full political and financial control of its affairs. However, it also led to long-term increasing collective indebtedness, which became worse with the crises of the seventeenth century. Throughout the sixteenth century the town always paid for the services of a physician, but in 1626 medical care was put into the hands of phlebotomists or blood-letters, clearly a reaction to the scarcity of trained doctors and the penurious state of the council treasury. Council accounts from 1672 once again have entries relating to the salary paid to a physician, 500 *reals* [at that time around twenty guineas]. After various different alternatives were tried the contracts became generalized as lasting one or two years, with the introduction of resident rates, so that householders themselves paid the

any case, towns and villages with fewer resources continued to maintain both a subsidized collective system and contracts, paid for by special rates, with surgeon-blood-letters based in the larger urban settlements. This reinforced the well-to-do status of such specialists in bone-setting, bleeding and the like. Thus, in 1734 the town of Castroalbón engaged the services of Jerónimo Martínez, surgeon and blood-letter approved by the *Protomedicato* and resident in La Bañeza. Among the terms of his contract was that he had to come to shave, trim the hair of and treat for any disease, carbuncle, or other injury or ailment, any of the householders or other residents of the town, prescribing them medicine, leeches or blood-letting, extracting teeth when necessary or if they requested it, and providing any other needful service. For this work he was to be paid by each householder two *heminas* [in Leon, approximately thirty-six litres or around a bushel] of standard-grade wheat and one pound of flax. Since he was resident in La Bañeza and had to care for his registered patients there and in the surrounding district, he was required to appoint an assistant suitably competent to bleed and to shave and to provide basic medicines for the sick under treatment, who was to reside in the town itself, so as to deal with sudden emergencies and visit patients every day that the surgeon himself was not able to come to do so¹⁸.

On these same lines, at the end of the eighteenth century, although advances in medicine and improvements in finances continued to be sparse, the main Leonese towns and Local Councils put a good deal of effort into ensuring they had the services of qualified physicians. These professionals attained considerable prestige and a high social status. They moved continually from one town to another as a function of the salaries on offer. When funds were ample, communities sought to have a constantly present doctor, and were willing to pay substantial emoluments. The town of Grajal de Campos is a significant instance, both because of the degree of self-government through its Council that it retained, despite having a lord of the manor, and because it continued to have collective and social arrangements for medical services, paid for mostly from town funds and the Council's treasury. Thus, in 1799 the qualified physician Francisco Zerón committed himself in a legal document to attend to all the householders and residents of the town, their children and servants, and the poor in the workhouse, every day, visiting any sick both morning and evening. If he wished to undertake any journey, only permitted on the

incumbent, even if it was the Council or councillors who drew up the contract, made some payment or provided lodgings for the physician. So, in 1753 an agreement was reached with Pedro Fernández, a qualified physician, by the terms of which all householders were to pay a yearly sum of two *reals* [somewhere between one shilling and one shilling and sixpence of the period] to ensure treatment for their families. Some residents were opposed to this two-*real* rate, but it was ordered that the amount be paid in three instalments to the Council, ensuring the doctor an income of some 300 *reals*. A.H.P.L. Boxes 9431, 9332 and 10281.

18 Municipal Archives of Castroalbón. Ledger number 3.

assumption that there were no patients currently under treatment, he still had to leave a locum to cover any emergencies. In return for his services, the town Council contracted to pay him a yearly sum, granting him the status of householder without requiring him to pay any local rates. As long as the arrangements continued, the payment was to consist of one head of cattle and one pig, plus fifty *cántaras* [about 80 litres or around 20 gallons] of wine, if he wished to take this payment in kind, with a cash payment of 3,700 debased or billon *reals*, equating to 1,480 true silver *reals* [approximately forty to fifty English guineas of the period], one-third to be deducted if the payment in kind was taken¹⁹. It can be seen from terms mentioned in this and other contracts, there was a progressive trend, differing from the practice in earlier centuries, to share out medical services among various different communities linked by ties of jurisdiction or proximity. This doubtless aided a larger number of individuals or rural communities to gain access to medical skills. It also strengthened the social position of qualified physicians, who were addressed with the formal polite title of *Don*. In the specific case of the Grajal contract, the Council allowed the doctor to travel out to villages near the urban area, as had been the custom, but he was not permitted under any circumstances, however urgent, to spend the night away from the town.

The specific cases analysed above confirm to some degree the results obtained from a sample based on contracts and lawyers' documents. These indicate the sorts of professional that received contracts and the terms and conditions imposed on them. In studying the sample, two periods, covering respectively the eighteenth and the nineteenth century were used, so as to allow any possible changes relating to the practice of medicine or the terms agreed. In the first period, of 68 contracts studied only 8% related to qualified physicians, all the others to the various different categories of surgeon, although there is a strong trend in the second half of the eighteenth century for preference to be given to master surgeons approved by the *Protomedicato*, a clear reflection of economic growth and greater social awareness of preventive medicine and of health. In view of the scarcity of physicians and their tendency to settle in large urban centres, towns and small cities could only gain access to them on a temporary shared basis. This to a certain extent obliged them to hire qualified surgeons who acted as replacement doctors and thus became the main medical practitioners. Although oversight and control of contracts and medical services lay with the Local Councils, during the eighteenth century the system of medical rates gradually spread to become universal. This meant that medical professionals received emoluments of two types. While the Council conceded to them householder rights such as that to graze a horse on common land, or exempted them from certain local taxes, householders individually contributed a payment in

19 A.H.P.L. Protocols, Box 4548.

Table 2. Education and curriculum vitae of Manuel Rico Merino, candidate for the post of city physician of Leon, 1798. A.H.P.L., Box 755.

| Year | Awards and literary and practical work |
|------|--|
| | Study of Latin in the City of Leon. Thirteen years of secondary and tertiary studies. Three years of philosophy and five of theology in the Monastery of Saint Dominic in Leon. |
| 1781 | Moved to the Classics section of the secondary school, passing his examinations <i>nemine discrepante</i> Three half-hour presentations awarded a score of twenty-four in a disputation with the Wrangler covering three topics in Theology and four in Philosophy, in which he produced seven telling arguments and other spontaneous points. |
| 1782 | One year of studies of algebra and one of experimental physics in the City of Valladolid. Three years of medical studies at the University of Valladolid, also attending lectures on Anatomy and Surgery. |
| 1784 | Intern in the Academy of Medicine, having been approved <i>nemine discrepante</i> . |
| 1785 | Awarded the degree of Bachelor of Philosophy. |
| 1786 | Gave a half-hour presentation awarded a score of twenty-four, expounding one of the aphorisms of Hippocrates that he was assigned at random, and responding to three half-hour disputations. This exercise was approved <i>nemine discrepante</i> , and he was accepted as a senior member of the Academy. He was involved in various other disputations within the institution. |
| 1787 | Presented a major paper in the University and Medical Faculty of Valladolid. Awarded the degree of Bachelor of Medicine by the University of Toledo. Two years of practical work at Saint John's Hospital, Burgos, in conjunction with Master Physician Felix Antón. Solely responsible for treating syphilis cases and certain other sick patients. |
| 1789 | Renewed his licence as physician before the tribunal of the central medical authorities [<i>Protomedicato</i>] in the City of Madrid. Physician of the town of Villaoz in the Province of Burgos; physician of the town of Fonbellida and its district in the Esgueva Valley. |
| 1790 | Selected as physician for the town of Villamañán. |
| 1794 | Physician in the town of Alaejos, where he was granted a contract. Immediately prior to leaving, he was offered a new contract by Villamañán at a higher salary and the same conditions. He thus remained in this post for eight years uninterruptedly to the full satisfaction of the residents of the town and its environs, as was well known. |

the form of a quantity of grain (wheat) each year. The amount varied, being on average around twenty kilograms per ratepayer to ensure medical treatment, ten for shaving services. Social status, as also their income in kind, was high for these practitioners. Consequently, contracts with a two-year term were gradually replaced towards the end of the century by agreements for an average term of eight years. In return, these surgeons took on an obligation to stay in the town day and night, to treat all the sick, including the poor, at no charge and, when the incumbent was a

barber-phlebotomist, to engage a qualified surgeon assistant to aid in treating householders²⁰.

Thanks to this greater social awareness, reflected in the increased number of contracts with medical professionals, the nineteenth century saw the slow introduction of certain changes. These were tightly linked both to advances in the knowledge of diseases and to the rising cost of medical services, as there was still a shortage of qualified professionals, while demand on the part of rural communities was growing. In this context, and closely linked to the strengthening of the political power of Local Councils, communities and their respective Councils tended to unite so as to share medical services, whether through old administrative and judicial organizations (District Councils), or through the new municipal institutions or Local Authorities (*ayuntamientos*) created by liberal reforms. Both contracts and the way that services were shared by various different communities not merely facilitated and improved provision, but also reduced costs, despite the strong growth in salaries which progressively became fixed entirely in cash, with an average amount exceeding 5,000 *reals* a year [equating to perhaps as much as 180 English guineas of the period]. This meant that thanks to the greater specialization of qualified surgeons, who might well be resident in another town, even though they made weekly visits to different localities, there was still a need to have barber-blood-letters in each community to take care of minor treatments, and especially to do shaving. This modified somewhat the sort of contract entered into and the terms relating to pay. While the system of rates in kind continued in use for barbers in the form of payment of a quantity of grain by householders, the cost of salaries for physicians and qualified surgeons was borne for the greater part by Local Councils and by the Local Authorities that later replaced them. This is a crucial aspect: it should be kept in mind that in the urban world and in those territories in which Local Council powers were to disappear, along with the communal resources that supported them, social differences became more acute, even in respect of access to medicine. In Leonese Local Council areas, even in mountainous zones, socialization of medicine not merely did not disappear, but actually became stronger and in a certain sense laid the foundations for current models of provision²¹.

20 The town of Algadefe during the second half of the eighteenth century had ten contracts with practitioners, either master barbers, or qualified master surgeons. In the first case the system for rates and service provision involved an obligation to reside constantly in the town as a householder, as well as requiring the barber to ensure surgical treatments through an obligation to nominate an approved person to attend and undertake visits at the hours fixed for them. For its part, the contract drawn up in 1786 with the incumbent master surgeon for a term of eight years specified that treatments required because of violent acts were to be paid for by whoever was convicted of committing them. A.H.P.L., Boxes 5978, 5979, 5980, 5985, 5988.

21 As an example, there is the contract signed in 1833 by the towns and villages forming the District Council of Mediana de los Arguellos in the town hall of the new Cármenes Local Authority with Eulogio Mendoza, the incumbent surgeon resident in Matallana de Valmadrigal.

In such a context, in view of the absence of planning and action by State institutions, the entire weight of medical provision and of aid centres, hospitals or hostels, fell on cities, towns and villages. Their respective Councils sought what ways they could to find remedies for disease and provide access to medicine. In the light of this, it is understandable why throughout the Modern Era there remained present in the Province a series of establishments whose main purpose was to aid travellers and pilgrims, a natural consequence of the fact that the Pilgrims' Way to Saint James of Compostella runs through this area. Local religious guilds with considerable incomes and resources, together with several of the towns and villages lying on the routes most frequently used by such travellers, bore the cost of such institutions throughout the Modern Era. The provision of medical personnel varied in accordance with the resources available to those patrons maintaining them and was closely tied in with the medical services for which each of the towns held a contract. At the end of the eighteenth century the Province of Leon had a network of such hospitals and hostels comprising eighteen centres maintained by larger towns and by cities, although some of them had no health workers and concentrated on charitable assistance to the poor and to travellers²². As can be seen from the table below, it was in the larger urban centres that hospitals were to be found with their own medical personnel, while small towns and rural settlements lacked sufficient means to hire such staff.

Against this background and in circumstances that remained more or less unchanged until well into the nineteenth century, the principal efforts of Leonese countryside communities, given the internal and external limitations affecting them, were directed towards getting the benefits of medical science and access to medical professionals who were regulated by the central medical authority or *Protomedicato*. The presence of the hospitals and hostels mentioned above at the end of the modern period, most of them lacking medical staff, was aimed mostly at the poor and at travellers. Moreover, their strong dependence on the resource of religious guilds and of towns caused them to lack sufficient means to alleviate disease. While guilds and Councils did with great difficulty manage to cope with poverty from the Middle Ages onwards, the disentanglement of their property in the early

Its conditions are clear. He was to treat as needed both rich and poor, both orphans and servants. He was to offer shaving services and was required to visit the district council area every fortnight, even if there were not sick. He was not to leave the area without a magistrate's permission, and this was not to be for periods in excess of three days. He was to live in Cármenes and if he were to be at home but refused to visit a patient, he was to pay a fine of five ducats [twenty *reals*, about ten to fifteen English shillings of the period]. The contract, for a term of three years, specified he was to receive annually 4,100 *reals* [approximately 135 contemporary English guineas], apart from other householder privileges. A.H.P.L. Box 4065.

Table 3. Hospitals and hostels.

| Town / village | Name of hospital / hostel | Doctors |
|-------------------------|---------------------------|---------|
| Astorga | Saint John's | 3 |
| | Five Guilds' | 2 |
| La Bañeza | Cross | 3 |
| Benavides | Saint Martin's | 0 |
| Leon | Saint Anthony the Abbot's | 4 |
| | Pilgrims' | 0 |
| Pardavé | Sick Pilgrims' | 0 |
| Pobladura de P. García | Assumption | 0 |
| Ponferrada | Queen's | 3 |
| Puebla de Lillo | Saint Isidore's | 0 |
| Puente Villarente | Villarente | 0 |
| S. Miguel de Dueñas | Mercy | 2 |
| Valderas | Trinity | 0 |
| Villadangos | Villadangos | 0 |
| Villademor | Saint Peter's | 0 |
| Villafranca del Bierzo | Saint James's | 1 |
| Villamañán | Saint John's | 0 |
| Villanueva de la Tercia | Pilgrims' | 0 |

Source: *Censo de 1787. Floridablanca*. I.N.E. [Spanish National Statistical Institute], Volume 3B. Madrid, 1989.

nineteenth century brought their activities to an end as they no longer had the minimum income from agricultural lands needed to support charitable works. In the light of this and with a centuries-long experience of the limitations of the fight against disease, it is understandable why Leonese Local Councils sought so desperately to engage the services of a fully-qualified physician. This must have been quite difficult, to judge by the small number of these more highly trained professionals and their concentration in urban centres.

In turn, the autonomy of each community, the individualism and self-sufficiency that at times took the shape of a rejection of neighbouring communities, even when forming part of the same administrative unit, led access to medicine, that is, to medical professionals, to be very restricted and dependent on the resources to hand. Nonetheless, even though elites, especially in urban areas, had more possibilities of gaining access to medicine, it seems clear that the system of Local Councils and the strength of these communities in seeking collective or community solutions favoured the inculcation of a way of thinking and of attitudes that sought collective benefits over individual. For many centuries Leonese communities with Local Councils had shown extensive and deep-seated socializing and collectivist behaviour patterns. These had to some degree reduced, even if they had not eliminated, social polarization and had brought basic services and access to certain means of production into the grasp of the community as a whole, independently of the position of a given family. Local Council monopolies over food supplies and above all their provision of free access to basic primary education and to medical and health services,

to the degree that these could be afforded and staff for them hired by the Council, was something taken for granted by Leonese communities run by Local Councils. This was because of the belief, collectively accepted, that only community spirit could provide a way of facing the challenges of life, in view of the weakness of individuals and of the households from which they came and of which they formed part.

However, changes occurring as the nineteenth century wore on, an increase in social polarization and in individualistic behaviours and attitudes, favoured by the policies of the liberal state, gradually eroded this community solidarity and collectivism. While the system of Local Councils lingered on, it seems clear that a process of dissolution of certain social values affected a whole set of solidarities and to a great degree also, Local Council funds. This retreat, despite the slow advances in medicine, would appear to explain in part the social and community difficulties in gaining access to medicine practised by the still relatively few qualified physicians. This meant that in the mid-nineteenth century just 30% of the population of Leon had direct access in theory to public medical provision.

Against this background, there was no visible change in the situation regarding demographic patterns in the first half of the nineteenth century. High death rates and the immobility of a highly traditional regime underline the scant impact on the rural world of advances in technology and medicine. Even when the crisis of the first years of the century had been overcome, neither the extensive administrative reforms, nor economic growth, unable to eliminate hunger or the cyclical agricultural crises, proved able to change the situation and the system. The new liberal State merely strove to impose a rigorous administrative centralization and to obtain resources for the treasury, even at the cost of a major process of disentailments. This brought with it negative effects and contributed to increased social polarization, breaking down the few links that still remained between urban and rural worlds and spreading *caciquismo* [pocket-borough-like political fixing] from the principal new power centres, that is the Provincial Councils and the new Local Authorities. Despite this, and the creation in the Province of Leon along of some three hundred new Local Authorities, the medical and health situation did not merely remain unchanged. Local Council communities gradually gave up some of their old collectivist ways to the extent that they lost former jurisdictional links with other communities with which they had been allied in the struggle for survival and for access to medical remedies. As was noted above, this was combined with new fiscal burdens imposed by the State and a decline in the income of Local Council treasuries, especially in mountain communities. It is thus to some degree understandable how there could be a deterioration in health provision in a highly rural society, depending on a subsistence economy and having very little capital.

None of the projects and decrees of the liberal State, not even the basic Constitutional Law on Health passed in 1855, seemed to be of any avail. This was all the

more so in that the countryside was seen as less and less prestigious and suffered from a major draining away of population. Those who stayed in many villages and small towns were barely able to maintain any of their old links in ties when the pressure from dominant urban oligarchies and the new Municipal Authorities was squeezing agricultural incomes more and more. Agricultural crises, hunger, pauperization and new epidemics combined with traditional diseases to keep gross mortality rates higher than 35 per thousand. In such a context it is possible to understand the death of more than 17,000 people, particularly young people, in León during 1918 because of the influenza epidemic. Poor living conditions and hunger were described in a contemporary weekly newspaper, speaking of schoolteachers, when it said that they were obliged to teach in unhygienic premises and live in unhealthy rooms lacking any comforts, where microbes found congenial circumstances. As they and their families were impoverished and lacked sufficient food, it was not strange to see them among the earliest victims of the dreadful neglect affecting health services.

Similar views were to be found in the so-called Medical Surveys undertaken during the final decades of the nineteenth century and first few decades of the twentieth by a group of qualified doctors resident in Cities like Leon and Ponferrada. These were a new approach to investigating the living conditions in cities in an attempt to put in place a full preventive policy, which, as usual, ran up against the lack of financial resources and the realities of inadequate structures. Nonetheless, the conclusions leave no room for doubt. They stress the deficient hygiene observed among the working classes. The latter lived off the produce they got from the plots they cultivated as tenants. Vegetable waste and the bran from the cereals from which they made bread were used to feed the pigs that they kept on the ground floor of the houses in which they lived. The stench from these animal quarters went straight up into the rooms and the rotting dung that accumulated gave rise to an infection-laden atmosphere that was often unbreathable. Likewise, these reports note that the disease causing the greatest number of deaths was enteritis. This was particularly prevalent in the under-fives, because of poor or insufficient nourishment during breast-feeding and weaning, combined with the misuse made of wine, which was given to infants during the first months of their lives under the false impression that it would make them hale and hearty²³.

It would seem clear that there is a direct relation between living conditions, food, the extremely rural status, even of the few small urban centres, and the diseases that continued to affect the population of Leon during the early decades of the twentieth century, whether infectious/contagious (tuberculosis) or respiratory or pulmonary (bronchitis and pneumonia). This was paralleled by limited abilities to gain access to medical advances, or even to medicine in general, other than the sparse

23 *La Historia de León*, Volume 4, pp.23–25. Leon, 1999.

provision that was gradually being introduced into urban centres in the circles of the ruling oligarchies. It is in such a context that must be seen the creation in 1925 of the Provincial Hygiene Institute, the chief activity of which was to fight tuberculosis. From that point on, despite the financial and political problems that were to affect Spain in the first half of the twentieth century, not only were demographic patterns to begin changing, but also a process of striving to overcome traditional diseases was started, the first result of which was the involvement of municipal administrative units, that is, Local Councils, in collective arrangements for ensuring medical services. The general practitioner, paid for by Local Councils and the rates levied on householders, not only became a commoner figure in the Leonese countryside, but joined in the struggle waged by State institutions to eradicate major pandemics. Although very slowly, it was from the 1960s onwards that a model of public health fostered by the State became definitively established, which in some sense overlaid the centres that the urban bourgeoisie and certain medical professionals, members of social elites, had built up in the 1950s.

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Childhood and Poverty in Leon in the Modern Period: Institutional Responses

Alfredo Martín García

The View of Children in the Spain of the Sixteenth to Eighteenth Centuries

In the sixteenth century the first steps began to be taken in Europe to bring into practice the theoretical models for protecting children that had started to evolve in the later Middle Ages. In the Spain of that time certain thinkers, such as Luis Vives or Miguel de Giginta¹, began to put forward solutions, especially with regard to abandoned children. In general, it was not a case of specific works on the question, but rather of discussion of the topic of childhood in a tangential way, integrated into their analyses of the overall phenomenon of poverty. Vives, in his famous *Socorro de los pobres* [Aiding the Poor], advocated the establishment in the chief cities of the realm of centres to aid abandoned children, where they would receive attention of all sorts². The idea of all these writers was closely linked to the need to keep children from begging, because of all the terrible drawbacks that this would bring, starting with the exploitation of minors and going on to their highly likely slide into delinquency. In brief, these policies brought together the traditional spirit of Christian charity from the Middle Ages³ and a growing fear of the poor as subversive. Alongside these points of view a major part was also played by more financial criteria; these sought to make individuals useful through intellectual,

1 Vives, Juan Luis, (2006), *Tratado del socorro de pobres* [Treatise on Aiding the Poor], (Unpublished sixteenth-century translation by Bernardo Pérez de Chinchón) Alicante: Generalitat de Valencia [Regional Government of Valencia] and Diputació de Alicante [Alicante Provincial Council] (First edition published in Latin in Bruges, 1525); Giginta, Manuel de (2000), *Tratado de remedio de pobres*, Barcelona: Ariel (First edition, Coimbra 1579).

2 Vives, Juan Luis, *Tratado del socorro...*, (2006), p. 189.

3 In accordance with this line of argument, poverty should be considered not so much a social curse as a blessing from God, since thanks to it the rich could gain salvation through giving alms. Cavillac, M. "Introducción" in Pérez de Herrera, Cristóbal, *Amparo de pobres*, Madrid: Espasa-Calpe, pp. LXXXV–LXXI (1975).

religious and vocational training⁴. Both Vives and the majority of the thinkers of the period held that there should be direct participation by the State in the work of gathering and supporting the poor. However, the results achieved were of no great significance, even though it seems clear that their thinking influenced the founding or development of a range of charitable institutions, generally supported by the Church, whether by members of the clergy or of religious associations.

As time passed, the image of children acquired sharper edges and gained a defined legal status. This change in the view of the world of childhood can be clearly noted already in the seventeenth century, under the influence of the Counter-Reformation. A more Christian set of customs and the discovery of children's souls gave infants dignity, as may be seen in treatises and legislation from the period⁵. This tendency was accentuated during the eighteenth century. At that time, the Enlightenment concepts of utilitarianism, philanthropy, stimulating population growth, and rationalism gave a new dimension to interest in childhood as a whole, and abandoned children in particular. As had already happened in the sixteenth century, writers of the Enlightenment once more stressed the need for greater involvement by the State in the task of aiding the marginalized. Their influence had practical consequences for legislation, but not in the form of direct management by the Crown of any establishments opened for such people, the Church retaining its primacy in these activities⁶.

The objective of this paper is to analyse the impact of all these changing views on assistance to children in a specific instance (the City of Leon) during a given period (Sixteenth to Eighteenth Centuries)⁷. A study of the case of Leon is of great interest for several reasons. The fact that the general characteristics of aid to children in a Spanish provincial city during the modern era are known helps judge accurately the importance of Crown legislation in this field. Similarly, an investigation of the main institutions devoted to this work during the centuries in question is helpful in understanding what the principal objectives of the actions of these foundations were and how they changed over the years. Among the modifications in the priorities set by centres in Leon for assistance, from the eighteenth century onwards it is striking how much stress was laid on education as a necessary bridge to the

4 Maravall, José Antonio "De la misericordia a la justicia social en la economía del trabajo: la obra de Fray Juan de Robles", in *Moneda y Crédito. Revista de Economía*, 148, (1979), pp. 57–88, pp. 59–60.

5 Ariés, Philippe, *El niño y la vida familiar en el Antiguo Régimen*, Madrid: Taurus, (1987), p. 69.

6 Cava López, Gema, *Infancia y sociedad en la Alta Extremadura durante el Antiguo Régimen*, Cáceres: Institución Cultural "El Brocense", (2000), pp. 42–43.

7 Abbreviations used hereafter: A.H.P.L. = *Archivo Histórico Provincial de León* [Leon Provincial Historical Archives]; A.CH.V. = *Archivo de la Real Chancillería de Valladolid* [Valladolid Royal Chancellery Archives]; A.M.L. = *Archivo Municipal de León* [Leon Municipal Archives].

integration of children into society. For this reason, particular attention will be paid to the question, consideration being given to its background and outcomes in the world of childhood in Leon.

Various Responses to the Phenomenon of Children in Need in the City of Leon: The Poor Fund, the Hospice and the Doctrinal School

The City of Leon, like so many other towns in the Europe of the time prior to constitutional monarchies, sought to meet the demand for aid for marginalized children through a range of institutions of various kinds. To meet the problem of foundlings and abandoned children, the Leonese set up two charitable bodies: the Poor Fund and the Hospice. In their origins, going back a long way in time, both were overwhelmingly religious in nature, in no way strange if it is kept in mind that it was precisely Christian charity that was the prime mover in the development of this sort of assistance⁸. While the Fund was a foundation dependent upon the Cathedral Chapter, the Hospice was born thanks to the desire for reform of Bishop Cayetano Cuadrillero. The status of the City of Leon as the See of a bishopric and capital of one of the kingdoms composing Spain led these institutions to extend their aid work not just to the City itself but also to its extensive Province. For its part, the third of the centres in existence in Leon at that time, the *Colegio de niños de la doctrina cristiana* [literally, Children's school of Christian doctrine], or Doctrinal School, was alone in not being directly managed by the Church, since control over it was exercised by the City Council. In any case, this centre, while devoted to the intellectual and vocational training of orphans, was also the fruit of the Christian concept of charity and the era's keenness on catechizing.

The Poor Fund The "Arca de Misericordia"

For much of the modern period, the work of aiding abandoned children in the City of Leon was the sole preserve of the *Arca de Misericordia de Nuestra Señora la Blanca* [literally, Chest of compassion of Our Lady the white virgin], or Poor Fund. Until it disappeared at the start of the nineteenth century, this charity was under the control of the Cathedral Chapter. Although the exact date of its foundation is not known, there are numerous references to its activity from the last few decades of the fifteenth century onwards. The Chapter's aid work continued over later years,

⁸ Fonte (DA) T.A., *No limiar da honra e da pobreza. A infância desvalida e abandonada no Alto Minho (1698–1924)* (Vila Praia de Âncora 2005), p. 114.

meeting the costs incurred for wet-nurses both from its own resources and with the alms of the faithful. As the sixteenth century wore on, the initially very sketchy organizational arrangements for the centre were gradually refined, and it gained its own financial resources. In parallel with this development, absolute subordination to the Chapter gradually gave way to a certain degree of autonomy, thanks to the diversification of sources of income. The charity acquired privileges from Rome, from the Crown and even from the Leonese church itself, as well as receiving donations from private individuals⁹. However, without any doubt the change of greatest importance with reference to achieving full financial self-sufficiency occurred in 1771, when it was awarded the income from a tax on the sale of wine, called the *arbitrio del vino*, or wine levy. This amounted to two *maravedis* per *azumbre*¹⁰ [very roughly equivalent in English terms of the period to half a farthing a pint] on wine sold in the city and certain parts of its surrounding Province.

It is no coincidence that receipt of this major favour occurred chronologically at the high point of Bourbon reformism. At that time, the Christian vision of aid to the needy was joined by the utilitarian views of the Crown, which saw in the loss of children an intolerable drain that put a brake on the growth of the population and hence on the economic development of the country. Besides, approval of this grant was also a response to complaints by the Chapter that with the limited budget the charity had it could not cope with the flood of abandoned children, coming not just from the Bishopric of Leon, but also from the Astorga diocese, including the towns of Villafranca del Bierzo and Ponferrada, as well as from the deanery of San Millán in the Bishopric of Oviedo and from those parts of the mountains falling within the Kingdom of Leon, right up to the boundary with the Principality of Asturias¹¹.

To solve these difficulties, the Chapter requested from the Crown the assignment of a sufficient and stable source of income which would not merely meet current costs, but might also allow the development of a more complete provision of assistance to children. Specifically, it might allow them access to educational and vocational training such that in the future they could enter the labour market with some hopes of success. The new tax, once consolidated, amounted to more than 50% of the institution's yearly income. Besides bringing financial stability to the body, the levy led to a major change in the process of gathering up foundlings from other parts of the Province. From 1772 onwards, those towns and villages that paid this tax were exempted from their obligation to

9 See Villacorta Rodríguez, T., *El Cabildo de la Catedral de León. Estudio Histórico-jurídico, siglos XII–XIX* (Leon 1974).

10 The *azumbre* was a measure for liquids approximately equivalent to two litres or four pints; the *maravedi* was at this time a small copper coin.

11 A.M.L., Box 729.

pay any of the costs for the care of foundlings from their area, since all such expenses were taken on by the charitable body.

The Doctrinal School

Another of the institutions intended to provide assistance linked to children that existed in the City of Leon was the Doctrinal School. Its creation and development over the sixteenth and seventeenth centuries mirror perfectly the parameters governing charity at that time, when it was seen as preferable to attend to and educate orphans, the children of “honourable families”, rather than foundlings, often the “fruit of sin”¹². The origins of this Leonese charity lie in the rise of institutions of this sort throughout the Kingdom of Castile during the sixteenth century. Effectively, while predecessor foundations of a similar nature are known from the late Middle Ages, it is usually the year 1540 that is taken as the start of the process. It was from that year that the Crown began to become involved in developing such works, exhorting local authorities to try to prevent participation by children in begging, helping them to learn a trade and covering their most basic needs. These measures, sanctioned by Charles V, were nothing more than an adaptation to a Spanish context of the guidelines that the Emperor had applied some years before in Flanders. The main way in which Castilian cities expressed their response to this request by the Crown was the creation of doctrinal schools. This was because they were affected by the development of a strong catechizing movement, headed by Saint John of Avila and his disciples, who aspired to an ambitious plan for the religious and educational reform of the lower classes¹³.

The process appears to have its true beginning in 1542 when Valladolid opened its school¹⁴. One year later, steps were initiated to create an establishment of the same characteristics in Madrid, and then the formula was extended rapidly throughout the land (in Burgos, Avila, Seville, Cadiz, Toledo, Jerez de la Frontera and elsewhere). In the 1550s the project was set on a sure footing thanks to support from Philip II in the shape of a Royal Warrant (1553), inspired by the memorandum presented a year earlier by Gregorio de Pesquera and Juan de Lequeitio to the Council of Castile. The objective of this royal order was to consolidate those foundations already in existence and promote new creations,

12 Caro López, C., *La línea en la sombra. Estudios sobre la asistencia y la represión de los marginados en Murcia durante el siglo XVIII* (Cartagena 1992), p. 38.

13 Santolaria Sierra, F., “Los colegios de doctrinos o de niños de la doctrina cristiana. Nuevos datos y fuentes documentales para su estudio” in *Hispania*, Vol. LVI–1, 192 (1996), pp. 267–290, p. 269.

14 See Fernández Martín, L., *Asistencia social en Valladolid. Siglos XVI–XVIII* (Valladolid 1999).

involving municipal authorities in maintaining them¹⁵. It is very likely that the Doctrinal School in Leon owed its origin to these measures taken by the Crown. This is, for the moment, a hypothesis lacking any documentary proof, since the source that ought to be able to provide this information (the Minute Books of the City Council) is not extant for this period. It is, nonetheless, certain that the school was already in operation in the 1560s, since in 1571 the Leon City Council, the patron of the foundation, paid the centre the arrears of emoluments that it should have handed over in 1567, 1568 and 1569¹⁶.

The school was set up in the Sanctuary of Our Lady of the Remedies, situated outside the city wall. To ensure it ran smoothly, the Council annually elected an individual to the post of Administrator of the Doctrine Children. Some of these administrators took a lively interest in the foundation, even contributing from their own funds to supporting the children. When the Council was faced by the arrival of a mass of poor in the city in July 1699, it handed the Remedies Sanctuary over to the Bishop so that a provisional hostel could be set up there. Don Gaspar de Teves, the children's administrator, took them off to his own home while this emergency was being resolved¹⁷.

Despite the commitment of the municipal authorities to the good functioning of the institution, it is certain that the school had right from the start only a very limited income. In the final third of the sixteenth century, the municipality contributed to it from its own funds just 6,000 *maravedis* a year [at that time equating very roughly to some 120 to 150 English shillings of the same period]. This is a very modest sum if compared, for instance, with the 50,000 *maravedis* that at around this time the Municipality of Toledo was giving to its school¹⁸. In addition to this fixed contribution, the Council came to the aid of the centre with money at moments of extreme need, especially when it became urgent to undertake repairs to the installations or to renew the pupils' clothing. Thus, at the beginning of September 1642 the Council enjoined Alderman Don Álvaro de Quirós Miranda to ensure the Doctrinal School children were properly clothed, and in October 1705, the municipality spent 1,800 *reals* [at this time the *real de plata* was a silver coin worth somewhat less than an English shilling, so that the full amount equates to fifty or sixty guineas of the period] on improvement works at the Sanctuary¹⁹. At other times, the City Council directed some of the money from fines imposed on

15 Santolaria Sierra, F., "Los colegios de doctrinos o de niños...", (1996), p. 284.

16 A.M.L., Box 37, *Libro de actas* [Minute Book] No. 9, folio 17.

17 A.M.L., Box 63, *Libro de actas* No. 54, folio 340 verso.

18 The amounts spent by Leon are more similar to those expended by the city of Logroño. Mora del Pozo, G., *El colegio de doctrinos y la enseñanza de primeras letras en Toledo. Siglos XVI a XIX* (Toledo 1984), p. 75; Lope Toledo, J. M., "Logroño en el siglo XVI. Los niños de la doctrina cristiana", pp. 419–432 in *Berceo*, 73 (1964), p. 420.

19 A.M.L., Boxes 50 and 65.

its staff to the benefit of the foundation or transferred to it the residues of income obtained from other sources. There are several examples of this to be found during the 1740s, when the Council gave the school the revenue from sales of beef from the animals killed in bullfights²⁰. As for the first of these kinds of extraordinary income, there is evidence from January 1714, when the Councillors decided to deduct 20 *reals* from their Chaplain's salary for failing to attending some of the masses to which he was required to go, and to apply this money to the school²¹.

Besides the financial contributions from the City Council, there were other sources of income: alms collected by the children themselves, donations by individuals and bequests in wills given so that the children would attend the funeral. Those bequeathing money in this way so as to have children present at their burial were trying to benefit from the children's reflected innocence at the tragic moment when they left the world, given their uncertainty about salvation²². This funerary practice was primarily linked to the wealthiest sectors of seventeenth-century Leonese society. Two examples would be the cases of Doña Juana Bañuelos and Doña Manuela de Aldama. Both stipulated in their wills, dating from 1675 and 1685 respectively, that the Doctrinal School children should be called to escort the coffin of the deceased to the graveside, wearing veils and praying for the soul of the departed²³. The decline of the school in the eighteenth century led to the disappearance of the practice at that time.

This range of revenues, unfortunately, never sufficed to cover all the expenditure the foundation required, leading to a financial shakiness that continued from its birth to its disappearance. As early as 1601, the children were obliged to leave the building because of the poor state of the facilities²⁴. At that time there were six little ones living in the school and receiving free primary education from the City's schoolmaster. One hundred years later, the school was still suffering from the same financial penury, as its administrator, Don Gaspar de Teves, pointed out in 1700. The cause of this instability lay, to quote the words of an alderman from 1642, in the fact that it had no income from endowments and that charitable donations were insufficient to cover its costs²⁵.

20 In September 1645 this amounted to 85 *reals*; in February 1650, to 100 *reals*. A.M.L., Boxes 51 and 52.

21 A.M.L.,

22 These sources of finance were very similar to those seen in the schools in other cities, such as Toledo or Palencia. González Gallego, I., "El proyecto didáctico de una institución educativa entre los siglos XVI y XIX: el Colegio de niños de la doctrina cristiana de Palencia (1544–1861)", pp. 475–497, in *Actas del I Congreso de Historia de Palencia*, Vol. III (Edad Moderna y Edad Contemporánea), Palencia 1987, p. 477.

23 A.H.P.L., *Protocolos notariales*, Boxes 333 and 459.

24 A.M.L., *Libros de actas*, Box 44.

25 A.M.L., Box 51.

This precarious state, together with the development of the Poor Fund, brought about the decline of the school, clearly visible in the mid-eighteenth century from the information provided as General Responses drawn up for the National Survey of the Marquis de la Ensenada in 1752. At that point, the old school no longer lodged any children and was evidently in a decrepit state²⁶. A few decades later, specifically in 1773, Alderman Don Antonio Escobar presented an ambitious project to rehabilitate the school and remedy this unfortunate situation. Escobar's plans, supported by the Leon City Council, were largely an outcome of the disputes that had arisen between the Council and the Cathedral Chapter over the granting by the Crown of the levy for the Poor Fund. The municipal authorities considered that the sums collected for the benefit of that charitable institution were much larger than its real needs. Consequently, they pressed for a suitable redistribution of the money in question, with some part of it to be spent on other necessities also relating to aid for the poor of the city and its environs. One of the possibilities suggested by the Councillors was the re-establishment of the Hostel for the Needy of Our Lady of the Remedies. In this way, it would be possible to collect up, offer care to, and make useful a significant number of children who were in need, either because they had no parents or because these had abandoned them. In the Councillors' opinion, this foundation would not merely benefit residents of the city, but also the inhabitants of all the villages round it that were paying the levy at that time²⁷. The project, however, did not prosper, the Doctrinal School disappearing definitively as new institutions, with a more modern conception of aid to the needy young, developed.

Bishop Cuadrillero's Hospice

It was in 1793 that the third aid centre in the city, the Hospice, first opened its doors. Its birth implied an undeniable advance in childhood protection policies in the City of Leon and its Province, both because of its ambitious objectives and because the building that housed the new institution had been purpose-built for its functions²⁸. The idea of setting up an establishment of this nature had already been mooted in 1750. However, the initiative came to nothing until years later, when a new Bishop, Don Cayetano Antonio Cuadrillero, came to take over the diocese in 1778. During his time as Bishop of Ciudad Rodrigo, this prelate had already set examples of reformist initiatives, founding a rather similar institution there, very

26 A.H.P.L., *Catastro de Ensenada* [Ensenada Survey], General Responses.

27 A.M.L., Box No. 76.

28 A plan of the building is to be found in the Archives of the Royal Chancellery of Valladolid. A.R.CH.V., *Planos y Dibujos* [Plans and Drawings], No. 182.

much on the lines of the policies adopted by other Enlightened bishops²⁹. Under his protection, the Crown resolved on 24 January 1786 to found a Hospice in the City of Leon. However, the Bishop's involvement in the creation of the new centre went beyond merely using his influences at Court, as he spent an appreciable amount on the affair: something of the order of three million *reals* [around one hundred thousand English guineas of the period].

Just as the Poor Fund had gradually built up a structured income that allowed it to enjoy relative autonomy, the Hospice followed the same route. It is true that in its first few years of operations funding came almost exclusively from the pocket of Bishop Cuadrillero, but as time went by it moved onto a financial footing that was less weak. This strengthening of the institution received an efficacious contribution from the careful management of Don Rafael Daniel, Archdeacon of Valderas. This clergyman was named by the Crown to take charge of the establishment in April 1800, after the illustrious Bishop himself had died.

In the early nineteenth century the co-existence of this new centre and the Poor Fund was somewhat problematic, leading to not a few disagreements that took the shape of noisy confrontations between Bishop Cuadrillero and his Chapter. It is possible that Cuadrillero's awareness of the opposition of the Chapter to his work led him to take the precaution of requesting that after his death the Hospice should remain under the control of the *Colecturía general de expolios y vacantes del reino* [Spanish State Office for Interim Administration of Church Property] and not of his successor as bishop, as would have been expected. The Bishop's suspicions were rapidly confirmed, with opposition to the centre growing more forceful after its founder's death in 1800. The new administrator complained a year later that a large part of the Cathedral Chapter disliked the Hospice so much that they had never gone inside it, not even out of curiosity to see the great building, something which struck passers-by. Despite these pressures, the Hospice came out victorious when it achieved a merger with the Poor Fund in 1802.

The financial consolidation of the Hospice, once it took over the Poor Fund, and continuing support from the Crown did not leave the Director idle. Another of his aims was to encourage manufacturing work in the centre. Specifically, in 1803 he sent a report to the Crown, in which he indicated his wish to make the Hospice into a flagship manufacturing centre that could compete even with goods imported from abroad. Prudent management by Archdeacon Daniel was crucial during the Peninsular War years (1808 to 1814), when, despite the gloomy general situation, he was able to keep the Hospice at more than acceptable levels of effectiveness. On 4 January 1809, five days after the French invaders occupied Leon, one part of the installations was converted into a temporary hospital for their Army. Fortunately,

29 See Sarrailh, J., *La España Ilustrada de la segunda mitad del siglo XVIII* (Madrid 1974), pp. 138–139.

the drop in income arising from difficulties the Hospice had in collecting what was due to it was to some extent compensated for by the good relations Archdeacon Daniel maintained with the new political authorities. On a personal level, this good understanding with the French caused him no little trouble at a later date. In June 1812, Don Rafael had to leave the city hurriedly in view of the threats uttered against him by Spanish partisans who accused him of being an *afrancesado* [Francophile traitor]. His hasty departure was one of the main causes of the decline into which the centre fell thereafter.

While during the Peninsular War the Hospice had suffered a major drop in the income it could collect, the reforms undertaken during the “Liberal Triennium” of 1820 to 1823 were no better for it, also having a negative effect on the revenues of the charitable organization, as has been observed in the case of other similar centres³⁰. Despite these fluctuations, so little to the benefit of the foundation, the Hospice did maintain a certain level of activity during the 1820s, under the administration of the priest Don José María Román. His departure in 1835, coupled with the sweeping political changes that brought about the definitive end of the Modern Period, left the Hospice plunged into a difficult financial crisis. This unsustainable situation continued even after the Provincial Council of Leon, under the terms of a Royal Order of 30 November 1838, took charge of the centre. The new managers, thanks to the granting of fresh sources of funding, succeeded in getting the establishment back onto its feet, restoring the training and manufacturing activities that had been dropped during the long period of decline³¹.

The Eighteenth Century: The Development of Education as an Objective for Aid

During the sixteenth and seventeenth centuries, as has already been pointed out, there were two Leonese institutions that carried out childhood aid work: the Poor Fund and the Doctrinal School. The objectives of those responsible for the Poor Fund were confined to offering very basic assistance to foundlings. They attempted to gain spiritual salvation for the infants, guaranteed by the sacrament of baptism, and saw to their feeding, wet-nurses being hired in for this purpose. If the babies managed to get through this crucial stage for their survival, the Fund tried to ensure their adoption, whereupon it considered its own obligations ended. These aims of such reduced scope were a response both to the particular view of childhood at the

30 This also happened in Salamanca. Torrubia Balagué., *Marginación y pobreza. Expósitos en Salamanca (1794–1825)*, Salamanca 2004, p. 64

31 Madoz, P., *Diccionario geográfico-estadístico-histórico de España y sus posesiones de Ultramar* (Valladolid 1983), p. 176.

time and to the limits imposed by the sparse income available to the institution. For its part, the Doctrinal School offered its attentions to a tiny group of orphans, rarely more than half a dozen, to judge by what little information is available. In this centre, unlike the Poor Fund's approach, an attempt was made to give a solid Christian upbringing, combined with basic intellectual knowledge, provided by the City's schoolmasters. Likewise, the School tried to direct its pupils onto the labour market, giving them access to the exercise of a trade under the aegis of the Municipality. The model of the Doctrinal School is of great interest, because it saw education as an essential element in aiding children, so as to ensure appropriate integration into society. Despite the good intentions of the project, it was curtailed by the financial penury that affected the charity from its very beginning and restricted its capacity for action.

This extremely limited range of assistance changed considerably during the eighteenth century. The ending of the activity of the Doctrinal School in that century was more than compensated for both by the birth of a new centre, the Hospice, and by the new range of assistance given by this and the old Poor Fund. Between the two institutions, a total of 14,774 children were helped during the period 1700 to 1830. Most of them, 11,653 (78.9%), continued to be foundlings. Nevertheless, other types of assistance were on the up and up: these involved fosterlings, hospice children and grant aid. The first were children entrusted to the institution by their parents, theoretically on a temporary basis, while they resolved the financial problems that were preventing them from raising their own offspring. This new group took up 10% of the total of aid given, involving 1,476 families. With the setting up of the Hospice in 1792 hospice children also make an appearance, that is, children who on entering the centre had already exceeded the maximum age stipulated for external placement, so that they were kept in the establishment with a view to giving them an education and vocational training. These, who in some sense replace the Doctrine School children who had disappeared during that century, represented 5.1% of total outlays. The remaining 6% was split between grant aid and assistance to the mothers who worked as wet-nurses and in child care in the institutions. The first of these consisted of financial assistance, generally in the form of cash, which the Hospice offered, fundamentally, to those parents requesting this sort of help, on condition that they committed themselves to raising their child at home. They were, in some sense, a more elaborate and modern version of fosterling and foundling arrangements, becoming general in particular during the first third of the nineteenth century.

Until the mid-eighteenth century, the Poor Fund carried on acting in its traditional way, restricting itself to the role of a centre redistributing the children that came to it, without direct participation in their education. However, from then onwards the institution started to take a more active part in the training of the youngsters who survived past weaning. Initially it had to rely on external education,

handing the child over to the City's public school or to some master craftsman³², which had the additional advantage of starting a process of social integration³³. This second route was frequently used by aid centres of this kind in eighteenth-century Spain, in view of the obvious financial benefits to the institution and the efficiency shown by the system³⁴.

The granting of the wine levy in 1772 brought notable changes to the policy followed by the Fund. From then on, as they had an appreciable financial surplus, the administrators were able to contemplate the possibility of setting up their own workshops within the institution, using paid staff. In any case, it was not just financial factors that influenced the new features taken on by the centre. The keenness on matters utilitarian and educational so typical of eighteenth-century reformism also contributed notably to encouragement of this new dimension, as did the new way of seeing children and a rather blind confidence in education as a cure for all evils³⁵. The first attempt on these lines was the creation of a spinning workshop. Between 1774 and 1776, the Fund spent a considerable sum of money on acquiring the equipment and raw materials needed to set up this establishment. In order to ensure adequate training for the children, it even gave a contract lasting rather more than a year to a German lady instructor whose task was to teach them to spin fine thread. Little by little, the manufactory fell into shape with the hiring of the requisite staff to ensure it functioned properly: in 1777, among others, the workshops had a master craftsman in woollen manufacture, a master wool-carder and a woman expert in combing wool³⁶. This initial foundation was just the first of several with similar aims, although external apprenticeships never disappeared, since the workshops could not absorb all the children housed in the centre. This

32 It was fairly common practice across Europe at this time. See Vidal Galache, F. and Vidal Galache, B., *Bordes y bastardos. Una historia de la inclusa de Madrid* (Madrid 1995), pp. 137 et seqq.; Fauve-Chamoux, A., "Changing Politics towards Abandoned Children at the end of the Ancien Régime and the Responsibility of a French Hospital Administration on Infant Mortality", in *World History Congress* (Session: The Role of Purposive Behavior in Mortality Reduction) (Oslo 2000) (www.h-net.org/~demog/mortpap/fauve_changl.doc), p. 10.

33 The sending of foundlings to public primary schools was also common in Saint James of Compostella or Valladolid. On occasions there was resistance from the schoolmasters, relating primarily to financial questions, since the centres did not pay any emoluments to the teachers. García Guerra, D., *El Hospital Real de Santiago (1499–1804)* (Corunna 1983), p. 355; Bartolomé Martínez, B., "La crianza y educación de los expósitos en España entre la Ilustración y el Romanticismo (1790–1835)", *Historia de la Educación*, 10 (1991), pp. 33–62, pp. 58–59.

34 Rodríguez González, A., "La utilidad del abandono: la expóstitas del hospital de Santa Cruz y el servicio doméstico en Toledo en la segunda mitad del siglo XVIII", in Irigoyen López, A. and Pérez Ortiz, A. L. eds., *Familia, transmisión y perpetuación (siglos XVI–XIX)* (Murcia 2002), pp. 75–89, p. 77.

35 Negrín Fajardo, O., "El niño expósito en el Despotismo...", pp. 53–54.

36 A.D.P.L. *Libros de cuentas del Arca de Misericordia*. [Poor Fund Account Books] Box 218.

traditional route was used more often as the numbers of children in the institution rose and mortality rates fell.

The Hospice founded by Bishop Cuadrillero in the 1790s was the continuer of the work started by the Poor Fund. The new centre even went beyond its predecessor, offering a type of aid that was novel to the City of Leon. This was the provision of vocational training, and even some basic general education, to a group of children who were older than the usual foundlings and fosterlings and who had hitherto had no direct relation with the establishment: these were the hospice children. Although, strictly speaking, this term could have been used to describe the whole infant population dependent on the Hospice and Poor Fund, here it will be restricted to meaning this new group who were helped by their charitable action. This is not a mere whim, as the administrators of the centre themselves used such a division in their registers. So, taking into account their differing origins, this study differentiates between hospice children and foundlings who survived being wet-nursed, even though eventually both groups merged into the same status, enjoying similar attention and services.

Putting the Young People into Work

In analysing the incorporation of the children from the centres in the City of Leon into society, no chronological divisions have been made, as cases of this sort are concentrated into the period starting in the mid-eighteenth century. Prior to this, almost all the youngsters who survived past weaning were handed over to be adopted. Hence, they fall outside the boundaries of this study, as their links with the institution were definitively broken, and so also any reference to their later journey through life. It is evident that this approach taken by the Poor Fund was not ideal, but it is equally clear that the adoption route was the only one possible for the protection of a minor who otherwise would be most likely to end up a beggar. For this reason, it is easy to share the view of Larquie, who states that it would be wrong to take excessive pity on them as “victims” when treated in this way³⁷.

It is an extremely complex matter to undertake a study of how the children were brought into society, because of the major confusions in the data provided by the sources. These are excessively prolix in respect of some irrelevant items of information, but often very sparse in data that would seem fundamental. Thus, a considerable percentage of entries are to be found in which it is known that the child started a course of instruction, but there is no reliable indication that this learning was successfully completed. This large grouping is brought together in the

³⁷ See Larquie, C., “La crianza de los niños madrileños abandonados en el siglo XVIII”, *Anales del Instituto de Estudios Madrileños* (1986), pp. 363–384.

statistics provided here under the generic heading of “lost” (Graphs 1 and 2). The grouping includes those individuals whose register entry ends with laconic expressions on the lines of “went away”, “left care”, “became independent”, “departed”, or “nothing further known”. In all these cases, it would be very complicated to try to tease out the shade of meaning lying behind such wordings, so that any attempt at further analysis would be highly problematic, not implying any real advance in the investigation.

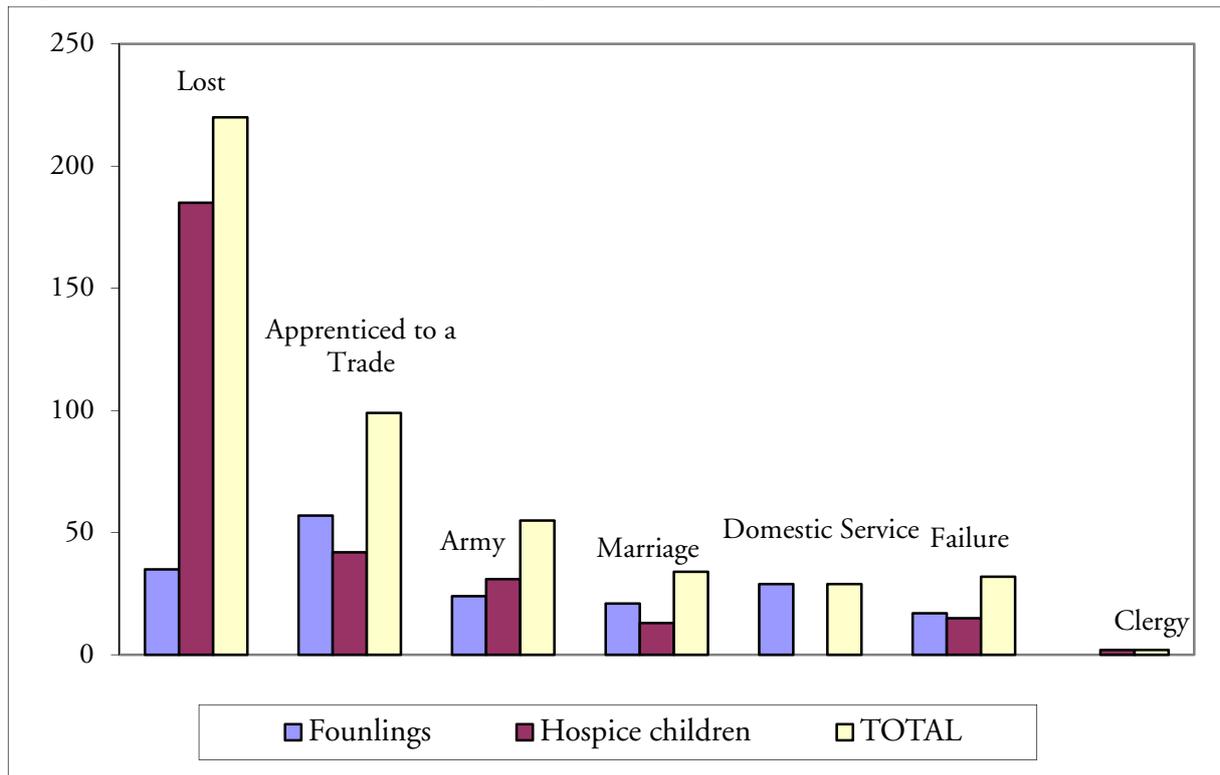
Another aspect constituting an obstacle to analysis is the relative frequency, especially for girls, of entering and leaving the institution. This circumstance doubtless made it difficult for the administrators to keep track, particularly when the young person decided unilaterally to leave the protection provided by the charity. Moreover, among boys there are also a large number of entries in which there is a change in the kind of instruction being provided, which makes follow-up harder. A few examples of this might be useful. In 1821 a young hospice boy from the establishment was sent out to learn the trade of cauldron-maker, but on returning to the centre was despatched again to be apprentice to a weaver. On 21 May 1839 another lad was sent off to train as a chair-maker, but a while later he was redirected to being a house-servant. In the light of these major variations, the statistics drawn up have taken account only of the closing item in the entry, in other words the last reference included in it.

After these caveats, necessary for a correct understanding of the data presented, analysis can begin. In it, the appropriate differentiation by sexes has been observed, in the light of the differing roles that males and females were assigned by the society of the period. Likewise, although an overall view is also offered, it seemed preferable to maintain the already mentioned internal differentiation between hospice children and foundlings. In total 846 records were studied, 471 relating to boys and 375 to girls³⁸. Girls are numerically prevalent among the foundlings, while boys are commoner among the hospice children. For males, this result corresponds to the logic of the day, since boys were more often handed over to this service than were girls. With regard to foundlings, the slight female predominance may be an outcome of the greater tendency of males to break off their link with the charity at an early stage, a behaviour pattern much less frequent among females, in view of the control exercised over them by institutions.

To begin with an analysis of the boys, what has already been indicated about the high percentage of “lost” cases should immediately be stressed, since they come to 46.7% of the total (figure 1). This result is clearly affected by the figures relating to hospice children, where 64.2% of the entries have no information on final destiny,

38 Those entries relating to foundlings and hospice children who died as adults without having left the institution have been omitted.

Figure 1. Final outcome for surviving boys from the Leon centres, 1700–1830.



as against 19.1% among foundlings. The origin of these striking differences must be related to the different ages at entry of the members of the two groups. It should be taken into account that the average age at which hospice children came into the charity’s care was 10.4 years, although a significant number were older than that on first entry. If it is remembered that the transition from childhood to adult status was much more abrupt in the society of those days, it is highly likely that this considerable number of “lost” hospice children is a consequence of their own course through life, which encouraged them to break their link with the institution when they no longer considered it useful for their interests. In fact, in many of these cases the entry ends with a succinct “nothing more known”.

Alongside this considerable number of lads for whom the reason for their break with the centre is unknown, there are two training routes that were most frequent: an apprenticeship to learn a trade and joining the armed forces. For the first of these routes the percentage of foundlings was much higher than for hospice children (31.1% versus 14.6%). However, the results for this group are strongly affected by the considerable number classed under the heading of “lost”. For some of these it is known that before breaking their link with the institution they had undergone some training by a master craftsman, although it is not certain whether this was completed or broken off unilaterally before completion. If these “lost” or “missing” cases are excluded, the percentages for foundlings and hospice children are very similar. In both groups, being apprenticed to a trade was the chief route (38.5% of the first group, 40% of the second). Within the range of trades, the

textile sector is predominant: most of the boys were entrusted to a tailor, a weaver, or a haberdasher. Less frequent were the trades of carpenter, blacksmith, locksmith, confectioner or dyer, among others. As well as apprenticeship to craftsmen in the city, the documents also reflect the presence of a very small number of boys who succeeded in training for professions that were more specialized, and thus of greater social prestige: silversmiths, clergy or surgeons.

This sort of instruction for boys did not first arise in the eighteenth century, although it is true that that was the period when it became general. The most immediate predecessor to the practice, developed particularly by the Poor Fund, is to be found in the Doctrinal School. This institution, at least during the seventeenth century, acted in a similar way. Formal documents for the agreement always followed the model recorded in the Municipal Minutes for 21 May 1699. On that day the City Council of Leon promised to pay Domingo de Valdés, weaver, 150 *reals* to teach his trade to a boy from the school. Payment was to be made in two instalments, one at the start of the apprenticeship, the other at the end³⁹.

In the case of those hospice children whose parentage was known, the period of training implied no outlay at all by their family. As a counterpart, any profit from the children's work was assigned to the institution, completely at first and partially later, in that the charity might assign them some small gratuity as a stimulus. In March 1822, when a lad was sent to train as a haberdasher for two years, it was indicated that for that time he would have no right to request any recompense for his work, even though others in the same establishment were paid, but that he would be entitled to be lodged, fed and clothed exactly like any member of the household⁴⁰. Some of these youngsters who completed their professional training ended up by working as master craftsmen in the institution that had arranged their apprenticeships. This was the case for the master weaver and master haberdasher that the Poor Fund was employing in 1801⁴¹. Others managed to find work away from Leon. This happened to a foundling supported by the Poor Fund, Antonio by name, who in January 1803 had obtained a certificate of examination as blacksmith and locksmith, for which success the institution paid him a gratuity of 66 *reals*. He stated that he had been speaking with the Council of Barcial del Barco, in the Benavente district about working as a blacksmith in that village under a contract that he expected to be signing with them in the following March. There were others: another foundling, Tomás Pareja, had left Leon at the age of 17 to continue an apprenticeship as guitar-maker with the master craftsman Don José Nieto, living in Montserrat Street in Madrid. The institution awarded him 40 *reals* towards the

39 A.M.L., Box 63.

40 A.H.P.L. *Libros registro de entradas del Hospicio de León*. [Entry Registers for the Leon Hospice]

41 A.H.P.L., *Sanidad y Beneficencia* [Health and Welfare], Box 339.

costs of the journey. Naturally, there was control by the institutions over the work carried out by these master craftsmen taking on apprentices, to avoid possible fraud. In April 1837 a foundling called Toribio was ordered back by the Leon Hospice from the house of the cobbler Miguel Sánchez, nicknamed “pot-head”, because the latter had not taught the boy the trade in question, but had used him to look after his pigs and to serve his paying guests⁴².

The second option was to serve the King in the Army. This route took a larger number of hospice children than foundlings, perhaps because episodes of warfare were more frequent in the first third of the nineteenth century. In any case, whether in the Peninsular War, in the invasion by the “hundred thousand sons of Saint Louis” sent by the French King to enable King Ferdinand to overturn his own liberal government, or in the Carlist Wars of succession, this did not imply obligatory mobilization for the lads, since on most occasions it was recorded that the decision to join up was voluntary. This was the case of a foundling called Dionisio who, at 17 years of age, and with a background of being rather unruly, joined the Twelfth Infantry Regiment on 28 July 1841 as a musician. After six years of service, he returned to the Hospice, but went back into the army a year later, as a substitute for Florencio Núñez, who had been selected as one of the conscripts for the town of Sahagún for 1848, a total of 5,000 *reals* being paid by Núñez for this substitution relieving him of the need to serve. Indeed, such a step of acting as a replacement for somebody who had been chosen as a conscript, with money being paid for this service, is quite frequent among the foundlings. The charity continued to exercise a monitoring role over the young man concerned until he was discharged from service to the Crown.

After these two occupational choices, marriage was the third most frequent way of becoming independent from the Hospice, involving 7.2% of the overall figures, 13.5% if the “missing” are left out of consideration. Evidently, the fact that the celebration of this ceremony brings the record to a close in no sense implies that it was the true cause of the ending of the link. It is logical to think that when a young fellow took this decision he would have the security of a job behind him and that this simply is not noted in the documents. The fourth most common outlet was domestic service, amounting to 6.2% of the total, 11.6% if inconclusive entries are omitted. However, this occupation appears only in the case of foundlings, perhaps because there was not an adequate infrastructure to absorb all those looking for an education. Besides, as a feature related to these deficiencies, it is possible that the fact that hospice children entered the charity’s care expressly with the aim of their obtaining suitable training meant that they got priority over the foundlings in assignments to a destination. These young servants were usually entrusted to a master without being given any pay at all while they were being trained, but might

42 A.H.P.L. *Libros registro de entradas del Hospicio de León*.

receive emoluments thereafter. In April 1843 Don Juan Antonio Prieto, resident at Herrín de Campos, had entrusted to him a foundling called Crisanto, on condition that he merely gave him board, lodging and clothing for the moment, but that when the boy reached the age of 17 years he would also have to pay him the wages he merited in accordance with the practice of the area⁴³.

In a few other instances, merely anecdotal in terms of their percentage impact, the ending of the link with the centre was related to a very late recognition of the parentage of the child. Finally, details show that in at least 12.7% of the cases in which the final outcome is noted in the record, the institutions failed in their programme for training, either because children ran away or because the centre found itself obliged to expel them for inappropriate behaviour. The impact of such failures was somewhat more evident among hospice children, where it reached 14.6% as against the 11.5% among foundlings. These differences, not in any case very considerable, may be linked to the greater independence of the former, who came into contact with the centres rather later. Besides, hospice children often might benefit from some family assistance that would serve as a bridge to breaking free, a type of help that foundlings lacked. It should be kept in mind, nonetheless, that this level of failures might be higher if all the required information were available for the large group of “missing”.

On some occasions the registers reflect the cause leading the administrators to expel a boy. In 1804 two of them were thrown out for petty theft. Three years later, a hospice child called Isidro Palacios was expelled for the same reason. Moreover, this case is a perfect example of the level of rebelliousness with which some of these lads reacted to the authority wielded by the centre, despite its repeated attempts to re-educate them. Young Palacios was only eight when expelled and had spent nine months in the centre’s care. When his mother passed away some time later, the institution re-admitted him, but he was involved thereafter in several escapes which ended up with his being put in prison, after which he went off to Zamora leaving no further trace⁴⁴. On other occasions, the punishments imposed were less severe, with the administration confiscating the boys’ money, so that any temptation to spend it on inappropriate vices would be removed.

Absconding was another instance of the way that some of the inmates resisted the rules set for the internal life of the Hospice⁴⁵. At other times, this may be seen as a reaction to the temporary loss of the links uniting them with their family surroundings, whether birth family or paid replacements. The youngsters in the centre were subjected to an iron discipline, hard to bear at their age, especially for

43 A.H.P.L. *Libros registro de entradas del Hospicio de León*.

44 A.H.P.L. *Libros registro de entradas del Hospicio de León*.

45 In the establishment in Zamora, it would seem that the rigorous discipline and harsh punishments were the cause of quite a few absconding. Galicia Pinto, M. I., *La Real Casa Hospicio de Zamora*, p. 119.

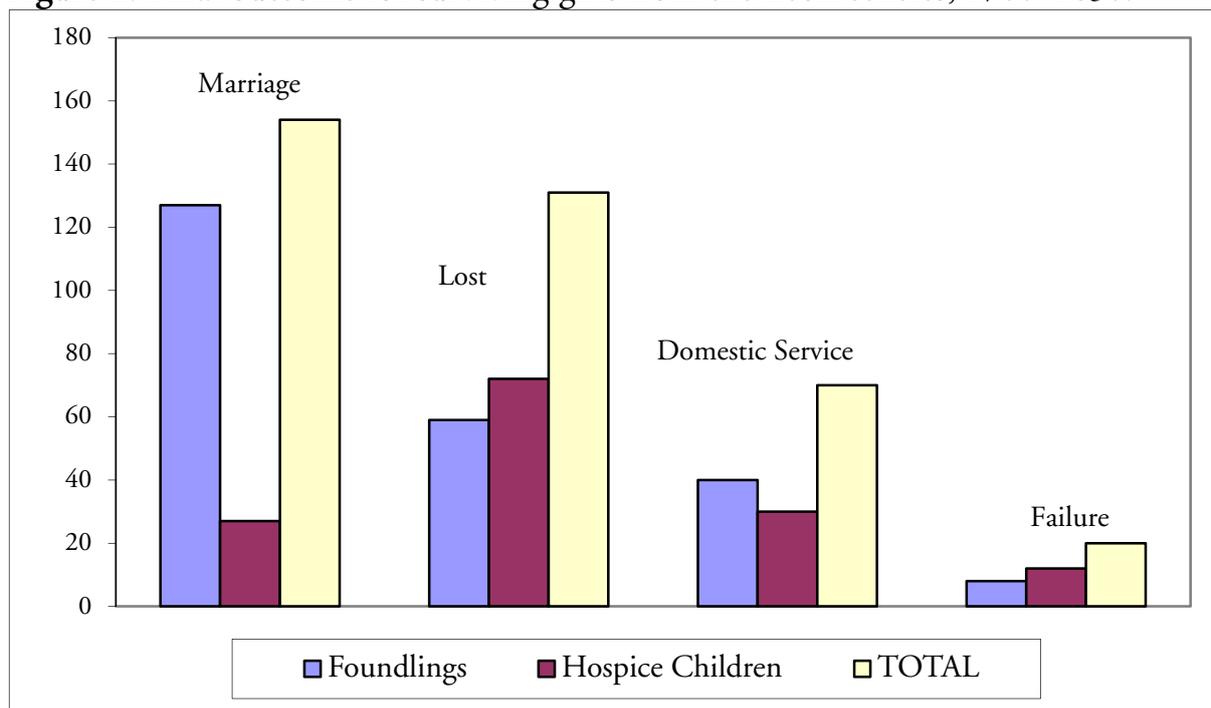
the more restless spirits. Without a scrupulous application of rigid and restrictive rules it would have been very difficult to keep the establishment under control, but on the other hand these could become excessively oppressive for many of those sheltered there. The statistics count exclusively those cases in which the escape brought the final break-away of the boy from the centre. However, on other occasions those responsible for the Hospice succeeded in getting the absconder back, calling for this purpose on the invaluable assistance of the civil authorities.

To move on to an analysis of the girls, it may be observed that the percentage of “lost” is noticeably lower than among the boys (41.1%), with a higher figure among the hospice children (51.1%) than among the foundling girls (25.2%), as was also the proportion in the male group (figure 2). For this reason, the explanation suggested in that case may serve here too. In their case, there is a smaller range of vocational outlets, which corresponds to the secondary part played by women in the society of the time. Among those girls whose final destination is known, the commonest outcome was a wedding, which represented 63.1% of the total, “missing” cases excluded. The major role of marriage as the final breaking off of links between a girl and the charity is closely related to the responsibility the administrators took upon themselves to protect the honour of girls in their care. Moreover, while in the case of males a wedding was not really a “vocational outlet”, for girls it can be seen as such, being the preferred destiny allotted to them by the ruling Catholic moral standard. In fact, the charities had a certain amount of money set aside to provide dowries. In 1833 the hospice assigned as dowry 320 *reals* to a foundling called Gertrudis, then aged 31, so she could marry a certain Manuel Baldeón in the parish of Saint Marina⁴⁶. To receive the money, this woman had to produce after the ceremony a certificate from the parish priest, while her husband had to sign the appropriate receipt. This is by no means the only instance, as there are similar records right through the eighteenth century, both from the Poor Fund and from the Hospice. Marriage between inmates was also not infrequent. This is what happened in September 1838, with the wedding between Lope Blanco and María García or that celebrated in May of 1848 between the foundlings Ceferino Blanco and Regina. their origin, began to work as servants at the age of about 15 years⁴⁷. If it is kept in mind that they married at 26 on average and that hospice girls entered the institution at about 11 years old, it is obvious that the time females spent as inmates was longer than that for males, for the moral and social reasons already mentioned. As noted above, going out to work did not involve a total break

46 In 1836 another woman was given 160 *reals* for this purpose, in 1850 another received 280 and in 1862 a third 550. A.H.P.L. *Libros registro de entradas del Hospicio de León*.

47 This was slightly older than girls in the Toledo institution in the second half of the eighteenth century, for whom the average was 13.5 years. Rodríguez González, A. “La utilidad del abandono...” p. 87.

Figure 2. Final outcome for surviving girls from the Leon centres, 1700–1830.



with the charity, since it continued to have a guardianship role in respect of these females⁴⁸. Besides, the time spent as a servant in any one private household was usually short, with stays under twelve months in length being predominant, and returns to the institution to wait for a new assignment frequent⁴⁹. During such waiting intervals, the administrators, in order to draw some benefit from this inactive workforce, could use the girls for the completion of specific tasks, whether within the centre (caring for foundlings, tending the garden, working in the kitchen, and the like) or to give temporary help to some neighbour. From time to time, also, girls with particular gifts for learning might end up by becoming part of the staff of the centre. This happened in respect of the assistant to the girls' schoolmistress in the Hospice in 1801. It also occurred in the case of a foundling girls called Valeriana, who spent a long time in domestic service, but in March 1840, when aged 22, was taken on to teach the girls in the centre, with wages of 15 *reals*.

Overall, absconding and expelled girls represented a lower percentage than among the males, at 8.2%. However, while for the foundlings as a group the figures are lower than for boys, for hospice girls they are slightly higher, the figures for girls expelled contributing decisively to this. Perhaps the long time-span of dependence and the iron control to which they were all subjected may have triggered a reaction

⁴⁸ Costa, M., "Pauperismo y educación femenina en Barcelona", *Pedralbes*, 23, 2003, pp. 399–423, p. 416.

⁴⁹ In Toledo it appears that increases in wages were what influenced changes of job. In Leon the files do not record this information. Rodríguez González, A. "La utilidad del abandono... p. 81.

of rebelliousness. Quite often, escapes by girls occurred when they took advantage of being in a private house where they were working as servants.

For their part, behind the majority of expulsions lay reasons of a moral nature, perhaps more clearly so than when boys were expelled, for obvious reasons. This was the case for the foundling who was sent to the household of Don José Blanco Chicarro as a servant in April 1822, of whom it was learnt two months later that she had run off from her job, and that while there she had led a “wicked” life, for which cause she was expelled. This does not imply there were not also instances of expulsions related to discipline, as happened to a girl who was punished in this way in October 1838 for being disrespectful, or to another, called Micaela Sánchez, who was involved in a fierce altercation with the schoolmistress⁵⁰.

In any case, the greater part of the females, like the males, ended by becoming fully integrated into society, while some of them even came to enjoy a relatively comfortable financial position. Among this group was Manuela Melchora García, a foundling who, despite remaining unmarried, had come to run a modest business selling clothing and footwear. In 1833, when she died, she bequeathed the stock of her shop to a good number of people of very varied social classes and named the Hospice residual legatee of the remainder of her property. This action bears witness to her gratitude to the centre that had brought her up and given her a helping hand at the most difficult points in her life⁵¹.

Internal Training: Workshops, General Education and Religion

Information about the vocational and general educational instruction given to the children in the care of the Poor Fund is very limited. All that is available are a few unconnected details that very sketchily outline what was done. It is known that those children who came back from being raised and weaned outside were given within the centre a rudimentary general and religious education while waiting there to start working in a job. In this way, the authorities running the Poor Fund, following the trends of the period, attempted to keep this marginalized group away from another form of social exclusion: intellectual poverty⁵². The data also appear to show training differentiated by sex: while girls were educated within the institution by an internal schoolmistress, boys were sent out to the classes given in the City’s public school, the connection with the Doctrinal School being evident

50 A.H.P.L., *Libros registro de entradas del Hospicio de León*.

51 A.H.P.L., *Sanidad y Beneficencia*, Box 339.

52 Moratinos Iglesias, J., *Historia de la Educación en Alicante desde el siglo XVIII hasta comienzos del siglo XIX*, Alicante 1986, p. 23.

once again⁵³. This separation was a reflection of the typical characteristics of the educational system of the day, which gave each sex a very specific role. Both males and females were given suitable religious instruction until they reached 14, this being an aspect considered fundamental at the period. As well as this, they learnt to read and write, while the girls were also instructed in how to do housework, so that they could help meet the needs of the centre⁵⁴ while preparing themselves for domestic service. For this reason, it is highly likely that the intensity of teaching of reading and writing was greater for boys than for girls⁵⁵.

A further objective adopted by the charity, besides offering basic instruction in reading and writing, was to give inmates the chance of getting recognized vocational training. In the case of boys, the fundamental aim was for them to acquire the skills to exercise some form of trade or craft⁵⁶. With this in mind, as has already been pointed out, until the 1770s they were handed over to master craftsmen in the City. From then onwards, the new financial situation enjoyed by the Poor Fund allowed it to act more directly in this task. For this purpose, it set up a small textile manufactory, which as time went by grew in size. This was a solution very much like what was done at this period by other centres of the same characteristics⁵⁷. The founding of this workshop did not, in any case, imply a definitive end to all training outside the institution, since its size did not permit it to absorb all of the inmates⁵⁸.

The two areas of education in which the Poor Fund involved itself were the same as the City's Hospice developed from the moment it was founded. The

53 The pattern of training for girls was very similar to what was done in Madrid. The main difference between the two cases is that, while in Leon training took place inside the centre, in the capital city girls were sent to the school of Our Lady of Peace as soon as they reached the age for apprenticeship. Vidal Galache, B. and Vidal Galache, F., "El colegio de Nuestra Señora de la Paz para niñas 'expuestas' de Madrid a mediados del siglo XVIII", *Anales del Instituto de Estudios Madrileños*, 30 (1991), pp. 191–208.

54 Sherwood, Joan, "El niño expósito, cifras de mortalidad en una inclusa del siglo XVIII", *Anales del Instituto de Estudios Madrileños*, 1981, 18, pp. 299–312.

55 See Viñao Frago, A., "Alfabetización, lectura y escritura en el Antiguo Régimen", en Escolano, A., *Leer y escribir en España. Doscientos años de alfabetización* (Madrid 1992), pp. 45–68, p. 51.

56 This is what happened in the Lisbon Children's Home as well, although in the Portuguese institution, created in 1780, the youngsters were offered a chance of going on to higher levels of study, whether at university or as military cadets. Fonte, T. A. da, *No limiar da honra e da pobreza. A infância desvalida e abandonada no Alto Minho (1698–1924)* (Vila Praia da Âncora 2005), p. 540.

57 Vid. Carreras Panchón, A., *El problema del niño expósito...*, p. 67; Cava López, M^a.G., *Infancia y sociedad en la Alta Extremadura durante el Antiguo Régimen*, Cáceres 2000, p. 157; Galicia Pinto, M. I., *La Real Casa Hospicio de Zamora...*, pp. 114–115.

58 The Zamora hospice also combined internal training with external and this was done by the Leon Hospice itself at a later stage. Galicia Pinto, M. I., *La Real Casa Hospicio de Zamora*, p. 114.

Enlightenment Bishop of Leon, Don Cayetano Cuadrillero, wished to apply in the centre he set up the utilitarian mentality that was so fashionable in reformist circles. The prelate paid at his own expense for the machinery and the master craftsmen needed for the creation of workshops intended to manufacture woollen cloth. Later on, taking advantage of the closure of the Royal Manufactory of Saint Ildefonso, six master craftsmen who had belonged to that establishment were taken on by the centre, which led the Bishop and the authorities of the charity to expand production into cotton cloth as well. This attempt was a resounding failure, on the one hand because of the high cost of raw materials, and on the other because of competition from foreign products, cheaper and considerably more stylish. In consequence, the cotton workshops finally closed, only the woollen manufactory remaining open. Moreover, even this was not always financially viable, although profits were not the sole aim of those responsible, since the training activity carried out in the workshops was as important as making money.

Not all the inmates were involved in these textile workshops, since others worked on maintaining the buildings and installations, while girls were given the domestic tasks of the centre to do⁵⁹. Additionally, although the manufacture of cloth was the most important activity carried out in the establishment, at certain times there were also workshops for tailoring, carpentry and shoe-making. These were intended to give the centre some degree of self-sufficiency, as well as to encourage a work ethic and to diversify the sorts of training on offer.

Final Conclusions

This study of the three charitable institutions in the Leon of the Modern Period (the Poor Fund, the Doctrinal School and the Hospice) has provided an insight into the inner workings of a question that was latent in the society of the day: the matter of assistance for poor or abandoned children. The three centres, managed by different institutions and with life-spans that also differed, undertook the work of protecting children in very similar ways in so far as their aims relating to educational and vocational training were concerned. All three stressed the importance of religious education, the teaching of basic reading and writing, and, above all, training for a trade, seen as the principal way to ensure a decent future for those in their care, although they did so with a marked differentiation by sex.

The concept of training as an objective for assistance is already glimpsed at in the sixteenth century when the Doctrinal School was established. Nevertheless, it was not until the eighteenth century that this objective acquired any significant dimensions, expressed in the form of the Poor Fund and the Hospice. This

59 A.H.P.L., *Sanidad y Beneficencia*, Box 339.

development was based on the financial solvency of the two centres and the appearance of the utilitarian views championed by the Bourbon dynasty.

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Women, Families and Social Welfare in Spain from the 18th Century to the Present

Juan Gracia Cárcamo

Introduction

Most historians coincide when they emphasize that a *Welfare State* (WS) has only existed in Spain since 1978, after the end of Franco's dictatorship. A modern WS was established very rapidly in Spain. A significant group of Spanish politicians hoped to imitate a WS model when the triumph of neo-conservatism and neo-liberalism in the western world made people question the convenience of the WS itself. In spite of the governments' efforts to consolidate the WS between 1978 and 1993, the experts (and public opinion) in Spain were then assuring that a large part of *Social Welfare* (SW) came from families. This explained, for example, that Spain was able to support high unemployment rates (22% in 1993) with insufficient aid from the State. These views have been shared by authors who differed greatly when considering the need for the WS¹. In any case, they also agreed that when *families* are referred to, this means that this task was taken on by women.

This text is an interpretive essay which studies a long-term historical social problem based on a recent historiography. Its analysis is, above all, qualitative and even more so with regards to the period before 1940, for there are still no full statistics on the evolution of Public Social Expenditure (in spite of very recent valuable contributions)²; as far as I know, there is none on *invisible* family contributions in national accounts. Although they are implicitly present, theoretical questions are not dealt with here. Examples of these are about whether it would be better to talk about WS *regimes* or *systems* before talking about WS, if the WS is one of the great

1 I. e., Pérez, V., "Sistema de Bienestar, familia y una estrategia liberal-comunitaria" in Fernández, J. M. et al., *Las estructuras del bienestar en Europa* (Madrid, 2000), 745–760; Navarro, V., *Bienestar insuficiente, democracia incompleta* (Barcelona, 2002). It has been written so much about this subject in contemporary Spanish historiography that bibliographical references have been reduced as much as possible.

2 Comín, F., "Sector público administrativo y Estado del bienestar", in Carreras, C. et al., *Estadísticas históricas de España: siglo XIX – XX* (2005), 873–964.

contributions that are impossible to eliminate from the European civilization, if it is of any use to talk about the *WS* “models”, whether a fourth southern European model³ should be added to the three known models of some author,⁴ if *familism* is characteristic of some European societies, etc.⁵

This text criticizes revisionist interpretations of Spanish history made in the last few years which contradict what documentary evidence from the past confirms. In assumption that Spain was supposedly the “eighth” industrial country in the developed world in the beginning of 21st century, these interpretations stated that its historical trajectory in the last two centuries was *normal* in Europe. My approach is based on the fact that this would only be true if the Continent were only reduced to its outlying countries, and even more to its southern area. Finally, asserting that families were historically the main social protection resource to poverty has been very well-known in historiography, at least for several decades.⁶ However, as far as I know, no study has been printed in Spanish historiography analyzing this subject in the long term⁷. The only modest aim of this text is to show a genealogy of that process.

The Unsuccessful Attempts to Reform Traditional Charity in the 18th Century

Spanish Governments had been introducing these reforms particularly after 1766. In that year, there were significant popular revolts as a result of high food prices, among other reasons. Some optimistic versions of the Enlightenment were confident that poverty would easily come to an end, because the main problem was that a large part of the Spanish population was unemployed. Everything would change if

3 Ferrara, M., “Los Estados del bienestar del Sur en la Europa social” in Sebastiá, S. et al., *El Estado del bienestar en la Europa del Sur* (Madrid, 1995), 85–111.

4 Esping-Andersen, G., *The three worlds of welfare* (Cambridge, 1990).

5 Saraceno, C.: “Familiarismo ambivalente y clientelismo categórico en el Estado de bienestar italiano” in Sarasa, S. et al., *El Estado del bienestar en la Europa del Sur* (Madrid, 1995), 261–288; Ibidem, *Mutamenti della famiglia e politiche sociali in Italia*, Bologna, 1998; Castel, R., *From Manual Workers to Wage Workers* (New Brunswick, 2002).

6 Laslett, P., “Family, kinship and collectivity as systems of support in pre-industrial Europe: a consideration of the nuclear-hardship hypothesis”, *Continuity and Change*, 3, 2 (1988), 153–175; Thomson, D.: “La protección social y los historiadores” in Bonfield, L. et al., *El mundo que hemos ganado: estudios sobre población y estructura social* (Madrid, 1990), 437–466.

7 This text is to a large extent the result of my point of view about ideas discussed with professors P. Carasa and M. Carbonell during some joint research a few years ago. I am in debt with these professors who know much more than me about this topic; cf. Carasa, P., Carbonell, M., Gracia, J., “Family Strategies, Gender and the Use of Public Services to Secure Well-being in Spain, 18th–20th centuries”, Third Symposium of COST Action A34, 2007 http://www.ub.edu/tig/GWBNet/BcnPapers/Carasa_Carbonell_Gracia_2007.pdf.

that population began to work. Apart from *SW*, there were laws concerning the “traditional” social problem in the *Old Regime* –the dangerous paupers, such as, for example, tramps.⁸ Inevitably, a solution was to force them to join the army. Governments boosted the creation of poorhouses to “correct” other paupers. In this case, teaching children and professional education for youths were stressed. Obviously, these punitive measures were insufficient. More work for women was also promoted, albeit for it to be done in their homes.⁹

We shall not discuss the traditional charity in the *Old Regime*, but it was clearly insufficient for attending to people in need.¹⁰ Also, the idea that the artisan guilds, religious brotherhoods, Catholic Church, etc. gave significant contributions to *SW* is wrong; that idea came from 19th century anti-liberal essayists who defended an idealized vision of the *Old Regime* which really only existed in their imagination.¹¹

What is true is that governments of the end of the 18th century promoted Home Welfare in cities, at the expense of the town councils. This meant giving aid to families, and therefore women in them were those who were in charge of managing it. The inexistence of a “real” State (in a contemporary sense) during the *Old Regime* had made the town councils traditionally take charge of helping poor “respectable” families. Whether these social services were public, at least in a current sense of the “public” concept, is debatable.¹² Also, the aid provided by the town halls did not always come from taxes or other public resources, but, in many cases, it came from donations, testamentary legacies... offered by the urban elite classes, or from charitable collections promoted (and managed) by those elite classes. This model of municipal home charity continued in the 19th century, and even a long time afterwards. For centuries the importance of the authorities created in the 18th century stood out in the city neighbourhoods (“mayors and neighbourhood messengers”) for informing the town halls of poor people’s needs.

Obviously a large number of the people who received social aid were women, but it does not make sense to emphasize a “feminization of poverty”, for it is a topic

8 Castel, R., *Les métamorphoses de la question sociale: une chronique du salariat* (Paris, 2000).

9 Carbonell, M., “Trabajo femenino y economías familiares”, in Morant, I., ed., *Historia de las mujeres en España y América Latina* (Madrid, 2005), pp. 237–262.

10 Marcos, A., “La Iglesia y la beneficencia en la Corona de Castilla durante la época moderna: mitos y realidades” in Abreu, L., *Igreja, caridade e assistência na Península Ibérica* (s. XVI–XVIII) (Evora, 2004), 97–131.

11 Gómez, F., “Problemas sociales y conservadurismo político durante el siglo XIX”, *Historia contemporánea*, 29 (2004), 591–624.

12 Carasa, P., “Lo privado y lo público en el sistema asistencial” in Abreu, L., ed., *op. cit.*, (Bilbao, 2007), pp. 141–172; Ibidem: “De la cultura de la protección a la cultura de la previsión”, in Castillo, S. ; Ruzafa, R., eds., *La previsión social en la Historia* (Madrid, 2009), pp. 35–66.

well-known by all historians.¹³ It is also well-known that some family models gave more protection than others: in Spain, the most protective families (the large ones) were located especially in areas near the Cantabrian Sea and the Pyrenees. There were family strategies which prevented poverty and which were well-known in the Atlantic European countries (putting back the age to get married, a high percentage of women who finally remained single, etc.). On the other hand, it is interesting to see that almost 10% of the “Aid Associations” in Madrid were exclusively made up of women during the 18th century.¹⁴ Although the geographic area was different, the 1904 official statistics (not too exact, on the other hand) showed only 2.4% of *Spanish Mutual Aid Societies* (similar to *Friendly Societies*) made up by women.

It would make no sense to exaggerate the importance of Social Aid in the Old Regime compared to the self-help developed by the families or persons themselves to achieve their well-being. In this way, in the face of a traditional historiography that pointed out the charity foundations that provided single youths with dowries for them to be able to get married, some urban study points out that scarcely 9% of the young women had access to them in the 18th century; faced with this, 70% of the working women in that city were servants whose major objective was to obtain a dowry to be able to get married.¹⁵

The 19th Century: from a State’s Non-Intervention to the Beginning of a Social Reform

We still do not quite know how *SW* was set up (or should we say, the lack of it?) after the Liberal Revolution before the end of the 19th century,¹⁶ in spite of some valuable regional studies.¹⁷ Although a recent revisionist historiography affirms the opposite, what does seem to be clear is that, in Spain (in comparison with the west European countries which went through a very significant early industrialization), there were no great problems of modern poverty in cities until the final decades of the 19th century. This would be due to the scant industrial development, except in

13 Carbonell, M., *Sobreviure a Barcelona: dones, pobresa i assistència al segle XVIII* (Barcelona, 1997).

14 Sánchez, E.: “Solidaridad popular femenina: las hermandades de socorro de mujeres en el Madrid del siglo XVIII” in Pérez Cantó, P. et al., *Autoras y protagonistas* (Madrid, 2000), 257–268.

15 Rial, S.: “Solas y pobres: las mujeres de la ciudades de Galicia ante la marginalidad y la prostitución”, *Semata*, 16 (2005), 301–332.

16 Esteban, M.: “Pobreza y asistencia social en la España de la Restauración” in Palacio, J. I., ed., *La reforma social en España: en el centenario del Instituto de Reformas Sociales* (Madrid, 2004), 25–37.

17 I. e., Díez, F., *La sociedad desasistida: el sistema benéfico-asistencial en la Valencia del siglo XIX* (Valencia, 1993).

very specific cities and regional centres for periods that were not always long-lasting. This is why an 1849 State survey only dealt with the social condition of farmers and their possibility of obtaining credit.¹⁸ The fact is that the 1848 revolution hardly had any effect on Spain's Social history (although it did affect Intellectual history).

The persistence of the *Old Regime's SW* models was considerable during a large part of the 19th century. Apart from the nationalization of the Church's assets in the First Liberal Revolution and other very specific episodes of the most radical liberalism, an early Agreement (*Concordat*) with the Vatican State in 1851 allowed Catholics to keep their influence, except in very short periods when there were anti-clerical progressive governments (1820–23, 1836–37, 1840–43, 1854–56, 1868–74...).

Until the end of the 19th century, the conservative governments defended the liberal abstention principles of the Minimum State in social problems, and, as in the past, they left the town halls to take care of them. So, statistics from 1856 (also of doubtful reliability),¹⁹ excluding the private charity institutions, showed the following data:

Table 1. Public charity institutions in 1856.

| Charity institutions | Number |
|----------------------|--------|
| State | 7 |
| Provinces | 106 |
| Municipalities | 868 |

Following these statistics, it was more significant that while 170,000 men and women were helped in institutions, there were 714,894 home-help services. Therefore, the predominant public assistance model was to help families so that, within them, dependant persons were attended by women. The help provided through the parishes where the same model for women to take care of poor families should also be taken into account, but this obviously does not appear on printed statistics.

It is very important to remember a process of religious feminization which took place throughout the 19th century. Although it is a feature common to Catholic and Protestant countries, in Spain, as in other Catholic nations, were adopted specific characteristics.²⁰ The gender model for distinguishing women and men in those

18 Palomares, J. M.: "La condición obrera en la España de la Restauración", in Palacio, J. I., *La reforma social en España* (Madrid, 2004), 71–97.

19 Iglesias, C., ed., *Ilustración y proyecto liberal: la lucha contra la pobreza* (Zaragoza, 2001).

20 Arce, R., *Dios, patria y hogar: la construcción social de la mujer española por el catolicismo y las derechas en el primer tercio del siglo XX* (Santander, 2008); Aresti, N., "El ángel del hogar y sus demonios: Ciencia, religión y género en la España del siglo XIX", *Historia contemporánea*, 21 (2000), 363–394; Llona, M., "El feminismo católico en los años veinte y sus antecedentes

nations was based on identifying men with science and modernity. On the other hand, women would be linked with religion and tradition. The general female model of *Angel of the home* would be defined by Catholic stereotypes like from the Catholic Counter-Reformation and *the strong woman* from the Bible.

This separation of private and public spheres did not prevent women of the bourgeoisie and the aristocracy from having a public space to act (v. gr., charity) and they were the *poor visitors*. This was a role reserved for women of the aristocracy and the high bourgeoisie, while their husbands began (or combined) their local or regional political career as well as belonging to the Boards of Directors of the *semi-public* charity institutions.

The Ladies of Charity very early copied the French example: the Saint Vincent de Paul Society existed in Madrid only 12 years after being set up in France. Although it was suppressed in the *progressive six-year period* (1868-74), this mostly female organization was quickly legalized by the conservatives after 1875. Incidentally, the *Associations Act*, only approved after 1887, recorded a considerable increase in Religious Congregations which were specialized in two aspects: Charity and Education. Pointing out that the importance of these Congregations grew after the difficulties the Religious Orders in France went through after the decrees of J. Ferry and other governments at the beginning of the 20th century is a very well-known topic in Spanish historiography. Therefore women were not only on the supply side for charity, but they also acted as special assistants. This was understood as a prolongation of their domestic responsibilities focused on educating their relatives and on taking care of dependent people (children, the sick, the elderly, etc.) in their families. This aspect was generally considered intensified in Southern Europe's *familism* model.²¹

It is assumed that the 1822 General Charities Act was the model for deciding on passing Social Assistance to civilian power following the provisions made in the 1812 Constitution. But that Act gave to *Sisters of Charity* an important role in taking care of paupers.²² The presence of Catholic nuns in public and private charity institutions would grow throughout that century, especially during the *Catholic Revival* after 1876. The number of Spanish nuns estimated at around 11,000

ideológicos”, *Vasconia*, 25 (1998), 283–299; Blasco, I., *Paradojas de la ortodoxia: política de masas y militancia católica femenina en España (1919–1939)* (Zaragoza, 2003); Salomón, M. P., “Laicismo, género y religión: perspectivas historiográficas”, *Ayer*, 61 (2006), 291–308; Moreno, M.: “Mujeres, clericalismo y asociacionismo católico”, in López, A. L. et al., *Clericalismo y asociacionismo católico en España, de la Restauración a la Transición* (Madrid, 2005), 107–131.

21 Saraceno, C., “Familiarismo ambivalente y clientelismo categórico en el Estado de bienestar italiano” in Sarasa, S. et al., *El Estado del bienestar en la Europa del Sur* (Madrid, 1995), 261–288.

22 López, C., “La pobreza en el pensamiento político: España, primera mitad del siglo XIX”, *Historia social*, 13(1992), 139–156.

women in the middle of the 19th century multiplied by four at the beginning of the 20th century.²³

Women also had a crucial role from the demand side for charity by dependent families. In the urban world, the poorest working-class women were not only those who were most in contact with parishes and religious associations asking for help. They were also those who went most to the municipal institutions asking for home help (food, clothing, coal, etc.) or they would act by registering in the register of paupers at their neighbourhood authorities to receive free medical aid.²⁴ Those registers for helping the poor were not widespread in Spain until 1891 when a *fear of revolution* had the conservative leaders concerned, even though they had been approved in a progressive *Health Act* in 1855 which was hardly applied until the end of this century. In fact, a few years before 1890, in the midst of social peace, governments had ignored the request to re-publish the 1873 Republican Act which protected children at work, for, according to the authorities, it was not necessary.

It is a well-known fact that when a certain social legislation began to exist (after the 1890 Berlin Congress), special thought once given to the *weakest workers* (women and children).²⁵ After that, concern for a high child mortality rate led to new Maternity Houses, Nursery Schools, School Holiday Camps and School Dining-rooms being opened in Spain for poor children within a population concern which was customary in many European countries of that period.

Attending to women must also be understood in a very important sphere in SW: Education. Both the contemporaries and the current historians have stressed that one of the most significant aspects of the 1857 Education Act was an accelerated rise in the female literacy rates in the final decades of the 19th century. In 1882, the author of that Act, C. Moyano, emphasized that educating girls had a basic function: it was not intended for them to dedicate themselves to “literary works”, but to be able to take better care of their families in the future.²⁶

The increase in schoolmistresses throughout the 19th century was an exception to the drop in qualifications typical of most female professions. Some schoolmistresses were the ones who understood most the needs of the working-class girls not qualified in public schools: they defended that these girls could join the classes with flexible time-tables to be able to combine their learning and family tasks. The data

23 Lannon, F., *Privilege, persecution, and prophecy: the Catholic Church in Spain, 1875–1975* (Oxford, 1987).

24 Gracia, J., “Pobreza y género en los comienzos de la primera industrialización vasca”, in González Mínguez, C. et al., eds., *Marginación y exclusión social en el País Vasco* (Bilbao, 2000), 125–149.

25 Nielfa, G., “Trabajo, legislación y género en la España contemporánea: los orígenes de la legislación laboral” in Sarasúa, C. et al., *¿Privilegios o eficiencia?* (Alicante, 2003), 39–56.

26 Lacalzada, M. J., “Las mujeres en la “cuestión social” de la Restauración: liberales y católicas (1875–1921)”, *Historia contemporánea*, 29 (2004), 691–718.

available on regular attendance of children at schools are not very reliable²⁷ and the same happens with the data given in the register of the poor to receive medical care; they show similar shortcomings by concealing a reality that was rather unfavourable for a State which was not so concerned about education as by wanting to make out that it supported literacy as much as possible.

That is why it is not safe to trust statistics which tell us about similar figures between boys and girls regarding their compulsory attendance at school at the end of the 19th century. The press at that time and at the beginning of the 20th century clearly showed that girls attended the municipal schools, designed as “schools for the poor”,²⁸ less regularly. They also left their schooling earlier because they had to take care of their younger brothers and sisters when their mothers were working, prepare meals for their relatives, take those meals to their parents and brothers, etc.

Apart from education, other institutions (like Savings Banks) were also involved in Charity in Spain during the 19th century (specifically after the 1880 Act). There were obviously very few unqualified workers who could save due to a low level of their salaries. However, in this case, there was one exception: the young women working in domestic service, which, in some cities, were almost half the savers.²⁹ In fact, at the end of the 19th century and at the beginning of the 20th, the most vulnerable working classes would go to moneylenders and pawnshops to get money. If what the press of that time saw was true, as the ones responsible for looking after the home, women were those who took charge of these problems. It is clear that this last phenomenon cannot be considered within Social Aid, but quite the contrary: as evidence of an absence not so much of *SW* but of an inexistence of proper micro-credit institutions. In cities like Saragossa, Bilbao, etc. where there had been important private banks since the middle of the 19th century, there were no municipal Savings Banks –including Pawnbrokers (*Montes de Piedad*) for the most vulnerable working-class groups³⁰ until the end of the 19th century or the beginning of the 20th. Local bankers-interests were more important than those of the poor families.

The importance of women’s role as Welfare providers in the bosom of families was repeated in the case of contacts with shopkeepers who, sometimes charging much higher prices or selling food products that were not in good condition, accepted the payments deferred by vulnerable workers’ wives, and other similar

27 Borrás, J. M., “Antes de nacer sabíamos trabajar: Absentismo escolar y trabajo infantil en el Madrid rural del primer tercio del siglo XX”, *Historia agraria*, 20 (2000), 169–194.

28 Carasa, P., “Por una historia social de la ciudad” in Serrallonga, J. et al., *La sociedad urbana en la España contemporánea* (Barcelona, 1994), 23–64.

29 Tortella, G., *Los orígenes del capitalismo en España: banca, industria y ferrocarriles en el siglo XIX*. Madrid, 1995; Carbonell, M.: “Género y previsión en la España del siglo XIX”, in Castillo, S; Ruzafa, R., eds., *op. cit.*, 157–170.

30 Carbonell, M., “Microcrédito y economías alternativas: los Montes de Piedad en España”, in Dios, S. et al., *Historia de la propiedad: crédito y garantía* (Salamanca, 2007), 359–374.

practices. The poor people's traditional methods in their effort to live made up for the lack of *SW*, and the most vulnerable families had to rely on undesirable help within a tradition of varied, complex and complementary survival strategies carried out by the most needy.

The fact that some of those strategies, like emigration, had a family, and not only an individual, component is something that has been argued in Spanish historiography.³¹ The tendency of emigrant families from certain areas to occupy nearby houses in certain neighbourhoods was obviously to make up for the same lack of *SW*, and not only at the end of the 19th century and the beginning of the 20th, but also in later times.³² Many ways in which the poor women contributed to what has been called family *micro-solidarity*, compared with social *macro-solidarity* (typical of *WS*), involved considerable inequality for them in comparison with men. This fact inevitably belongs to what tends to be called women's "invisibility" in History, of which there are sometimes references in dubious reliable sources (such as literary sources which, of course, do not *represent* social reality, but they *over-represent* it).

Occasionally resorting to the charity provided by the town halls (combining money from them and collections of money promoted by the elite classes to get donations) was not incompatible with turning to other forms of help, such as home help or medical-pharmaceutical aid, at certain stages of the life cycle or the economic situation. The latter sometimes included up to 40% of the total population in some cities at the end of the 19th century, i.e. many of the unqualified working-class families.³³ This did not prevent those percentages from being drastically cut after a short number of years for in one or another town council there were other needs that were considered more urgent, or because the political groups that controlled local powers had changed.

There are very many reasons offered by historians to explain the precarious existence of a real Social Reform in Spain. This is not the place to deal with them, and it is even less the moment to point out the regulations, decrees and reforming laws that range from the establishment of the first Industrial Accident Insurance in 1900 (not by chance just after Italy or France, and copying their models) to the very belated Unemployment Insurance in 1961 (only preceded by an special Insurance for Technological Unemployment not many years before).³⁴ In actual fact, that

31 Pareja, A., "Un viaje en familia" in González, M. et al., *Los movimientos migratorios en las sociedades modernas* (Bilbao, 1996), 115–134.

32 García, R., *Historias de emigración: factores de expulsión y selección de capital humano en la emigración a la Ría de Bilbao (1877–1935)*, (Bilbao, 2004).

33 Carasa, P., "La familia de los grupos populares próximos a la pobreza en la sociedad castellana decimonónica", *Revista de Demografía Histórica*, 12 (2–3) (1994), 253–300; Gracia, J., "Aspirando a sobrevivir: hogares y familias pobres en Bilbao a finales del siglo XIX", in Castells L., ed., *El rumor de lo cotidiano* (Bilbao, 1999), 117–158.

34 Castillo, S., ed., *Solidaridad, seguridad, bienestar: 100 años de protección social en España* (Madrid, 2008); Tortuero, J. L., ed., *Cien años de protección social en España* (Madrid 2007).

Reform would be no more than a set of laws and regulations (no less than 531 between 1900 and 1910³⁵, that very often were not complied with). This is how it was proclaimed by working-class leaders -or foreign observers who stressed that that was common to southern European countries.³⁶

As was the custom in other countries, social reforms in laws gave special preference to women; they were laws that protected them in their work, as occurred with children and other “fragile subjects”, for they were individuals with absolutely no citizenship. They planned maternal rest at work after the birth (but without being paid any money at the beginning, in 1900), the female shop workers’ right to have a seat to rest, regulation of the maximum working hours for female factory workers or for those sector in which women were a majority (like the textile sector), the prohibition of female night work, etc. These meant there was a conception of gender which saw working-class mothers as ignorant -if not guilty, of the high child mortality rate- who had to be educated in childcare by male health professionals (i.e. doctors) with a pro-natal concern.³⁷ After half a century, a health adviser boasted because, from 1900 to 1960, that mortality rate had dropped from figures over 100% to 32%, although, as current historians remember, there had already been doctors who observed at that time that the public water piping and drainage had been just as or more beneficial than the childcare concerns.³⁸ Although different political regimes tried to take the merit for improving health policies, it is not surprising that the evolution of Italy and Spain’s figures were very similar, sometimes under very different political conditions, and this was due to the similarity in social and economic conditions which were more important than the specific political measures.³⁹

It cannot be denied that maternity and babyhood aid institutions, which depended on local charity (such as the so-called *Gota de Leche*) increased their activity; they went from attending to 5% of the child population in 1914 to 25% in 1925.⁴⁰ However, this was still very little. It is not surprising that the “flag-waving” sentiments of an old, ruined empire in decline were appealed to in order to promote a Social Reform, such as when one of the most influent reformist

35 Garrido, A.: “Parlamento y “cuestión social” en la Restauración”, *Historia contemporánea*, 29 (2004), 719–734.

36 Marvaud, A., *La question social en Espagne* (Paris, 1910).

37 Palacio, I., *Mujeres ignorantes, madres culpables: adoctrinamiento y divulgación materno-infantil en la primera mitad del siglo XX* (Valencia, 2003).

38 Rodríguez, E., ed., “The health of children in modern history: episodes for embedding science, culture and politics”, *Dynamis*, 23 (2003), 17–166.

39 Pozzi, L., Robles, E., “La mortalidad infantil en los años de la transición: una reflexión desde las experiencias italiana y española”, *Revista de Demografía Histórica*, 15 (1) (1997), 165–200.

40 Rodríguez, E., “Medicina y Acción social en la España del primer tercio del siglo XIX”, in López, C., ed, *De la beneficencia al bienestar social* (Madrid, 1986), 227–266.

intellectuals (A. Buylla) indicated in 1892 that the Spanish Social Care Service was the worst in Europe, even after Portugal; like when in the nineteen-thirties the progressive politicians of the second Republic stated that, in some aspect, the Spanish social legislation was further behind than in Turkey, which had the same purpose of stirring patriotic consciences. It was a case of looking towards Europe in a rather naïve manner the way the so-called *regenerationists* (very often in favour of a Social State) had done in search of modernization after the end of the final remains of the Old empire in 1898.

Some authors have made an effort to point out that the conservative social Catholics were very important in these social reforms.⁴¹ For them, the state regulation would be a convergent strategy with those carried out by religious charity through *Christian Revival* institutions where women had a predominant role. The reality was that both the conservatives and the left-wing reformists were thinking of models from Central Europe (like Germany), although very different ones. The difference regarding Germany, Belgium, etc. was that the Spanish social Catholicism did not create real strong Christian unions (except for some regional cases), but paternalistic organizations depending on the elite classes' charity.

In these Christian organizations, women had an essential role,⁴² unlike in the socialist or anarchist unions where it was clear that the idea of respectability of working-class families was that women should not work for low salaries, in such a way that they “took away” jobs of work from their husbands, sons or brothers. The Christian female unions were very strong in Spanish cities due to the paternalistic help they provided, apart from other reasons already explained. Here we cannot go into details on the activities of these unions which defended the Catholic family model through free Sunday schools for servants or other female workers, mutual aid societies, school dining-rooms and nursery schools, etc.

In the rural world of a large part of the north of Spain where there was a majority of owners of small farms, the Christian unions had a masculine component due to a strong presence of traditional religion which was not restricted to women, as opposed to in the cities. These Christian unions were not after a Social State, but a modernized form of charity. But neither were the powerful anarchist unions looking for it, nor were the Marxist groups wanting Social Reform, but they were after a socialist State (except for reformist minorities of Spanish socialism), which was very

41 V. gr., Montero, F., “Los católicos y la reforma social, 1890–1914”, in Palacio, J. I., *La reforma social en España* (Madrid, 2004), 99–128; Ibidem: “El catolicismo social en España, 1890–1936”, *Sociedad y Utopía*, 17 (2001), 115–134; Ibidem: “Conservadurismo y cuestión social”, in Tusell, J. et al., *Las derechas en la España contemporánea* (Madrid, 1997), 59–76; Ibidem, *Orígenes y antecedentes de la Previsión Social* (Madrid, 1988), etc.

42 García, M., “Los sindicatos católicos femeninos, 1900–1930”, *Historia* 16, 69 (1982), 19–30.

different. So, few political powers were really interested in it in a radicalized Spain until 1939.

Many of the female voluntary Mutual Aid Societies (often not very “voluntary”, for they were subsidized by paternalistic businessmen who obliged their female workers to join these societies) were Catholic. Since women were unable to finance *SW* for themselves due to their low salaries, it is also understood that often circumstances like the impossibility of working due to pregnancy, birth-giving or “typical women’s illnesses” were not covered by that insurance. In many male Mutual Aid Societies, women were admitted as beneficiaries, but only as relatives of the “bread-winning” regular members (just as in the case of other family members like children, etc.), or when they were single or widows.⁴³ This was all a result of the fact that, according to gender stereotypes, working-class women’s place was in their home, looking after their families, *moralizing* them, but, *naturally* they had to stay away from the factories.

Most “social” laws were approved, above all, by conservative governments (i.e., close to the *Catholic Revival*). This was coherent with a certain organic and communitarian sense of society by the conservative politicians which was not shared by the Liberal Party. However, those organicist principles were also defended by a radical reformist left wing which was very influential in certain intellectual circles (the so-called *Krausists*)⁴⁴. The Liberal Party defended absolute individualism. It fostered educational reforms for the working classes to be able to overcome poverty, but it did not promote activities that meant a more active participation in economic activities of a protective state. However, there was no risk of excesses in this sense in the Spain of that time. In any case, these last aspects correspond to the political and Intellectual history of Welfare in Spain and not to Social history, so we shall not be dealing with them more here, for they are also well-known from an old historiography.

There are multiple reasons for explaining the prolonged absence of a *Social State*, and its complete explanation has completely nothing to do with this text. However, it cannot be forgotten that the inappropriate reforms of the State Treasury since 1845 avoided, among other issues, Income Tax. On the other hand, indirect taxes were chosen and they continued to be collected in town councils until a late stage. It is not surprising that the Public Social Expenditure between 1850 and 1960 was estimated at never exceeding 1% of the GDP.⁴⁵ It was consistent with the fact that

43 Castillo, S., ed., *Solidaridad desde abajo* (Madrid, 1994).

44 The influence of a German philosopher, K. Krause, on Spain through left-wing intellectuals with an influence on education and other fields is a subject that has been deeply studied by historians, but it cannot be examined in these pages.

45 Espuelas, S.; Vilar, M., “La evolución del gasto social público en España, 1850–1963”, IX Congreso Internacional de la AEHE (Asociación Española de Historia Económica), (Murcia, 2008) <http://www.um.es/ixcongresoaehe/pdfB4/Fatores%20determinantes.pdf>.

the Public Expenditure percentage within the GDP was only 9.7% in 1901, and the worst thing was that, in 1952, it was still around 8.7%.⁴⁶ A WS could not exist while a modern tax state did not exist.

From Fragmentary Social Insurances to a “Social State” under the Franco’s Regime

There is no consensus among historians on the development of SW in the Primo de Rivera dictatorship (1923-1930). Even though its corporatism was far from fascism, it is mentioned that it may have been an example of social protection “through other means”, or a type of (frustrated) attempt at “passive consent” to control the population, following the well-known described model for fascist Italy. In practice, it meant maintaining the old local charity and intra-family solidarity, even in spite of the cooperation with the reformist socialists, of a *Work Code*, of a certain improvement in education, of the creation of the *Childcare School* or the *Health School*⁴⁷, etc. There can be no doubt about the fact that the elite medical class (opposed to any *Compulsory Sickness Insurance*) was very strong during that dictatorship. If in 1924 a famous expert on social affairs forecasted that the Charity Organization would soon be coming to an end (according to his thoughts, when Compulsory Sickness Insurance was created), this would not happen in Spain until 1942. In fact, the attempts of a certain left-wing monarchist politicians -such J. Chapaprieta’s which ultimately entailed the introduction of an Income Tax⁴⁸ – were forgotten.

The 1925 figures spoke volumes about it: in a country with 25 million inhabitants, only about four hundred thousand had social insurance.⁴⁹ The main organization that promoted Reforms [*Instituto de Reformas Sociales (IRS)*, i.e. *Social Reform Institute*] was eliminated and there were thoughts of abolishing *Instituto Nacional de Previsión (INP)*, i.e. *National Welfare Institute*. In an irregular fashion, money funds reserved for protecting old age (due to the *Compulsory Retirement*) were illegally transferred to promote education. In 1923 the Charity Statistics showed the following:⁵⁰

46 I. e., Comín, F., “Las formas históricas del estado de bienestar: el caso español”, Álvarez, A. et al., *Dilemas del estado de bienestar* (Madrid, 1996), 29–58; Ibidem & Gálvez, L., “De la beneficencia al estado del bienestar social, pasando por los seguros sociales”, *Revista de la Historia de la Economía y de la Empresa*, 4, (2010), 9–20.

47 Rodríguez, E., *Salud pública en España: ciencia, profesión y política (siglos XVIII–XX)* (Granada, 2005).

48 Martorell, M. A., “La reforma del Estado liberal”, *Hispania*, LVIII/1(1998), 261–282.

49 Guillén, A. M., “Un siglo de previsión social en España”, *Ayer*, 25(1997), 151–178.

50 Cuesta, J., “Evolución de la previsión social española en el primer tercio del siglo XX: los primeros seguros sociales en los años veinte” in López Alonso, C., ed., *De la beneficencia al bienestar social: cuatro siglos de acción social* (Madrid, 1986), pp. 195–226.

Table 2. Spanish Welfare institutions 1923.

| Charity institutions | Percentage |
|------------------------|------------|
| State | 3.6 |
| Provincial Governments | 56.1 |
| Local Authorities | 40.1 |

Under the dictatorship of General Primo de Rivera, the central State Charity organizations were led by the Catholic ladies who defended what was sometimes called *organized feminism*, which meant that the working-class women were to take care of the family micro-solidarity. Any attempt by the monarchist democratic left wing to introduce the *Maternity Insurance*, already planned in 1923, was stopped. It was enacted in 1929, but only rhetorically, with no practical effects.

That last Compulsory Insurance was not put into effect until 1931, under a second progressive Republic and with the Socialist Party dominating the Ministry of Labour. This delay was not by chance: when the insurance was put into effect by the progressive Republic, the forecast of 140,000 beneficiary mothers was proved to be wrong, because 390,520 women were attended to. Since the II Republic in power (1931-1936) had many other problems, it could not focus its efforts on carrying out a Social Reform.⁵¹ One thing did happen: the increase in public education was boosted with a very large Social Expenditure. The paternalistic forms of Catholic aid for the poor were underestimated in a strongly anti-clerical context. As a Chancellor of the Exchequer (M. Ruiz-Funes) confessed in the midst of a depression in the thirties, the lack of State revenue prevented an Unemployment Insurance from being introduced, but guarantees for forgotten rural sectors were extended, a social legislation on industrial accidents was improved, etc., and a *Compulsory Sickness Insurance* plan was drawn up, even though the doctors were clearly against it. The Spanish Civil War (1936-1939) stopped the plan from being carried out when it was about to be discussed in Parliament, although some versions -according to comments made by a Franco's Minister of Labour, J. A. Girón- assume that the subsequent dictatorship took that project out of an office drawer to put it into effect.⁵²

From an Inefficient Corporate *Social State* to the First Development of Social Security (1937–1975)

51 Mazuecos, A.: "La política social socialista durante el primer bienio republicano: trabajo, previsión y sanidad", *Estudios de Historia Social*, 14 (1980),135–155.

52 Molinero, C., *La captación de las masas: política social y propaganda en el régimen franquista* (Madrid, 2005).

General Franco himself was the one who soon classified his regime as a *Social State* (1940) in the first years of his dictatorship, when imitating the victorious European fascisms of WW II was most accentuated. Between 1937 and 1944, it was rhetorically said, within a modern action for coercively persuading the masses, copied from European totalitarianism, that the “old bourgeois charity” made no sense in the face of a pretended *national-syndicalist* “Social Justice”.⁵³

The “hybrid” nature of Franco’s regime, in which several anti-revolutionary groups (Catholics, fascists, the military, conservatives, monarchists, business sectors, etc.) joined forces, had a big influence on the chaos and lack of coordination typical of the *SW* in the Franco’s state. As an example of a complete lack of planning, it can be noted that, when Franco died, there were up to over 7 Ministries in charge of Health (often with ideologically opposing views).

There has been evidence that in the face of the traditional gender models, an attempt was made to establish rhetorical models in the discourse of a new “social woman” (and of *SW*). These would be the models defended by the creators of the *Winter Aid* (which later became *Auxilio Social*, i.e. *Social Aid*), influenced by the Nazi example of *Winterhilfe*, or those of the women in the Female Section of Franco’s Single-Party (*FET*). However, those models failed faced with the traditional stereotypes of the Christian woman and charity (defended by the Catholics who headed the Ministry of Education, the traditionalists of the Ministry of Justice or the conservative military of the Home Office, etc.). The ministries headed by conservative politicians, monarchists and the military, also supported by some doctors who opposed the interventionist Social State, did not want to go one millimetre beyond social Catholicism.

The creation of some kind of Compulsory Insurance (the *Old Age Insurance* (1939), the *Compulsory Sickness Insurance* (*SOE*) (1942), the *Old Age and Disablement Insurance* (*SOVI*) (1947), etc. and laws like the *Health Act* (1944) were the result of a pretended “new Social State”. This was defined in the first of the *Fundamental Laws* of Franco’s regime which made up the dictatorship’s pseudo-constitutional framework: the *Fundamental Labour Law* (1938). This was based on the fascist nationalism-syndicalism, although it also depended on the Catholic principles. This law expressly stated that its objective was “to free women from the factories and workshops” (sic). In the face of innovating woman models proposed in the previous progressive second Republic, it was an attempt to make women, as mothers and wives, take care of the children, the elderly and the sick in their homes. There was no need for any Welfare State, although this was, in fact, the opposite of

⁵³ Ibidem, *loc. cit.*; Ibidem, “El reclamo de la “justicia social” en las políticas de consenso del régimen franquista”, *Historia social*, 56 (2006), 93–110.

the totalitarian *Warfare State*: the families continued to be the ones who took charge of a large number of social obligations.⁵⁴

The two main political sectors of the dictatorship (the fascists and the Catholic nationals) struggled in an attempt to control women within that Welfare. In the face of *Social Aid*, soon placed under the Home Office, led by men, diminishing its fascist bias⁵⁵, the Female Section of the *FET* (placed within the Party's Ministry), led by women, presented a power that became more persistent in time. Above all, their concern was childcare, the reduction of the high child mortality rate through spreading knowledge of Maternity in the rural world (with Home Schools for future mothers), etc., or Homes for working mothers, Nursery Schools, the so called *Female Social Service* -compulsory for women, just as Military Service was for men.⁵⁶ It was a matter of reducing the 100,000 children who died officially every year in the forties by following what were the three social objectives proclaimed by Franco: childcare, to eliminate tuberculosis and to solve housing problems.

Many of these problems were the consequence of an economy destroyed in a civil war and of isolation thanks to the democratic countries since Nazi Germany was defeated, in such a way that, until 1950, the industrial production rates and the per capita income of 1930 were not recovered. Diseases that were almost extinct in the thirties persisted until 1957. So, there was a failure with regards to disease in spite of the *Compulsory Sickness Insurance*. This had nothing to do with a *Social State* approach designed as a right for the citizens, which was inexistent during Franco's Regime, and contrary to the *WS* model made based on the well-know reports of W. Beveridge (1942-1944) and theories of T. H. Marshal in 1950. A *Compulsory Sickness Insurance* emerged only to help economically weak workers (scarcely one third of the population in the forties). The doctors' interests, defended by the Catholic military groups that controlled the General Management of Health in the Home Office, managed to make its impact restricted. The medical class was not jeopardised. To the contrary, around 1960, two thirds of the general practitioners were included in the *CSI* and enjoyed the increased income which combining their activity in private and public healthcare activity provided them.

54 Guillén, A. M., *Políticas de reforma sanitaria en España: de la restauración a la democracia* (Madrid, 1996).

55 Cenarro, A., *La sonrisa de la Falange: auxilio social en la guerra civil y en la posguerra* (Barcelona, 2005); *Ibidem*, *Los niños de Auxilio Social* (Madrid, 2009).

56 Bernabéu, J., "Madres y enfermeras. Demografía y salud en la política poblacionista del primer franquismo, 1939-1950", *Revista de Demografía Histórica*, 20 (1) (2002), 123-144; *Ibidem* et al., "Niveles de vida y salud en la España del primer franquismo: las desigualdades en la mortalidad infantil", *Revista de Demografía Histórica*, 24 (1) (2006), 181-202.

56 Bernabéu, J.: "Madres y enfermeras. Demografía y salud en la política poblacionista del primer franquismo, 1939-1950", *Revista de Demografía Histórica*, 20 (1) (2002), 123-144; *Ibidem* et al.: "Niveles de vida y salud en la España del primer franquismo: las desigualdades en la mortalidad infantil", *Revista de Demografía Histórica*, 24 (1) (2006), 181-202.

The *re-Christianizing* nature of the Regime, restored by F. Franco in the forties, was shown in many aspects. Priests were on the Charity Boards again, and although it took some time for a new *Concordat* to be signed with the Church (from 1941 to 1953), the re-Christianizing rhythm of education were overwhelming. Since the channelling of American Aid through *Caritas* in 1951, help for families by the Catholic world was strengthened. *Caritas* was formed in 1942 by the union of the old S. V. de Paul and *Catholic Action Conferences*; it was a group with a strong female component and it was composed of 500,000 *visitors of the poor* (providing food and clothing, but also education). The Catholic organizations' great ability for becoming *modern* guaranteed the persistence of Catholic institutions in *SW* up to the present day. After the eighties and until today, *Caritas* faced the challenges of the *new poverty* and social exclusion by forming part of the so-called *Third Sector*, *Voluntary Services* or NGOs.

The Franco regime's inheritance in the social panorama was rather unfortunate. In 1960, the *Compulsory Sickness Insurance* hardly attended to 50% of the population. In that year, only 4.1% of the hospital beds were included in this insurance (compared to 30.3% which depended on the town councils or 33.2% on private institutions). The archaic Department of Charity Organizations was maintained in 1976 as an example of a rather old-fashioned model. In 1975 the money transfers from the Spanish State to the Social Security were 0.4% compared to the 12.1% in the OECD. The percentage of the social expenditure in the GDP in 1975 was 12% in Spain (compared with 20.1% in the OECD). In that same year in Spain, the Public Expenditure was 24.7% of the GDP (and 40.2% in the OECD countries).

As stated, without a modern tax system, it was impossible to maintain a modern Social State. In its absence, an economy characterized by a low female employment rate was the fundamental welfare supplier for families during the Franco's dictatorship.

It cannot be denied that there was a progress in the Franco's regime about Social Policy, even before the sixties. A *medicalisation* policy, which is currently being discussed, was developed. So, births aided by doctors were: ⁵⁷

Table 3. Births attended by doctors in Franco's Spain (%).

| Year | Percent (%) |
|------|-------------|
| 1943 | 1 |
| 1953 | 14 |
| 1960 | 45 |

The possible effects of the influence of the promoting Social Aid and Female Section educational campaigns on the rural world cannot be discarded, although their

⁵⁷ Rodríguez, E., "La construcción de la salud infantil: Ciencia, medicina y educación en la transición sanitaria en España", *Historia contemporánea*, 18 (1999), 19–52.

effects must not be exaggerated, blown up by the dictatorship's propaganda. But the chaos and lack of coordination introduced in the health framework by *Compulsory Mutual Aid Societies* controlled by *National-Syndicalist Organization* or *Special Regimes of Social Security* (somehow following the old trade unionism) were a heavy inheritance for Spain after 1975.

The fact that the *Social Security Act* signed in 1963 was not put into effect until 1967 and was reformed in 1972 (*Ley de Perfeccionamiento/Perfecting Act*) was a sign of the health care dysfunctionality of an economy that was growing rapidly (at an annual rate of 7% in the sixties, i.e. the second highest in the western world after Japan). The Social Security grew, for its liquid assets went from being 58% of the State budgets in 1967 to 98% in 1974. However, this development was anarchic and rather inefficient.

There were advances in certain sectors, for example, a Social Housing Policy which had advanced little under the liberal legislation after 1911. This was one of the objectives of the propaganda policy of the fascist trade unions. In 1952 they calculated that there was a lack of 700,000 houses in Spain, but their capacity to provide a solution was limited (24,000 houses between 1942 and 1954 and, allegedly, 73,814 in 1955 and 1956). But it would be senseless to confuse WS with populisms like the Housing Policy implemented by a fascist politician (J. A. Girón).

From the Origin of a Welfare State to the Present (1976–2004)

The development of WS and the importance of women and families' contribution to overcome their shortages in Spain has been the object not only of studies by historians but, above all, by sociologists and economists.⁵⁸

In these studies, regardless of the fact that the data may vary slightly, it is clear that there is a series of indisputable aspects. So, Spain's agreement with the more developed Europe, after the dictator's death, was made between 1976 and 1985, especially by governments from the political centre and not so much by the Social-

58 Guillén, A. M., *Políticas de reforma sanitaria, loc. cit.*; Ibidem: "Protección social y ciudadanía: el caso español" in Sánchez, C., *Género y ciudadanía: revisiones desde el ámbito privado* (Madrid, 1999), 313–340; Alba, A., *Instituciones, igualdad de oportunidades y bienestar económico en España* (Bilbao, 2005); Garde, J. A., *Políticas sociales y Estado de Bienestar en España*, Madrid, 1999; Ibidem, *Informe 2003: Políticas sociales y Estado de Bienestar en España* (Madrid, 2003); Pérez, V. et al., *Familia y sistema de bienestar: la experiencia española con el paro, las pensiones, la sanidad y la educación* (Madrid, 1998); Navarro, V., *Bienestar insuficiente, democracia incompleta* (Barcelona, 2002), etc.

ist Party. In this way 3.6 million people receiving pensions in 1976 went up to 5.4 million in 1985. The following figures are significant: ⁵⁹

Table 4. Percentage of Spanish social services within the GDP (1985–1998).

| Year | Percent |
|------|---------|
| 1958 | 1.4% |
| 1967 | 3.7% |
| 1975 | 5.8% |
| 1976 | 10.0% |
| 1981 | 14.1% |
| 1986 | 13.9% |
| 1993 | 16.9% |
| 1998 | 14.0% |

This was in a period of economic recession, which caused a public deficit. Although there was a significant tax reform, the extent of black economies in Spain was very high. For instance, 1.5 million new tax payers appeared in only one year (1986-1987), but estimates on the economy not recorded in the national accounts data referred to figures of around 20% of the GDP.

The convergence of the data relating to the amount of Social Expenditure in the GDP of the EU15 occurred especially since a general strike from 1988 to 1993. Then, under the conservative governments, the Social Expenditure percentage was reduced (and, obviously, also the Public Expenditure percentage) with respect to the GDP.⁶⁰

Table 5. Spanish Social Expenditure. Percentage of GDP (1992–2001).

| | 1992 | 2001 |
|-------|-------|-------|
| Spain | 22.4% | 20.1% |
| EU15 | 27.7% | 27.5% |

The evolution of the nineties in the 20th century experienced a reduction in the public deficit in an accelerated attempt to fulfil the forecasts to be able to enter the single currency at any price.

Not all of this should be considered as “anti-social”, because the 14% unemployment rate, which had not dropped since the eighties (stated as reaching 22% in 1993) began to fall, especially in the first years of this 21st century. The creation of employment and wealth under neo-liberal politics in the nineties did not, however, remedy the fact that there was a low employment rate for women between 15 and 64 years old (no doubt “ideal” for looking after the families), which was then the

⁵⁹ Navarro, V., ed., *El Estado del bienestar en España* (Madrid, 2004).

⁶⁰ Muñoz, R., ed., *El Estado de bienestar en perspectiva comparada* (Madrid, 2000), 17–108.

lowest of the EU15. Neither did it solve the very low percentage of the child population under 3 years old being attended at nursery schools (according to what was said, there were less than in Greece and Portugal, imitating old stereotypes inherited from the past) and a small part of the elderly population being attended at Old People's Homes. Maintaining this was possible thanks to an existence of the so-called "grandma-mums" who took care of their grandchildren until they were 3 years of age, and to an increase in nuclear families (in which the elderly parents were attended to by one of their children's family, preferably daughters). In coherence with this, other social expenditures not extensively dealt with here (such as education expenses) continued to be low. This is how they were in 2002: ⁶¹

Table 6. Education expenditure. Percentage of GDP in 2002.

| | |
|-------|------|
| Spain | 4.5% |
| OECD | 5.3% |

Conclusions

The growth of the *WS* in Spain since 1976 is undeniable. The weight of previous inheritances (including the 40 years that passed between 1936 and 1975, but not only them) explains a care model which the importance of families and women as suppliers of well-being cannot be denied. Here, no mention has been made of changes in the Spanish demography, signs of which were especially shown between 1996 and 2007 due to a strong immigration (including women occupied taking care of children and elderly people in the homes), especially from Africa and Latin America, which caused and changing panorama. In the beginning of 2008 we are faced with a more uncertain future than ever, if possible, which prevents forecasts from being made which, as is well known, are not reached to a large extent and, in any case, are far from the historians' competence.

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⁶¹ Garde, J. A., *Informe 2003...*, *loc. cit.*

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‘Giusta la benefica intenzione del Re’: the Bourbon Cowpox Vaccination Campaign in Sicily

Sicily [...] acquired the vaccine through the intervention of the Sea.
(Moore; 1815, p. 266)

John Chircop

Introduction

This study starts by contextualising the arm-to-arm, sea-borne, transfer and diffusion of the cowpox vaccine in Sicily in the war conditions of the early 19th century which led to a new geopolitical configuration of the central Mediterranean – this being reflected in the island’s troubled transition from French occupation to a British protectorate and its subsequent integration in the Kingdom of Two Sicilies. Against this backdrop, the Bourbon monarchy enthusiastically sanctioned Edward Jenner’s cowpox vaccination method and launched it as one of its principal public projects. What follows is an analysis of the intricate links which this mass vaccination campaign came to have with the prevailing state ideology and the power structures of the *Regno* – with specific reference to Sicily.

Delineating the research parameters of this study, Sicily provides us with what could be termed the ‘peripheral experience’ of a public health operation which emanated from the state centre of power – in Naples – and unfolded throughout the Southern Italian territories, passing through a chain of intermediating institutions and local representatives, and eventually encountering a popular culture very much suspicious of the intentions of the monarchy. Picturing the whole campaign from this peripheral experience provides a vantage point from where to investigate the multifaceted encounters which this state mass immunisation campaign had with this island’s environmental, social and cultural landscape.

By examining this public health vaccination campaign in the specific conditions and political economy of Sicily during the Restoration period, it will be possible to make a thorough analysis of what *prima facie* seemed a veritable paradox: that of

having a conservative Bourbon government adopting the most advanced medicine just discovered, and organising one of the earliest examples of state-sponsored non-compulsory immunisation programmes in history. This line of investigation equally helps to bring to the fore and investigate the role played by the counter-reformist Roman Catholic Church, particularly at the parish level, as well as the part played by religious belief and ritual, and the role of the parish priests, in the spread of the *vaccinae* in their communities. Moreover, focusing on the intricate connections which the vaccination campaign against smallpox came to have with the prevailing power structures of the state, Church and other power institutions, lands us straight into the historiographical debate on the *mezzogiorno* during the Restoration period, and more specifically in that concerning the history of public health in Sicily before Italian unification. For these last thirty years or so, revisionist historians have been highly critical of the previous *Meridionalismo* theoretical paradigm, which framed the history of the South during the Restoration period, as lacking a historical appreciation of the complex structures of administration adopted by the Bourbon regime, by and large presenting it as one which tried to turn back the clock to pre-Napoleonic times. Revisionist historians, equipped with more theoretically elaborate methods, taking a wider comparative approach, and relinquishing the strong ideological attachment of the previous *Meridionalismo* historical school, have been painstakingly reconstructing the pre-unification period, paying particular attention not to gloss over the social, cultural and economic distinctions of the territories making up the kingdom of Two Sicilies – most particularly when it comes to Sicily.¹ The ensuing archival-based corpus of historical literature relating to the various aspects of the Bourbon monarchy's government and its institutions demonstrates this regime's attempts to combine a deeply entrenched conservatism with a drive for administrative modernisation, particularly in the fiscal system and in public health.²

This new approach to southern Italian – and Sicilian – history has spurred a growing scholarly interest in the history of public health of this region in general. However, relatively little has been published on the social, cultural and political

1 See for instance Piero Bevilacqua, *Breve Storia dell'Italia Meridionale dall'Ottocento a oggi* (Roma, 1993); P. Pezzino, *Un paradiso abitato dai diavoli. Società, elites, istituzioni nel mezzogiorno contemporaneo* (Milano, 1992), pp. 98–101; A. Scirocco, 'L'Amministrazione Civile: istituzioni, funzionari, carrieri' in A. Massafra ed., *Il Mezzogiorno preunitario. Economia, Società e Istituzioni* (Bari, 1988), pp. 365–378. Cf. also papers in John A. Davis and Paul Ginsborg eds., *Society and Politics in the Age of the Risorgimento. Essays in Honour of Denis MackSmith* (Cambridge, 1991).

2 Jonathan Morris, 'Challenging Meridionalism. Constructing a New History for Southern Italy' in Robert Lumley and Jonathan Morris eds., *The New History of the Italian South. The Mezzogiorno Revisited* (Exeter, 1997), pp. 8–9.

issues surrounding the Bourbon cowpox vaccination campaign in Sicily,³ in spite of the pivotal part it played in the modernisation of the public health sector there. Definitely, this has not been caused by a lack of accessible primary documentation. The *Archivio di Stato* in Palermo holds the voluminous records of the *Commissione Centrale di Vaccinazione* (Central Commission for Vaccination), which managed the immunisation campaign on the island. This documentation has actually provided the bulk of the primary sources used to investigate the principal issues treated in this study, starting from the more structural ones – such as the multi-functioning of the network of the provincial and communal vaccination commissions; to issues of human agency – which include the roles played by the official vaccination agents and local state representatives (the mayor or *sindaco* and the *intendente*); but also the organisational, cultural and human difficulties met by all these campaign agents in various parts of Sicily. These detailed records also enable a lively and nuanced reconstruction of the daily practices of the public vaccinators, the local parish priests and the midwives, who immediately emerge as protagonists of this vaccination campaign within the neighbourhoods and the households – providing deeper insights into the constraints, the various modes of cooperation and the conflicts they faced in their daily tasks. As this research approach gives importance to human issues –including subjective perceptions – found in this mass vaccination experience, the underlying people’s perspective of this study starts becoming evident. It becomes even more so when touching on matters which are usually not treated, such as the exploitation of vulnerable foundlings and orphans as part of this campaign, or the people’s mixed feelings and varying reactions to this ‘new inoculation’ method. The *varioleae vaccinae* was, after all, intended for and applied on sensitive individual bodies.

Transferring Cowpox Vaccine to Sicily

As happened on many other historical occasions, when warfare served as a catalyst for the rapid transfer of new medical inventions, so did the Anglo-French Wars (more specifically the British naval-military campaign against the French in 1801) convey Edward Jenner’s cowpox vaccination⁴ to the Central Mediterranean. *Variolae Vaccinae*, proclaimed as an extraordinary preventive medicine, immediately attracted the attention of the British army authorities and the Admiralty, which

3 One significant work dealing with this subject being P. Pierri, ‘La vaccinazione antivaiolosa nel Regno delle due Sicilie’, in *Archivio storico per le province napoletane*, CVI, 1988, pp. 409–418.

4 Edward Jenner, a British physician, discovered that cowpox virus conferred immunisation against smallpox in 1796 and divulged his ideas and method with his book *An Inquiry into the Causes and Effects of Variolae Vaccinae* (London, 1789).

prefigured its use to immunise their military and naval corps deployed overseas in circumstances of conflict and empire building against one of the most atrocious contagious diseases which was known to decimate legions. Following a successful trial on a batch of eleven sailors,⁵ orders were given to start vaccinating the British naval crews serving on board the fleet, and the forces stationed in the various ports, of the Mediterranean. This medical procedure was left in the hands of Joseph Marshall and John Walker, both doctors and ‘missionaries’ of Jenner’s cowpox method. They left Plymouth accompanying a naval expedition to Egypt with a supply of the *variolae*, a fresh stock of which was secured for this long voyage by the ‘inoculation’ of a low rank sailor and probably a couple of boys who were recruited and taken aboard for this purpose.⁶ Once it was proved safe and did not disturb or hinder the sailors’ duties on board,⁷ the vaccine was approved and adopted on all warships forming the fleet. Transferred arm-to-arm, with the ‘virus’ reproducing itself in each person, the cowpox vaccine matter was carried to and introduced in Gibraltar, Minorca and Malta – all being under British control and lying on the strategic route to the East. After immunising the garrisons stationed in each of these colonial ports, the vaccine was provided free to the native populations coming in direct contact with them⁸ – the procedure by which it was introduced being very similar. The colonial governors and crown representatives in each of these outposts authorised the first trials to be conducted on native foundlings and orphans,⁹ these being the bodies upon which such medical experiments were usually performed before risking the great majority of (legitimate) children.¹⁰ Confined in institutions, these infants were easily available for experiment and to be used as human sources to supply fresh cowpox matter at a time when it was difficult to preserve it for any length of time. Each trial was conducted under the watchful eyes of native medics

5 *The Evidence At Large, As Laid Before the Committee of the House of Commons respecting Dr Jenner’s Discovery of Vaccine Inoculation: together with the Debate which followed and some observations* (London, 1805), p. 64; James Moore, *The History of the SmallPox* (London, 1815), p. 266.

6 Abate Bellet D.S.], *Continuazione Di Fatti e D’Osservazioni Intorno al vaiuolo Della Vacca fatta da Odoardo Jenner (tradotto dal Inglese in Italiano)* (Malta, 1801), p. 30; Paul Cassar, ‘Edward Jenner and the Introduction of Vaccination in Malta’, *Medical History Journal* (January, 1969), 13, 1, p. 70; Ian Glynn and Jenifer Glynn, *The Life and Death of Smallpox* (Exmouth, 2005), p. 121; Moore, p. 265.

7 *The Evidence*, p. 66.

8 For the introduction of cowpox vaccine in Gibraltar, Malta and Minorca see Sam Benady, *Civil Hospitals and Epidemics in Gibraltar* (Gibraltar, 1994), p. 94; John Hennen, *Sketches of the Medical Topography of the Mediterranean comprising an Account of Gibraltar, The Ionian Islands and Malta* (London, 1830), p. 118; Cassar, pp. 70–71.

9 Cf., *The Evidence*, p. 66.

10 [Abate Bellet], p. 29; Glynn, pp. 121, 168–169.

and surgeons to convince them of the beneficial outcome of the vaccine, and to instruct them in Jenner's cowpox principle and practical method.¹¹

Parting ways in Malta, Doctor Walker continued his journey, accompanying the expedition to Egypt in order to vaccinate the British forces deployed there, while Joseph Marshall crossed to Sicily, then also under British protection.¹² In Palermo, where a recent smallpox epidemic had just left over 8,000 persons dead and many others blind and disfigured, the vaccine was enthusiastically received by the Bourbons whose recent dynastic medical history included family members who had died or carried the scars left by the disease. Most notably, Jenner's cowpox vaccination method was sanctioned by the potent Catholic Church which proved to be a driving force behind the launching and the long-lasting campaign in Sicily. Marshall took over a Jesuit seminary in Palermo and turned it into a vaccination hospital, run on the same lines as that established in Malta. As he himself related, the first vaccination successes in Sicily 'excited a strong desire for its practice in Naples where the small pox has always been considered as very fatal'.¹³ Crossing over to Naples, he founded the *Istituto di Vaccinazione Jenneriana* (Institute for Jennerian Vaccination), which served as a medical clinic for the cultivation of the cowpox lymph and as a vaccination school from where medics carried 'both the knowledge of the disease and means for the practice of it, into their respective provinces'.¹⁴ From here the vaccine was introduced in the towns and villages around Sicily, and to such islands as Pantelleria,¹⁵ again using orphans and foundlings for trials and as carriers of the cowpox matter.

With the Restoration of the Kingdom of Two Sicilies under King Ferdinand 1 in 1815,¹⁶ cowpox vaccination, which was already being practised, was taken up by the

11 Besides being instructed in the use of this preventive medicine, local physicians were introduced to Jenner's medical ideas and method through the publication of books and manuals. These included one authored by Joseph Marshall himself, *Sul vaiuolo vaccinico* (Palermo, 1801), as well as a translation in Italian of Edward Jenner's book, *A Continuation of Facts and Observations*, translated by Abate Bellot in Malta during the same year with the title *Continuazione Di Fatti e D'Osservazioni Intorno al vaiuolo Della Vacca fatta da Odoardo Jenner (tradotto dal Inglese in Italiano dall' Abate Bellet D.S.* (Malta, 1801).

12 R.T. Wilson, *A Narrative of the British Expedition to Egypt* (London, 1803), pp. 2–3.

13 *The Evidence*, p. 66.

14 *Ibid.*, pp.65–66. Marshall reported that he performed more than 10,000 vaccinations in all.

15 Although by 1829 no cases of smallpox were reported in Pantelleria, the *intendenza* of Trapani decided to send a ready vaccinated foundling: '*nella prossima primavera avra' cura anche un bambino proietto inoculato in questa di spedire in quest'Isola, per cosi far propagare cola' la vaccinazione*' (cf. 'Stato generale dei Vaccinati nel 1829', *Intendenza, Valle di Trapani*, no. 3131, 12 Mar., 1830 [All correspondence referred to in this paper is incoming, if not otherwise stated. All documents hereafter are taken from the records of the *Commissione Centrale di Vaccinazione at the Archivio di Stato* in Palermo]).

16 With the Vienna settlement, Sicily and Naples were integrated in the Kingdom of Two Sicilies under the Bourbon King Ferdinando IV (thus becoming Ferdinando I), who entered Naples in June 1815.

new regime as one of its principal public projects, and actually the one which the Bourbons would come to be identified with by many sectors of the population. For the monarchy, providing free vaccination against smallpox meant assuring as much as possible the healthy reproduction of its subjects which, according to its entrenched mercantilist principles, was fundamental for the consolidation of the king's authority. In practical terms, mass immunisation fitted well in the regime's power strategy, being used to secure a modicum of control over larger sections of the poor populace, and to foster social consent to its rule. Cowpox vaccination was indeed continuously represented as the most intimate charitable act of the Bourbon monarchy directed towards each and every one of its poor subjects. Thus in the towns and villages it was announced with such phrases as: '*La vaccinazione, giusta la benefica intenzione del Re*'¹⁷ – presenting a notion which would impregnate most of the monarchy's discourse of charitable benevolence accompanying the spread of the cowpox vaccine throughout the Kingdom.

Actually, the Bourbon proclamation of cowpox vaccination to the people in paternalist, benevolent, terms was preceded by the British, whose conveyance of this *vaccinae* across the western Mediterranean to Sicily had been couched in a colonial discourse of the civilising mission, which presented its benefits to the human body as representing their munificence towards these southern people. One contemporary British author, James Moore, clearly expressed this view in an address to the Sicilian people:

[You] fortunate people that [have been] rescued from the conquest might [now] also be preserved from small pox¹⁸ [...]. Unlike the black Africans with their [...] uncultivated, undeveloped, mental facilities [who] are only a little superior to those of the animals which range the desert [and who] probably must long remain in a great measure deprived of the preventive of small pox.¹⁹

Essentially, according to this civilising discourse, cowpox vaccination was meant to be a step further in civilising the body and bringing order in society – an idea which was appropriated and further elaborated by the Bourbon monarchy in its own image and for its own ends.

17 Commissione Provinciale Vaccinica, Valle di Catania, no. 3, 26 July 1819.

18 Moore, p. 266.

19 Ibid., p. 273.

Bourbon Vaccination Strategy and the Modernisation of the Public Health System

With the Restoration, Sicily came under the Bourbon monarchy's highly hierarchical administrative system, controlled from Naples,²⁰ which was itself a legacy left by the previous Napoleonic regime but which in reality, as John A. Davis argues, had already made itself evident as from the second half of the 18th century.²¹ As a consequence, from its previous position as the historical capital of Sicily, Palermo was reduced to one of seven administrative centres. Loss of autonomy, coupled with a series of unpopular government measures, starting with the imposition of conscription,²² provoked intense anti-Bourbon opposition which would burst in a series of rebellions.²³ This in turn pressured the regime to hand over a measure of administrative power to the Sicilian elites, not least with the creation of a Ministry for Sicily which, for a period of time,²⁴ provided the necessary impetus for the initiation of badly needed public projects, mainly the construction of a road network (which was designed to connect Palermo with the urban centres of Messina, Siracusa, Girgenti and Trapani),²⁵ and the reorganisation of the public health system – two public ventures which were closely interconnected. Concurrently, the state aimed to modernise the administration of the fiscal apparatus and the multi-institutional charitable system.²⁶ These reforms would boost the state's share in the control of the dense network of charity establishments, hospices and hospitals which existed throughout the *Mezzogiorno*, including Sicily. But although these initiatives were founded on the legal principles set by the previous French Murratian administration, even the first public health decrees (that of 14th September 1815, followed by those of February and December 1816)²⁷ reflected the specific social and cultural circumstances of southern Italy, foremost of

20 Stuart Woolf, *History of Italy 1700–1860. The Social Constraints of Political Change* (London-New York, 1991), p. 241.

21 John A. Davis, 'Health, Cure and Poor Relief in Southern Europe in the 18th and 19th Centuries' in Ole Peter Grell, Andrew Cunningham and Bernd Raeck eds., *Health Care and Poor Relief in 18th and 19th Century Southern Europe* (Aldershot, 2005), p. 19.

22 *Ibid.*, pp. 19–20.

23 Vittorio Geijeses, *La Storia di Napoli dalle origini ai nostri giorni* (Napoli, 1978), pp. 729–30.

24 G. Botti, 'Strutture Sanitarie e malati nell'Ottocento borbonico', in Massafra, pp. 122–123.

25 Although plans were laid during this period, it took several decades for the main roads to be finished (G. Perez, 'La Sicilia e le sue strade' (Palermo 1861) in C. Trasselli ed., *Un Secolo di politica stradale in Sicilia* (Roma-Caltanissetta, 1963).

26 On the ways in which the Bourbon government attempted to deal with the problem of poverty and beggary in the *Regno*, especially in Naples, cf. Lucia Valenzi, 'Linee di Intervento del governo borbonico nei confronti della povertà', in Massafra, pp. 1207–1215.

27 *Ibid.*, pp. 1211–1212.

which was the political imperative to maintain the thick layer of poor relief and public health services founded on the traditional principles – and state ideology – of public charity. In this context, the law of the 20th October 1819, entitled *Legge organica sulla pubblica salute ne' domini di qua e di la' del Faro*, was designed to generally augment the presence of the state in most matters dealing with hospitalisation and public poor relief, leading to a more equal and balanced State-Church relationship – this being considered essential for the upkeep of the Restoration monarchy. In substance, therefore, the on-going legislative reforms which were intended to both modernise the administration of the public health system and strengthen the state ideology of benevolent charity, produced what historians G. Botta and V. Barbati describe as ‘one of the most analytic and detailed [legislative frameworks] from those of the pre-unification states’ in Italy.²⁸ At the same time, of course, this intensified state *assistenzialismo* of an already financially onerous public health and poor relief system.

However, as much as these legislative-administrative initiatives consolidated the state’s universal charitable ideology and increased its share in the management of the bulky layer of charitable institutions, they also prompted the application of new scientific ideas in public health, as observed with the efforts made to separate the mentally ill from the sick others; with the setting up of hospitals based on modern clinical practice for the observation and cure of the sick (in contrast to the old poor-relief idea of maintaining charity institutions for the indiscriminate sheltering of the sick, the old and the infirm); and with the training of doctors in modern clinical medicine.²⁹ In all of this, the cowpox vaccination campaign played a leading part, instilling the fresh principle of preventive medicine, while still employing the conventional protectionist ideas of public sanitation, such as forced isolationism and quarantine.³⁰ In this sense, the implementation of this programme represented the Bourbon regime’s wider political-public health strategy. Brought under the auspices of the Royal family and provided with a territory-wide network of vaccination committees, confirms the political weight which the Bourbon regime put on this mass vaccination campaign.

Consequently, when it came to Sicily, this non-compulsory vaccination programme would prove to be one of the most tangible projects realised by the Bourbon administration, making itself directly felt in each community and in the households, within a social landscape where the state was commonly perceived as remote from local affairs. While immunising the Sicilian population against one of

28 V.Barbati, ‘L’Igiene Pubblica in tempi anormali’, in *Atti del Congresso celebrativo del centenario delle leggi amministrative di unificazione* (Vicenza, 1967), vol. 2, p. 157.

29 Laura Guidi & Lucia Valenzi, ‘Malattia, Povertà’, *Devianza Femminile. Follia nelle Istituzioni Napoletane di Pubblica Beneficenza*, in Massafra, pp. 1179–1180.

30 Commissione Provinciale di Vaccinazione, Valle di Messina, no. 174, 31 Dec 1827; Cf. also Peter Baldwin, *Contagion and the State in Europe, 1830–1930* (Cambridge, 2005), p. 246.

the worst contagious diseases in existence, this campaign also intended to extend and sharpen the state's biopolitical practices in this part of the Kingdom, confirming how, as James C. Riley noted, health prevention and social surveillance complemented each other in the implementation of public health projects in history.³¹

The vaccination campaign itself was structured on, and intertwined with, all levels of the state administrative structure and power hierarchy, including the local state agencies and representatives throughout the Kingdom's territories. In Sicily, the whole project was managed by the central commission for vaccination (*Commissione Centrale di Vaccinazione*) in Palermo, which was established by the royal decree of the 20th of October 1818 and operated through an island-wide network of *commissioni* at the provincial and communal levels (*commissioni provinciali* and *commissioni comunali*), with the capillary ends of the network being the local vaccination boards or *giunte di vaccinazione*. Each *giunta* was made up of the mayor (*sindaco*), any other state functionary on the spot, as well as the vaccinator and the parish priest. Their main responsibility lay in vaccinating as many inhabitants as possible in their localities. They were to meet regularly and see that all quarterly statistics were properly kept and sent to the centre.³² Besides, they were to regularly report back to the *intendenza* and the central commission of vaccination in Palermo on matters directly related to the progress or otherwise of the cowpox vaccine in the communities under their care.³³ Notwithstanding such multiple duties, these local *giunte* depended on the *comune* for basic resources, including the provision of public vaccinators and supplies of fresh vaccine. Made up of persons elected from lists of local power figures, from the landowning and professional elites, and nominated by the state, the commune was given control of the fiscal affairs, policing, public works and public health, but with all decisions needing the final approval of the *intendente*. This led the vaccination campaign to become inextricably tied to local politics, revolving around the *intendente* who articulated what Robert Putman terms the deeply rooted local 'vertical networks of hierarchy'.³⁴ This meant that the reach of the political contacts of the *intendente*, and his abilities to negotiate with the central commission of vaccination and with the different levels of the government bureaucracy, could make all the difference when it came to

31 James C. Riley, *Rising Life Expectancy. A Global History* (Cambridge, 2001), p. 71.

32 'Per la rimessa delle mappe quadrimestrali di vaccinazione' [printed circular]. Enclosure in Commissione Provinciale di Vaccinazione, Messina, no. 423, 29 Apr 1830.

33 'Per vaccinarci subito tutti gli individui che non lo sono', *ibid.*; Dall'Intendente (Duca di Samatino), Intendenza, Valle di Catania, no. 1816, 22 July 1819.

34 Robert Putman, *Making Democracy Work. Civic Traditions in Modern Italy* (Princeton, 1993), p. 16.

secure provisions required for vaccination in any commune, in circumstances in which these were not easily forthcoming.³⁵

The pivotal role played by the *intendente* in this campaign is illustrated by the fact that it was through his office that the fresh supplies of cowpox lymph, or ‘*pus vaccinico*’ as it was locally called, usually passed.³⁶ He was the person responsible to make this vaccine available to the mayors³⁷ and the local vaccinators,³⁸ as well as to supervise the work of the *giunte di vaccinazione*, oversee the actual immunisation process in the communes,³⁹ and report back to both the provincial and the central commissions.⁴⁰ The *intendente* was also to make available the communal hall as an ‘inoculation centre’, if no local hospital existed, to circulate official notices and to use all other means available to inform the public as to the time and place to vaccinate their children.⁴¹ Moreover, he was duty-bound to present himself on site where natural smallpox outbreaks occurred,⁴² and apply his authority to call out the police and ask for military assistance to stop contagion and to keep public order.⁴³ Records show the *intendenti* usually taking a hard line attitude. Believing in the old protectionist sanitary principles,⁴⁴ they were very much inclined to instantly employ quarantine – ‘*per impedire contatto con gli ammalati*’ – and to use force to isolate households or whole neighbourhoods, and to find an ‘isolated place where to enclose the diseased’.⁴⁵ Although they were key agents of the state vaccination campaign in their communes, the *intendenti* were to seek the advice and collaboration of locally respected personalities, including the mayors (*sindaci*) and the parish

35 On the unequal distribution of these basic resources cf. Intendenza, Valle di Palermo, no. 5173, 7 Apr. 1827; ‘Stato di Vaccinazione’, Intendenza della Valle di Palermo, no. 16802, Apr 1829. See also *conclusion* below.

36 Intendenza, Valle di Palermo, no. 3595, 12 Mar 1827.

37 Commissione Vaccinica, Valle di Catania, no. 34, 3 Sep 1829; Intendenza, Valle di Palermo, no. 16802, 10 Oct 1829.

38 Intendenza, Valle di Palermo, no. 5173, 7 Apr 1827; ‘Stato di Vaccinazione’, Intendenza, Valle di Palermo, no. 1680, 1 Oct 1829.

39 ‘*Interessa il Sigr. Intendente a far metter a disposizione della giunta della sezione i gendarmi*’ (Commissione Vaccinica, Valle di Catania, no. 2304, 7 June 1830); Senatore delle sezione del molo, Intendenza, Palermo, no. 92, 20 Apr 1827.

40 Commissione Vaccinica Provinciale, Siracusa, no. 116, 27 Aug 1827 and no. 136, 27 Dec 1827.

41 Commissione Provinciale di Vaccinazione, Messina, no. 43, 10 Mar 1823.

42 ‘Per Vaccinarsi subito tutti gli individui che non le sono stati’ [printed circular], Commissione Provinciale di Vaccinazione, Messina, no. 423, 29 Apr 1830.

43 I componenti della Commissione al Sindaco Preside. della Giunta Vaccinica di Messina, no. 423, 29 Apr 1830; Intendenza, Valle di Palermo, no. 9981, 12 July 1827.

44 Intendenza, Valle di Palermo, no. 4040, 21 Mar 1827; Commissione Provinciale di Vaccinazione, Valle di Messina, no. 174, 31 Dec 1827.

45 Commissione Provinciale di Vaccinazione, Valle di Messina, no. 174, 31 Dec 1827.

priests,⁴⁶ who had a more intimate knowledge of the communities under their care and who were better versed in the customs and mentality of the local people.

The Vaccinator, the Parish Priest and the Midwife

When it came to the actual vaccination procedure in the community, the public vaccinator was certainly the key person. After being instructed in Jenner's cowpox method, doctors obtained a vaccination warrant from the provincial commission of vaccination, and were sent to any town, village, or *sezione* of the larger urban centres⁴⁷ where their duties were required.⁴⁸ One of their first tasks was to seek the cooperation of the local parish priest, the local physicians – if any – and the midwives, and watch over them to make sure that they were 'abiding by their duties when it came to introduce the vaccination practice to the people'.⁴⁹ Newly arrived vaccinators were usually instructed to get in touch with the *sindaco* to be handed a supply of the '*pus vaccinico*'. It was standard procedure to start with the local foundlings or orphans⁵⁰ before proceeding to immunise family children and as many other individuals as they were able to, giving precedence to the newly born. With the help of the mayor and the parish priest, this procedure was to be performed either in the local vaccination centre or town hall (on notified days and times of the week), or else by going door to door, as local circumstances dictated. They were also to keep a rigorous record of those whom they vaccinated, fill in the official forms, and send all the statistical data and related information, on a quarterly and yearly basis, to the provincial commission.⁵¹ They were also to record in detail any occurrence of 'natural smallpox' in any household or neighbourhood under their care,⁵² and to keep a sharp eye on those families who refused vaccination, holding the local *giunta* and the *commissione* or *intendenza* regularly informed. Added to these surveillance tasks, they were also compelled to proceed immediately

46 Commissione Provinciale di Vaccinazione, Valle di Messina, n.n., 10 May 1823; Intendenza della Valle di Palermo, no. 9981, 12 July 1827.

47 Intendenza, Valle di Catania, no. 2049, 31 Jan 1828.

48 I Componenti della Commissione, al Preside. Commissione Provinciale di Vaccinazione, Valle di Messina, 19 Dec 1823. In the meantime, a doctor could be issued with a temporary permit to act as provisional vaccinator ('Della Istruzione del medico comunale provvisorio', Commissione Provinciale della Vaccinazione, Messina, no. 869, 5 Aug 1830).

49 Commissione Provinciale di Vaccinazione, Valle di Messina, no. 185, 29 Nov 1823.

50 I Componenti della Commissione, al Preside. Commissione Provinciale, Valle di Messina, 19 Dec 1823.

51 Intendenza di Messina, no. 1994, 24 Feb 1823; Commissione Provinciale di Vaccinazione, no. 444, 2 May 1830.

52 Lettera di S. Puli (Pubblico Vaccinatore), al Preside. Commissione di Vaccinazione, Palermo, n.n., 1 Feb 1830.

to any ‘contagion site’, isolate the diseased, and vaccinate those coming in contact with them or who lived in their proximity.⁵³

To motivate public vaccinators in their ‘vaccination crusade’, the authorities publicly praised those of them who demonstrated enthusiasm and who put themselves at the forefront of the campaign,⁵⁴ as well as those who experimented with harvesting cowpox lymph from local herds or with new methods for the supply and preservation of ‘the virus’. It recommended them to the government for the granting of prizes in cash or other official awards or gifts.⁵⁵ Such happened to Dr Domenico Nicotra, public vaccinator in Catania, who in 1806 was one of the first to introduce the cowpox vaccine in that province. By 1827, Nicotra had vaccinated 7,203 individuals, and in 1821 was responsible for setting up the ‘*commissione sul virus sulla vacca*’ in Sicily. He was referred to in heroic terms and treated with respect.⁵⁶ In contrast, those public vaccinators, like any other members of the *giunta vaccinica*, who were found to be negligent in their duties,⁵⁷ were warned, shamed or even suspended in conformity with regulations.⁵⁸ The *commissione* could either issue a warning or suspend them,⁵⁹ although it seems that in reality it often hesitated to – and usually did not – do so, fearing that this might paralyse the whole campaign in that locality.⁶⁰

The community vaccinator did not only rely on the logistical support (indeed for the supplies of the cowpox vaccine itself) of the *intendente* and the *sindaco*, but came under their direct responsibility and supervision. This manifold dependence on the local state representatives frequently proved problematic, as happened in Santa Lucia in 1830, where the mayor was accused of not following standard procedures, thus putting the whole campaign at risk.⁶¹ Public vaccinators, however, faced other difficulties in their daily tasks. Quite frequently they were not paid on time and did not receive any cash for months – this leading to demotivation and foot-

53 ‘Per Vaccinarsi subito tutti gli individui che non lo sono stati’ [printed circular], Commissione Provinciale di Vaccinazione al Preside. della Giunta, Messina, no. 423, 29 Apr 1830.

54 Commissione di Vaccinazione, Valle di Catania, n.n., 8 Feb 1830.

55 [printed circular], Commissione Provinciale di Vaccinazione, Palermo, no. 423, 29 Apr 1830.

56 Commissione Vaccinica, Valle di Catania, no. 23, 8 Mar 1827.

57 ‘Dello Sviluppo di vajuolo in una ragazza di campagna di S. Angelo’, Commissione Provinciale di Vaccinazione, Messina, no. 916, 19 Oct 1830.

58 ‘Per Vaccinarsi subito tutti gli individui che non lo sono stati’ [printed circular], Commissione Provinciale di Vaccinazione, Palermo, no. 423, 29 Apr 1830.

59 Commissione Provinciale di Vaccinazione, Provincia di Siracusa, no. 136, 27 Dec 1827; Commissione Provinciale di Vaccinazione, Palermo, no. 916, 19 Oct 1830.

60 ‘Sullo sviluppo del vajuolo in St Angelo in Messina’, Commissione Provinciale di Vaccinazione, Messina, no. 916, 19 Oct 1830.

61 ‘Per vaccinarsi subito tutti’ [printed circular], Commissione Provinciale di Vaccinazione, Messina, no. 423, 29 Apr 1830.

dragging.⁶² Besides, they had to stop their procedures on those many occasions when the vaccine matter was unavailable or when it was received in the wrong – or ‘extreme’ hot and cold – months of the year,⁶³ which they generally perceived as making people, especially infants ‘little adapted to vaccination, [and thus having to] leave it to another more docile season’.⁶⁴

Then again, one utmost difficulty encountered by the *vaccinatori* was their inability to persuade many of the parents to get their children and themselves vaccinated. They commonly faced prejudice, and an aversion to cowpox vaccine,⁶⁵ by households and whole neighbourhoods, partly due to the fact that they were usually outsiders to the community in which they were practising. Their medical scientific notions contrasted, if not dramatically conflicted, with the belief on health and traditional healing practices of the local folk. Many people identified their tasks with the scarification of the skin, and this raised further apprehension⁶⁶ and intensified parents’ reluctance to let their children undergo this procedure. All this of course slowed down the pace of immunisation in many localities throughout the island.

When vaccinators were asked by their superiors to explain the causes for the sluggish pace of the immunisation process in their area, they often came to put the blame on the ‘ignorance and superstition’ of the locals,⁶⁷ this itself showing their incongruence with and inability to comprehend local culture. Although the support of the *giunte* and the physical presence of the *sindaco* or the mayor were important to confer an aura of respect to the whole procedure, and to help solve a range of formal difficulties, they made little difference when it came to win over the confidence of reluctant parents. Reports from different locations distant from the capital, as well as from the overcrowded poverty-stricken quarters in the main urban centres, demonstrate that on various occasions many of those families who accepted cowpox vaccination were led to do so following the direct intervention of the local parish priest.

It was common practice for the mayor to ask the parish priest to accompany and to precede the arrival of the public vaccinator in specific neighbourhoods.⁶⁸ As well

62 Commissione Vaccinica Provinciale, Siracusa, no. 116, 27 Aug 1827.

63 ‘*effetto dal calda stagione che agendo fortemente sulla salute de teneri ragazzi*’ (Intendenza, Valle di Trapani, no. 13796, n.d.; ‘per la rigidita’ del tempo’ (Intendenza, Valle di Palermo, no. 13796, n.d., 12 Mar 1827.

64 ‘Risultati della Vaccinazione nel periodo di anni otto’, L’Intendenza, Valle di Trapani, no. 13796, Jan 1828.

65 Commissione Vaccinica, Valle di Catania, no. 23, 8 Mar 1827; Enclosure in Intendenza, Valle di Trapani, no. 13796, Jan 1828.

66 Giorgio Cosmacini, *Storia della Medicina e della Sanita’ in Italia* (Roma-Bari, 2005), p. 283.

67 Enclosure in Commissione Provinciale di Vaccinazione, Trapani, no. 13796, Jan 1828.

68 Intendenza, Valle di Palermo, no. 19069, 3 Nov 1828; Commissione Vaccinica di Catania, no. 36, June 1830.

as being present during the actual vaccination, the *parroco* was also expected to proceed to the site where outbreaks of smallpox had been reported in order to persuade his parishioners to ‘take the cowpox vaccine’, and to provide a sense of deference to the whole procedure as well as to help in the keeping of public order.⁶⁹ Such active participation of the parish curator in this public health campaign⁷⁰ depended on the respect which the parishioners had towards him as their moral and religious pastor (and as their confessor), as well as their spokesman and mediator⁷¹ with the state representatives and the local *giunta vaccinica*.

The parish priests employed a range of persuasion tactics, including that of publicly addressing ‘all heads of families’ to accept the cowpox during their sermons on the providential benefits accruing from the vaccine. This they did from their church pulpit, from where they also read new regulations and notices regarding the preventive.⁷² They also organised religious processions to accompany the public vaccinators in those poor residential quarters where the people showed aversion to or overtly refused cowpox vaccination.⁷³ It seems that this collective religious ritual was employed as early as 1801 to get the poor to accept the cowpox vaccine in Palermo, as vividly described by Joseph Marshall himself in a letter to Edward Jenner:

It was not unusual to see in the morning of the public inoculation at the Hospital a procession of men, women and children, conducted through the streets by a priest carrying a cross, com[ing] to be inoculated. By these popular means it met not with opposition and the common people expressed themselves certain that it was a blessing sent from Heaven, though discovered by one heretic and practiced by another.⁷⁴

Some parish priests employed other means to cultivate trust in the cowpox vaccine, such as soliciting local state representatives to get their children vaccinated in public to serve as an example for the whole community. On one occasion, the curator of a

69 ‘Sul vajuolo naturale’, Intendenza, Valle di Palermo, no. 19069, 3 Nov 1828.

70 For cases of clergy helping out in the vaccination campaign in the other Italian states cf. U Tucci, ‘Il vaiolo tra epidemia e prevenzione’ in F. della peruta ed., *Storia d’Italia, Annali 7, Malattia e Medicina* (Torino, 1984), pp. 410–411.

71 Cf. Antonio Gramsci, *Selections from the Prison Notebooks* (London, 1970), pp. 5–7, 13–14; L. Allegra, ‘Il Parroco: un mediatore fra alta e bassa cultura’ in C. Vivanti ed., *Storia d’Italia, Annali 4, Intelletuali e Potere*, (Torino, 1981), pp. 897–945; Terry Eagleton, *Heathcliff and the Great Hunger. Studies in Irish Culture* (London, 1996), pp. 77–78.

72 Commissione Provinciale di Vaccinazione, Valle di Catania, no. 36, 7 June 1830, ‘Sul vajuolo naturale’, Intendenza, Valle di Palermo, no. 19069, 3 Nov 1828, for the report by the local *giunta* with regard to the ‘zealous manner in which the local *parroco* preached in order to persuade the people on the advantages of the vaccine’.

73 *Encyclopedia Britannica 1890* <http://reformation.org.1890-britannica.html>; Commissione Vaccinica, Valle di Catania, no. 36, 7 June 1830.

74 As quoted in Glynn, p. 121.

parish in Palermo publicly called upon the *sindaci* to ‘vaccinate their own children as indeed they did’ – their example being immediately followed by some five hundred people.⁷⁵

That parish priests were crucial in the immunisation campaign at the community level was confirmed by the central commission’s resolution to have them occupy a seat in the local *giunte di vaccinazione*, together with the mayor and other members from the local elite.⁷⁶ Being formally incorporated in the public health vaccination programme, the parish curators came to be duty-bound by the government health regulations and the tasks imposed by the central commission of vaccination, one of which was to mark and watch over those families who refused the procedure. In this capacity, they were requested by the vaccination commissions to provide them with the ‘real numbers’ of those children who were not vaccinated in their parish.⁷⁷

The fact that the Vatican had accepted Jennerian vaccination early on,⁷⁸ with Pope Pius VII adopting it in his states in 1814, provided the parish curators with the needed sanction to take an active part in the Bourbon vaccination campaign. Their active participation does not seem to have declined to any substantial measure when, later on, Pope Leone XII (1823 to 1829) expressed himself negatively towards the mass propagation of the cowpox vaccine,⁷⁹ and issued a circular (on 15 September 1824) which revised the Vatican’s previously enthusiastic policy, stressing that if practiced, vaccination was to be kept non-compulsory.⁸⁰ The fact that it was never made compulsory in the Kingdom of Two Sicilies was one reason which kept many – although, of course, not all – of the parish curators supportive and active in this campaign.

Yet again, although effective at the parish community level, the influence of the parish priest did not always penetrate all households and convince parents to vaccinate their children. The common folk perceived the parish priest in ambiguous terms, both as their spokesman but also as the official representative of the institutional Catholic Church and (particularly through his connections with the local

75 Il Senatore della sezione dell molo, Palermo, no. 131, 18 June 1827.

76 Il Senatore della sezione del molo, Palermo, no. 432, 24 Apr 1828.

77 Commissione Vaccinica Provinciale, Siracusa, no. 136, 27 Dec 1827.

78 Martin Papenheim, ‘The Pope, the Beggar, the Sick, and the Brotherhoods: Health Care and Poor Relief in 18th and 19th Century Rome’, in Ole Peter Grell *et al*, pp. 142–180.

79 Historians have interpreted this as a reactionary move on the part of the Vatican, and of the Pope as being rigorously against Jenner’s cowpox vaccination (cf. B. Croce, *Storia d’Europa nel secolo decimono*, (Bari, 1832), as in Tucci, p. 412). On the other hand there was a strong tradition of Catholic clerical resistance – especially in the schools of theology – against inoculation; see Giorgio Cosmacini, *La religiosita’ della medicina. Dall’antichita’ a oggi* (Bari, 2007), pp. 105–108.

80 [Giacomo Tommasini], *Raccolta Completa delle Opere mediche dal Professore Giacomo Tommasini uno dei 40 della Societa’ Italiana etc.etc. con note aggiunte ed emende tipografiche* (Bologna, 1836), pp. 19–20. Ordinance of 1824 – which revoked the edict of June 1822. Apart from the rhetoric which he might have uttered against vaccination on several occasions, in actual fact Pope Leo XIII limited his prohibition to compulsory vaccination only (cf. Tucci, p. 412).

elite and the government functionaries sitting with him in the *giunta*) as an agent of state officialdom. On many instances, just like the public vaccinator, the parish priest was not native of the place where he was exercising his pastoral duties, and this partly diminished his influence on the parishioners. In such circumstances, the use of moral sanctions and pressures were not always appreciated by the parents, and frequently carried even less credibility with the mothers who were earmarked as the main targets by the regime's vaccination campaign. In contrast to issues relating to the soul, when it came to matters of health and cure of the female and infant bodies, it was the midwife (*levatrici* or *mammane*) who carried real weight and influence on the mother's mode of thinking and behaviour, not only during pregnancy and the post-partum period, but throughout her child's infancy.⁸¹

Unlike many parish priests, midwives were not identified with the all-male vaccination commissions and the *giunte* by the people. While exclusion from these state regulative and surveillance bodies did not give midwives any official decision-making capacities, it, perhaps unwittingly, contributed to solidify the – organic – trust and confidence in which they were held by local women, born out of physical and psychological intimacy. To be sure, midwives – being depositories of knowledge on matters concerning female and infant bodies, childbirth and curing practices – were fetched for advice and practical assistance during illness and on matters of contraception and fertility.⁸² Living in the same neighbourhood, they were usually readily available to all females at all times. Of course, it was due to all these factors, especially the esteem they were held in, that the *levatrici* were instantly identified by the public health authorities as the obvious persons most able to convince mothers that vaccination was safe and beneficial to their infants.⁸³ They were seen as those who could override, if not completely eliminate, the prejudice and the fear of vaccination from the households,⁸⁴ both in the rural and mountainous districts as well as in the crammed quarters of the large urban centres throughout Sicily.⁸⁵

81 Cf. A. Gissi, 'Levatrici e controllo delle nascite nell'Europa del Novecento', *Medicina & Storia: Rivista di Storia della Medicina e della Sanità*, (2004), 7, pp. 139–166.

82 Ibid.

83 Caterina Tisci, 'Le Levatrici e la diffusione della vaccinazione antivaiolosa nel Regno di Napoli', in *Revista Internacional de Culturas & Literatures* (Dec 2005), 3, pp. 1–3. For other parts of Italy, France and Britain cf. Jacques Gelis, 'Quando le donne partorivano senza medico' in Jacques Le Goff and Jean-Charles Sournia eds. *Per una Storia delle malattie* (Bari, 1986), p. 269; Michael Bennett, 'Jenner's Ladies: Women and Vaccination against smallpox in early nineteenth century Britain', *History: the Journal of the Historical Association*, vol. 93, 312, pp. 497–98.

84 Commissione Vaccinica, Valle di Catania, no. 23, 8 Mar, 1827; Intendenza, Valle di Palermo, no. 18524, 23 Oct 1828.

85 Y.M. Berce, *Le Chaudeon et la lancette. Croyances Populaires et médecine preventive 1789–1830* (Paris, 1984), p. 109; G. Consmacini, 'Curare e aver cura nel primo Ottocento', p. 22.

The regulations of the central commission of vaccination compelled midwives to assist in all aspects of the vaccination campaign in their locality⁸⁶ as a condition for the renewal of their official warrant.⁸⁷ Those who did not abide by their official duties were to be reported by the local *giunta* to the *intendente* who would, after communicating with the *Ministero dell Interno*, order the *protomedico* to suspend them from their service.⁸⁸ They were not only required to lay the ground – the social terrain of trust – for the community vaccinator, and to accompany him to the households or lead the parents to the vaccination centre, but were also expected to become knowledgeable about the *innesto vaccinico*. In this way they were better prepared to educate mothers on the benefits of the vaccine to their newborn, to directly help the vaccinator (both during the procedure and in revaccination), and to be able to act on any negative symptoms observed in vaccinated children.⁸⁹ Additionally, regulations compelled all midwives to keep a watchful eye on the ‘state of natural smallpox’ in their localities, and to report cases of the disease which they could come to know of during their daily itinerary of family visits. In these instances they were to contact the vaccinator right away and help him immunise those coming in contact with the diseased.⁹⁰ Midwives played all these active roles as part of their daily routine, remaining the first – and usually the only – link between the mothers and the public vaccinator. They also acted as interpreters, explaining the substance of medical discourse,⁹¹ and inculcated the new principles of prevention and avoidance in relation to smallpox and other contagious disease in their communities.

Slowing Down the Pace: Structural, Cultural and Human Constraints

The widespread aversion against the cowpox vaccine⁹² proved to be one of the principal problems which slowed down and, in many circumstances, disrupted this campaign. Refusal to be vaccinated was most common among the poorer majority of the people, and indeed it came to be ascribed, by the local civil authorities and

86 Commissione Provinciale di Messina, n.n., 10 May 1823.

87 It was through their active involvement in this mass vaccination campaign that midwives came to be incorporated as a specific category within a highly hierarchical male-dominated medical establishment. They were, of course, subjected to the orders and patriarchal attitudes of the male medics and, in this case, of the public vaccinator.

88 *Ibid.*, p. 2.

89 Tisci, p. 1.

90 Commissione Vaccinica della Valle, Catania, no. 36, 7 June 1830.

91 Gissi, pp. 139–166.

92 Tucci, p. 416; cf. for instance Commissione di Vaccinazione, Valle di Trapani, Cancelleria Comunale di Castelmare, no. 476, 7 Oct 1830.

by the vaccinators themselves to their ‘superstition, prejudice and ignorance’.⁹³ Most of the blame was usually put on the ‘uncultivated heads of the families’, who were normally the ones called upon to take their children to be vaccinated but declined to do so.⁹⁴ Even if the lack of information on the immunisation benefits which cowpox vaccination would provide⁹⁵ played a significant part in this reluctance, in reality this was caused by a multiplicity of factors, including the parents’ overwhelming preoccupation with earning a living,⁹⁶ to which ‘inoculation’ was less of a concern. But there was also the fear of scarifying the infants with the lancet, and the belief that cowpox vaccine would bring about the ‘minotaurisation’ (‘minotaurizzazione’) of the human body, or else induce in humans ‘diseases of a bovine nature’ (‘i mali propri della natura bovina’). This commonly found anxiety, coupled with a deep mistrust of the local representatives of the state who managed the campaign and frequently of the vaccinators themselves,⁹⁷ contributed to generate further reluctance to – and, on many occasions, outright refusal of – the vaccine.⁹⁸

With collective fear, shame played its part in holding back many of the poor from receiving the cowpox vaccine, especially when this was provided in the town hall. In a locality forming part of the commune of Girgenti, many of the poor villagers who lived in destitution did not respond ‘to the beat of the drums’ ordered by the *sindaco* to direct them to be vaccinated in the local *cancelleria*, ‘being so ashamed of publicly showing their misery’.⁹⁹ At the same time, the pride of the handful of local wealthy families led them to resist having their children ‘inoculated in a public location’,¹⁰⁰ this of course bringing to a complete halt the whole vaccination programme against smallpox in this community, and prompting the local authorities to reassess their earlier decision to stop public vaccinators from offering vaccination in private homes.

Suspicion of the cowpox vaccine was further engendered by the political instability and the social tensions which prevailed in Sicily – especially in the larger urban centres – throughout the period framing this study, and which were marked

93 ‘Ignoranza, la superstizione popolare appongono alla vaccine, han saputo a modo degli animi de loro compatrioti’, Enclosure in Commissione Provinciale di Vaccinazione, Valle di Trapani, n.n., n.d.

94 Intendenza di Messina, no. 3086, 27 Dec 1827; Intendenza, Valle di Palermo, no. 18214, 20 Oct 1828; Commissione Provinciale di Vaccinazione, Valle di Trapani, no. 13, 31 Jan 1829.

95 Intendenza, Valle di Palermo, no. 18524, 23 Oct 1828.

96 Enclosure, Commissione Provinciale di Vaccinazione, Valle di Trapani, nn. n.d.

97 Giorgio Cosmacini, ‘Curare e avere cura nel primo ottocento’, pp. 589–627.

98 Intendenza, Valle di Palermo, no. 18524, 23 Oct 1828; Commissione Vaccinica di Catania, no. 23, 8 Mar 1827.

99 Commissione Centrale di Vaccinazione, Palermo, no. 265, Apr 1824.

100 Ibid.

by the anti-Bourbon rebellions of 1820, 1831,¹⁰¹ and 1837 when a cholera epidemic was followed by a full-blown insurrection in Palermo. After spreading to Siracusa and Catania, this rebellion was brutally repressed by government forces;¹⁰² yet it was again followed by other outbreaks, the principal ones being the revolt of April 1848 and that of April 1860 in Palermo, which again spread all over the island. In this atmosphere of discontent, anti-Bourbon radical liberals and Sicilian autonomists amplified and manipulated the existing reluctance to vaccination by, for instance, divulging the myth that the Bourbon monarchy was employing the cowpox vaccine to slowly poison people, as was also attributed to the spread of the cholera epidemic of 1837.¹⁰³

Facing these multiple difficulties, many public vaccinators, together with the local state representatives, recommended to the health authorities to make cowpox vaccination compulsory. This proposal found the support of the provincial commissions of vaccination,¹⁰⁴ as well as the central commission in Palermo, which came to argue, time and again,¹⁰⁵ that compulsion would solve the problem of the people's reluctance once and for all, and would rationalise and facilitate the state vaccination programme.¹⁰⁶ These recommendations were however never implemented by the Bourbon monarchy.¹⁰⁷

The more structural factors which contributed to the obstruction of the vaccination campaign in Sicily included the already referred to unequal distribution of state financial and public medical resources throughout the island.¹⁰⁸ From the correspondence and the reports sent by the *giunte* and the *sindaci* to the Palermo commission, the unavailability or insufficient number of public vaccinators stands out as one main problem¹⁰⁹ with, for instance, Messina having only two vaccinators

101 Geijeses, p. 764.

102 A. Forti Messina, 'Il Colera e le condizioni igienico sanitari di Napoli nel 1836–37', *Storia Urbana*, 3, 1977, pp. 3–4.

103 Ibid.

104 'Una legge coattiva che obbligasse i parenti de neofiti a vaccarli spirato appena il primo mese lor eta' come aveva anche di obbligo in presentarli all'ufficio dello stato appena nati' Enclosure in Commissione Provinciale di Vaccinazione, Valle di Trapani, n.n., 12 Aug 1829.

105 Tucci, p. 416.

106 Intendenza di Messina, no. 1419, 9 July 1829; Tucci, p. 416.

107 Compulsory vaccination was first adopted in the principality of Piombino (Lucca) in 1806. It would take down to 1888, in the post-unification period, for it to be made compulsory throughout Italy.

108 Commissione Provinciale di Vaccinazione, Valle di Messina, no. 125, 20 Sep 1827; Commissione Provinciale Vaccinica, Siracusa, no. 116, 27 Aug 1827.

109 Commissione Vaccinica, Valle di Caltanissetta, no. 96, 12 June 1830; Intendenza di Messina, no. 14191, 9 July 1829.

to service 48 *casali* in 1829.¹¹⁰ The long distances, as well as the undeveloped state of the internal communication/transport system – the flow made worse still by the prevailing political and social instability – throughout the Sicilian territory¹¹¹ continued to severely hamper the rapid dispatch of the preventive vaccine to the local *giunte* at a time when there was no reliable method to preserve it.¹¹² This was coupled with the frequently insufficient quantity or total lack of fresh cowpox vaccine¹¹³ which disrupted the process of immunisation at the local level, as evidenced by the voluminous letters and reports from Messina, Trapani, Catania and Caltanissetta, with one letter stating that this was ‘creating disorders in the process of vaccination’.¹¹⁴ Fresh supplies of the *variolae*, ordered by public vaccinators through their mayor and the *Intendenza*, on too many occasions took too long to get dispatched in crystal tubes¹¹⁵ (which was found to be the best method of transporting the cowpox matter at the time), and arrived on location¹¹⁶ frequently ‘getting spoilt’, owing to the long journey and the hot climate. This evidently complicated matters for the local vaccinator, as it generated further mistrust in the whole campaign. Moreover, as already noted, when the vaccine matter arrived in ‘extreme seasons’ – high summer or winter – vaccinators were apprehensive of using it on infants, leaving it to ‘a more docile season’,¹¹⁷ by which time it risked becoming ineffective. A routine complaint among the vaccinators was that they did not have enough vaccine available at the right time to be used on the children who were presented to them, and this did not only happen in remote areas but even in the poor quarters of central Palermo.¹¹⁸

110 Intendenza di Messina, no. 11193, 23 May 1829; ‘Pei Vaccinatori di Messina’, Intendenza di Messina, no. 14191, 9 July 1829, leading to many communes having experienced little vaccination (Commissione Vaccinica Provinciale, Siracusa, no. 116, 45 May 1827).

111 Desmond Gregory, *Sicily: The Insecure Base. A History of the British occupation of Sicily, 1806–1815*, (London-Ontario, 1988), p. 38; On the state of the roads cf. Perez, pp. 82–101; The first plan for a railway in Sicily being made in 1859 (with the first line Palermo-Bagheria (13,337 km) starting to be laid down only in 1861 and opening it up in April 1863. The Bourbons were the first in Italy to have constructed a railway (Napoli-Portici) in October 1863 (R. Giuffrida, *Politica ed Economia nella Sicilia dell’Ottocento* (Palermo, 1980), p. 239.

112 Tucci, p. 417; Glynn, p. 117.

113 ‘Virus nel Comune di Caltanissetta’, L’Intendente, Caltanissetta al Preside. della Commissione Centrale di Vaccinazione, Palermo, no. 3595, 12 Mar 1827; Intendenza, Valle di Palermo, no. 3173, 7 Apr 1827.

114 Commissione Provinciale Vaccinica, Siracusa, no. 116, 27 Aug 1827; ‘Stato di Vaccinazione di Palermo’, Intendente, Valle di Palermo, no. 16802, 1 Oct 1829.

115 Enclosure in Commissione di Vaccinazione, Messina, no. 1205, 18 Nov 1830.

116 Valle di Trapani, Cancelleria comunale di Castellamare, no. 1476, 7 Oct. 1830; Intendenza, Valle di Palermo, no. 829, 23 May 1827 and no. 573, 7 Apr 1827; Comando delle Armi in Sicilia (Sezione 4°), Palermo, no. 3992, 26 Oct 1828.

117 Cf. Intendenza, Valle di Palermo, no. 3595, 13 Mar 1827; also no. 829, 23 Mar 1827.

118 Intendenza, Valle di Palermo, no. 4040, 21 Mar 1827; Intendenza, Valle di Palermo, no. 17456, 7 Oct 1828; Intendenza, Valle di Palermo, no. 829, 23 Mar 1827.

As elsewhere, the principal problem encountered by this vaccination campaign to control and eradicate smallpox was related to the epidemiology of this disease. Known to be highly endemic in many parts of Sicily,¹¹⁹ this disease favoured the densely populated urban, suburban and remote village living quarters of the poor. In the long term, although showing signs of general abatement, its incidence in many poor neighbourhoods remained high. It mainly carried away or disfigured pre-seven-year-old children who lived in a state of indigence and destitution, such as those inhabiting the overcrowded unsanitary quarters in Palermo, Catania, Siracusa and Messina.¹²⁰ The *quartiere Santa Cristina*,¹²¹ the *quartiere Sant'Agata* in Palermo, and the *quartiere de Pizzilari* in Messina, as in other comparable neighbourhoods in similar localities and rural villages¹²² throughout Sicily created the ideal conditions for the incubation and spread of *vaiola*.¹²³ Such densely crammed residential quarters not only experienced frequent outbreaks and resurgences of smallpox (which were also due to the neglect of re-vaccination),¹²⁴ but were also the most hard hit during the ferocious smallpox epidemics in Sicily, such as that of 1838-1839. In one of these destitute neighbourhoods, public vaccinators reported that they could not proceed to vaccinate the children who were found undernourished, as their bodies were so 'extremely fragile' that they could not 'take the cowpox'.¹²⁵

Somewhat ironically, these same outbreaks of smallpox, with their horrible death tolls and the loss of sight or disfiguration of those who survived,¹²⁶ as well as the hasty and unceremonious internment of the bodies in unconsecrated grounds, prompted parents to overcome their reluctance and to rush their children to be vaccinated. One such case occurred in Avola in 1827, where the bodies of two infants who died of smallpox were buried in a coffin '*ben lutata con calce ed altro*' in uncon-

119 Tucci, pp. 416–417.

120 Intendenza, Valle di Palermo, no. 964, 10 May 1827: 'Informo sull Vajuolo naturale', Il Regio Protomedico Sostituto, no.45, 26 Nov 1827; Intendenza, Valle di Palermo, no. 15940, 28 Oct 1830; Woolf, p. 290.

121 Intendenza, Valle di Palermo, no. 6964, 10 May 1827.

122 'Pello Sviluppo di vajuolo in una ragazza di compagnia di St Angelo', Commissione Provinciale di Vaccinazione, Messina, no. 916, 19 Oct 1830.

123 Intendenza di Messina, no. 3086, 27 Dec 1827; Commissione Provinciale di Vaccinazione, Valle di Messina, no. 1205, 18 Nov 1830; Commissione Provinciale di Vaccinazione, Valle di Messina, no. 174, 31 Dec 1827; 'Su vajuolo naturale in Avola', Il Regio Protomedico, Commissione Centrale di Vaccinazione, Palermo, no. 45, 26 Nov 1827; 'Il vajuolo naturale in Casalnuovo', Commissione Vaccinica, Valle di Catania, no. 36, 7 June 1830; Intendenza, Valle di Palermo, no. 1957, 30 Aug 1819 (for smallpox occurrence in Montemaggiore); Tucci, p. 402.

124 'Informo sul vajuolo natural in Avola', Il Regio Protomedico Sostituto, Palermo, no. 45, 26 Nov 1827; Gregory, p. 39; Woolf, p. 290.

125 'Risultati della Vaccinazione nella Valle di Trapani', Enclosure in Commissione Provinciale, Valle di Trapani, no. 13796, n.d.

126 Commissione Vaccinica, Valle di Catania, no. 37, 7 June 1830.

secrated ground, instead of the Catholic parish cemetery – an act which horrified the community and stirred most of the reluctant villagers to take their children to the vaccinator without further ado.¹²⁷ As a matter of fact, collective panic, brought about by such outbreaks of *vaiola*,¹²⁸ accelerated vaccination in the community in a way that no tactic crafted by the public health authorities and the agents of the vaccination campaign could have ever achieved.¹²⁹

Conclusion

One general conclusion which can be drawn from this study is that while the Bourbon government invested in an energetic mass vaccination campaign against smallpox, it lacked an accompanying strategy to seriously deal with and reduce the widespread poverty and the unsanitary conditions which most of the people lived in, and which formed the ideal conditions for the frequent outbreaks and spread of *vaiola* as well as other contagious disease. Neither were the deeply ingrained culture and state ideology of charity-based poor relief ever really challenged, not even with the series of administrative reforms implemented in the public health and poor relief welfare sectors. On the contrary, traditional principles of charitable benevolence were consolidated as a cornerstone of the Bourbon monarchy's state ideology and power strategy, through which it sought to extend social control and foster consent for its rule, particularly in Sicily, where the state was commonly perceived as distant from local affairs. It has been shown how actually the Bourbon regime attempted to amalgamate an entrenched conservatism with efforts at administrative modernisation of the thick layer of charitable establishments, hospitals and poor relief services. Being one of the first massive public projects launched by the Restoration monarchy, this vaccination campaign echoed, and indeed articulated, this combined government agenda – itself introducing the new notion of preventive medicine while employing the more conventional practices – based on state mercantilist protectionist beliefs, which entailed containing smallpox contagion as well as diffusing the cowpox vaccine throughout Sicily.

Moreover, the ways in which this vaccination programme – directed to each individual body – was implemented and operated provided an excellent case study

127 'Vajuolo Epidemico', Il Regio Protomedico Sostituto, Avola, no. 46, 29 Nov 1827; another two dead children were taken by the Capuchin Friars and buried in their grounds, out of the inhabited area.

128 Intendenza di Palermo, no. 1957, 30 Aug 1819.

129 La Commissione, Valle di Catania, no. 2, 6 May 1819; cf. also Intendenza, Valle di Palermo, no. 4040, 21 Mar 1827; cf. 'Vajuolo in Castiglione e delle misure', Commissione Vaccinica, Valle di Catania, no. 344, 3 Sep 1829; Commissione Vaccinica di Catania, no. 36, 8 Feb 1830. For a similar case in Montemaggiore see Intendenza, Valle di Palermo, no. 1957, 30 May 1819.

of how prevention and surveillance complemented each other in the history of public health. This has been illustrated by a range of examples which include the systematic gathering of statistics and other information on households and neighbourhoods, the listing and close watching of those who were reluctant to vaccinate their families, and the employment of the police and the military to prevent further contagion and social unrest. In these ways, while immunising the people against smallpox, mass vaccination assisted the Bourbon regime in keeping a modicum of public order in the disturbed Sicilian social and political landscape, although, as this study also shows, this was not always achieved.

On another level, being so intricately intermeshed with the regime's political designs and the prevailing power structures, this vaccination programme became heavily dependent on the state administrative arrangements – at the communal and provincial levels. It also depended on the local representatives (mainly the *intendenti* and the mayors) who became its pivotal agents on the spot, even for the supply of basic resources, to secure a sufficient quantity of vaccine matter and the needed number of vaccinators in a locality. But on the other hand, narrowing down analysis at the local community and neighbourhood levels, the vital roles played by local personalities clearly emerges. Conjointly with the public vaccinator, who was officially sent to one location or another, the local parish priest and the midwives were pivotal to the spread of the cowpox vaccination in their town, village and neighbourhood. Dedicating a substantial part of its research to the daily practices of each of these protagonists, this study has been able to mark the practices and tasks of each of these personalities, and to measure their weight in the immunisation campaign in their localities. It has shown how, for instance, the public vaccinator, albeit being the one who actually immunised each individual, was frequently unable to convince households to accept the cowpox vaccine in the first place. At this juncture, the local *parroco* comes out as the one who could persuade his parishioners, in general, of the need to be vaccinated – through his moral and social sway, and by employing a range of persuasive tactics. But even more than the parish curator, it was the midwife, whose trust by the mothers and the family far outweighed the faith which they might have had towards the other two male agents of the vaccination campaign. And, it was mostly due to these *mammame* that more and more parents came to vaccinate their infants against smallpox, notwithstanding the multiplicity of structural and organisational difficulties which came to hold back, and frequently disrupt, the introduction and spread of this vaccine in the various communes of the island.

Procuring social trust through the art of persuasion was ubiquitous in the complex human experience making up the immunisation campaign of the Sicilian population. Perhaps a significant contribution made by this study is that of having illustrated that, coupled with trust – and indeed mistrust – people's subjective perceptions, both real and the more hazy; their irrational attitudes or religious

beliefs; shame and pride; their shared world views; and notions of health, care and cure of the body – as expressed either in the fatalistic acceptance of, or the varying measures of fear or reluctance to, vaccination – had a profound bearing on the whole cowpox vaccination campaign in Sicily.

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Cholera in the Portuguese Region of Alto Minho in the Second Half of the Nineteenth Century: Epidemic Outbreaks, Treatment and Behaviours

Alexandra Esteves and Marta Lobo de Araújo

In the 19th century in result of the inherent advances of the industrializing process, the distances were shortened, distant regions became nearer and the circulation of people and goods through several parts of the globe was easier. The diseases also spread more quickly, assuming sometimes uncontrollable proportions, not only by land, but also by sea, through boats that, in addition of transporting people and goods, also served as means of transmission of epidemics into different countries and continents.

Along the 19th century cholera¹ was one of the diseases that, both on land or by the sea, reached several areas of the European continent, causing a strong impact in the western civilization, not only in demographic and economical level, but also in social and cultural ones.

The disruptions caused by the illness, aggravated by the incompetence initially revealed by the authorities to avoid and fight this pathology, contributed to the appearance of not much coherent and even imaginative explanations and theories, in the desperate attempt of finding justification and solution for an evil that was affecting all, direct or indirectly. As an example, in 1866, in the sequence of the

1 Cholera is a disease caused by the so called *Vibrio Cholerae*, an agent transmittable through the water and from contaminated foods, or through the straight contact with contaminated individuals. Consult Ponce Herrero, Gabino. “Él Cólera en Alpera y Bonete. Siglo XIX.”, *Revista de Estudios Albacetenses*, n.º 13, 1984, pp. 53–72. Asian cholera was known since old times, having references to this disease in Hindu books. See Lemos, Maximiano, *História da Medicina em Portugal. Doutrinas e Instituições*, vol. I, Lisboa, D. Quixote, 1991, pp. 230–233. The first european references done on cholera were advanced by Gaspar Correia, in his work *Lendas da Índia*, in 1543 and, by Garcia da Orta, in 1563, which analyzed the disease from the medical point of view. On this subject see Cunha, Fanny Font Xavier da, “Evolução histórica da ciência médica e política patrimonial”, *Cadernos de Cultura. Medicina na Beira Interior da Pré-História ao Século XX*, n.º 16, pp. 67–72 and Ferreira, F. A. Gonçalves. *História da Saúde e dos Serviços de Saúde em Portugal*, Lisboa, Fundação Calouste Gulbenkian, 1990, p. 179.

epidemic outbreak of cholera, which emerged in Portugal in 1865, the newspaper *O Vianense*, published an article of the *Gazette de France*, where it is revealed the discovery of cholera by a doctor, who stated the idea that the origins of the Asian cholera were connected with the emission of poisonous gases freed by the bodies that, thousands of years ago were burnt in India. These gases were concentrated in the sky of the tropics, lifted to the most elevated regions of the atmosphere during the day, but after the sunset, they descended to the inferior regions, in order to being mixed with the water and the food, penetrating the lungs through breathing. When this poisonous gas was introduced into body, it caused the very own symptoms of cholera, as dysentery, vomiting and cramps.²

This theory met the normally accepted idea, until the discovery of the bacterial agents responsible for the infection, in which the infectious diseases were caused by *miasmas*, in other words, invisible substances emanated from organic materials in decomposition.³

Initially, the ignorance of the causes and ways of transmission of cholera made believe that the yellow fever, cholera, malaria and typhoid were not more than the same disease, but with different symptoms.⁴ These mistakes were resolved when Robert Koch, in 1883, discovered the bacillus of cholera.

Original from the delta of the Ganges, in India, the cholera assumed, for the first time, epidemic proportions in an outbreak that took place in the period between 1817 and 1823, having reached, in a first phase, China, Oceania, the Philippines and Japan, reaching, subsequently, Asia Minor and Egypt. A second outbreak took place between 1826 and 1837, with its origin again in the delta of the Ganges, having spread for the first time to Western Europe transported by soldiers and populations. From this point there were different epidemics of cholera throughout Europe and they devastated several regions. So, with bigger or less amplitude, a third outbreak happened between 1841 and 1862, a fourth between 1864 and 1875, and a fifth between 1882 and 1896, and yet to mention an epidemic of cholera that appeared in 1899.⁵ Cholera reaches Portugal in 1832.⁶ The disease may have been

2 *O Vianense*, n.º 1306, 27 de Novembro de 1866.

3 Tally Ujvari, Stefan Cunha, *A História e suas Epidemias. A convivência do homem com os microrganismos*, Rio de Janeiro (Editora Senac Rio, 2003), pp. 153–157.

4 See Jiménez, Juab Bta Mateos. “Nacimiento de la Sanidad Internacional” *Revista Española de Salud Pública*, vol. 80, (2006), p. 654.

5 On several outbreaks of cholera consult Svobodný, Petr, “The Health of the Population and Health Policy in 19th century Bohemia: The Case of Asiatic Cholera (1830s–1900s)”, in Abreu, Laurinda (Ed.), *European Health and Social Welfare Policies* (Compostela Group of Universities and the PhoenixTN, European Thematic Network on Health and Social Welfare Policies, 2004), pp. 200–215.

6 To point out that the date is not generally agreed, so, in the opinion of some authors, the cholera invaded Portugal earlier, more precisely in 1826. Viegas, Valentino; Frada, João; Miguel, José Pereira. *A Direcção-Geral de Saúde. Notas Históricas* (Lisboa, 2006), p. 7.

carried to Portugal, by ships from the city of Ostende, in Belgium, that were heading to the city of Oporto in aid of the liberal armies. Quickly, it was spread throughout the North of the country. At this time, the country was plunged in a civil war, which opposed the liberal forces to the absolutists. After reaching the city of Oporto, cholera spread throughout the country, causing a total of 40.000 victims.⁷

However, this first outbreak did not reach any of the councils of the county of Viana do Castelo, located in Alto Minho, a region in the North of Portugal, but it affected several regions of the country, with particular severity Lisbon, where the victims' number reached the 13 000.⁸

The aim of our analysis consists in evaluating the impact that the epidemics of cholera caused in Alto Minho, region composed by the councils of Arcos de Valdevez, Caminha, Castro Laboreiro, Paredes de Coura, Melgaço, Monção, Ponte da Barca, Ponte de Lima, Viana do Castelo, Vila Nova de Cerveira e Valadares. This was an essentially agricultural region, where a great part of people were dedicated to agriculture and had the land as their main source of subsistence. Region where the needy classes had a poor food diet, subjected to the cereal crises, whose houses did not have the cleaning and salubrity conditions and the habits of personal hygiene were insufficiently implemented. This scenery was contributing for the appearance of diseases between the poorest, that could acquire an endemic aspect, originating epidemics that placed this region in fear.

After this first outbreak, measures and operating dispositions were carried out, in order to stop the entrance of cholera in Portugal, as well as other epidemics. In 1837, it was created the Public Health Council, working in the dependence of the Ministry of the Kingdom, to supervise all the aspects that were connected with health. With the same target the delegate's and sub delegate`s posts were created for the Public Health Council, working in all the counties and councils, and for each parish the post of leader of health was created, which would be fulfilled by the *regedor*.⁹ These changes, unleashed by Passos Manuel altered in a significant way the concept of health in Portugal. Without neglecting the cure, the priority was centered in the prevention of the disease, as you can notice through the importance attributed to the inspection actions that were carried out in potentially unhealthy

7 On the advancements of cholera in national territory read Roque, João Lourenço, “Epidemias no distrito de Coimbra no século XIX (1830–1870), in *Revista Portuguesa de História*, 34, (2000), pp. 22–25.

8 Cholera reaches Portugal in 1832 transported by ships originating from the Belgian city of Ostende, which were addressing to the city of Oporto. Quickly the disease spread to all the north of the country. Read Cunha, Fanny Font Xavier da, “Evolução histórica da ciência médica e política patrimonial”, *Cadernos de Cultura*, p. 68.

9 Regedor - Administrative authority of a parish.

spaces, or by the recommendations given to the city halls to look after the cleaning of these places.¹⁰

In 1848/1849, cholera was devastating Europe again, which led the Portuguese authorities to take several prophylactic and preventive measures, not always well accepted by the local populations.

Only in the fiftieth decade of the eight hundreds, cholera will appear in the county of Viana do Castelo. Meantime, the administrative authorities were taking the proper precautions and putting into practice the directives drawn by the health delegate. At local level, they were looking for creating awareness in people of the importance of the personal hygiene, the cares to have with the food, with the cleaning of their houses and even with the moment of death. In terms of the public hygiene, one was advised for the cleaning of the streets and the public spaces, the inspection of places of sale of nourishing goods, and the cautions to have with the corpses' funerals. On the other hand, in spite of the creation of hospitals for cholera patients¹¹, several structures of organizing and support were created, for instance the help commissions set up in all the council parishes belonging to the county of Viana do Castelo.

Although in the wrong way, the cholera's miasmatic origin was ruling, and it is certain that it contributed to important developments in terms of the individual and public hygiene. To this purpose, it assumed particular relevance the fact that the populations were starting to be aware of the filthy and unhealthy places that were making easy the propagation of infectious diseases. In 1856, in a local newspaper of Viana do Castelo, a reference is made to the existence in the city "*of many deposits of filth*", mentioning butchers, factories and places selling food goods, giving particular distinction to the square where fish was sold, so "*it is nauseating the pestilential smell that there is breathed*"¹², and about the prison located in the centre of the city, which, was not being aired properly, "*preserves a corrupt air.*"¹³

It was feared that the entrance of cholera in the Alto Minho was going to be by the sea, through boats coming from the *dirty ports* and that were mooring in the ports of Viana do Castelo and Caminha, or still by river and land road, in result of the regular contacts with the neighbour Galiza. In fact, these fears of penetration of cholera through the frontier with that Spanish province were based due to the cir-

10 On this subject consult Viegas, Valentino; Frada, João; Miguel, José Pereira. *A Direcção-Geral de Saúde. Notas Históricas*, pp. 9–15.

11 Esteves, Alexandra, *Assistência às vítimas de cólera no Alto Minho na primeira metade do século XIX*. (in press).

12 Big cities, like, for example, London also were corrupted by the bad smells. George Gissing, in his work *The Nether World*, he tells this about the biggest European metropolis of that time: "the air is poisoned by the odor of lack of cleaning". See Charlot, Monica: Marx Roland (dir.), *Londres, 1851–1901. A era vitoriana ou o triunfo das desigualdades* (Lisboa, Terramar, 1995), p. 56.

13 *Aurora do Lima*, 27 de Maio de 1856, n. 65.

ulation of people between the two sides of the frontier, which has took the Portuguese authorities, to impose a sanitary cord, at the least suspicion of the presence of some cholera outbreak in Galiza,. However, this measure was not always understood and respected by the populations, especially by the poor, that needed to maintain the connections with that neighbor of the other side of the frontier to insure their survival, just like in the case of the fishermen of Caminha.

In 1853¹⁴ the cholera invaded Galiza. In December of the same year, in the village of Valença, belonging to the county of Viana do Castelo, a woman, who was known to have been in that Spanish province some days before, manifested the symptoms of the disease. Facing this first case, immediate measures were taken to avoid the propagation of the illness, cutting the communications with Galiza and isolating the house of the contaminated family.¹⁵

On the 3rd of January of 1854, the health delegate informed the civil governor of the county of Viana do Castelo of the non-existence of any case of cholera in Valença, as the situation was controlled in that district.¹⁶ However, he noticed the maintenance of the epidemic in the neighbour Galiza, underlining therefore the necessity of the maintenance of the sanitary cord and the cut of communications with that region. Bay the way it matters to say that the Galician authorities not always showed their collaboration in the combat of the disease, showing, some times, a certain resistance in admitting the existence of cholera in their territory. As a matter of fact, there were frequent complaints by the Portuguese heath authorities to the Civil Governor because of this behaviour and of the damages that it could cause in the public health. Such an attitude had to do, especially, with the negative impact that the sanitary measures imposed by the Portuguese were causing in their economy. Therefore it was necessary a very careful attendance by the Portuguese authorities of the sanitary situation of the neighbor Galiza.

The council administrator of Vila Nova de Cerveira knowing of the cases of cholera in the council of Valença, not only cuts communications with Spain, but also ordered that the relations with Valença should be restricted to guarantee the efficiency of the sanitary measures planted in his council.¹⁷ He officiated to the Spanish authorities of Tuy and Vigo in order to obtain more information on the incidents of the illness in those places, but he didn't get any answer. In January of 1854, the same administrator informs the civil governor of the difficulty in maintaining the cuts of communication with the Galiza, because of the fishermen, therefore he found necessary the intervention of the military strength to enforce this

14 The Galiza had big outbreaks of cholera in 1833, 1853 e 1863. Simon Lorda e Rúa, Dominguez M., "Él cólera de 1885 en Ourense", *Minius XIV*, 2006, p. 270.

15 Historical archive of the Civil Government of Viana do Castelo (henceforth AHGCVC), received Correspondence of the health delegate, n.º 1.13.6.10-1, not paginated.

16 Ibid.

17 Ibid.

decision. He commanded the apprehension of the barges of the fishermen and placed policemen in the points of the river passage to make this measure possible.¹⁸ Also he asked the commander of the fourth military division, for the house of the government of the square of the town in order to establish a hospital there for the treatment of cholera patients, and he formulated a petition to the brotherhoods, in particular to their treasurers, in order to dispose an amount of their funds to help the poor patients, if cholera reached that district, which did not come to happen.¹⁹

The council administrator of Monção equally let know to the civil governor that the cholera persists in the Galician coast, presumably in result of the infection through an English boat, whose crew was presenting symptoms of cholera. Due to the geographical proximity, the communications were cut with Galiza, and it was proceeded with the organization of help commissions and according to the arrangements of the city hall, they took hygiene measurements, such as domiciliary visits to check the cleanliness and the cleaning of the houses, especially the poor ones, inspection of the consumable foods and of the places of sale and the cleaning of the public spaces of the town.²⁰ A special preoccupation happened from the part of the authorities in installing and generalizing a set of practices of hygiene and prevention with the intention of safeguarding the public health. For that it was necessary to educate the populations, especially the poorest extracts, whose houses, shared very often with animals, were accumulating all types of filth and whose residences were favoring the appearance and the propagation of diseases.

The council administrator of Caminha, recognizing the importance of the cut of communications with Galiza, officiated to his homonym of La Guardia, asking him to obstruct the passage of people of that village to Caminha, in order to fulfill integrally the principle of cut of communications.²¹ However, since it will be shown further on, this administrator faced the difficulties and the resistances caused by the imposition of the cut of communications with the nearby region. Knowing that the port of Lugo was infected, this same authority, questioned the civil governor of the county of Viana do Castelo on the proceedings to take if infected ships moored in the port of Caminha.²² Such behavior demonstrates that the administrative authorities were still not properly informed on measures regarding the vessels originating from contaminated ports, and that might constitute one of the roads of propagation of cholera. The council administrator of Caminha also notices the shortage of the charities gathered by the help commissions in the different communities of the council, since they wouldn't serve for much, if cholera reaches that county, which

18 Ibid.

19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.

will happen in the next year, in 1855.²³ This way the above-mentioned administrator was revealing some of the fragilities inherent to the measures extolled in the sense of avoiding the penetration of cholera.

In the beginning of January of 1854, the health delegate is invited by the Spanish authorities to participate in a commission of doctors and, according to superior orders, they should go through the different points of the Galician province to observe the cases of cholera that were happening there. This meeting had the participation of nine doctors, from Pontevedra, Redondela and Tui, and was headed by the Governor of the province. However, the health delegate of the county of Viana do Castelo refused to accept this invitation, due to the cut of communications that were still happening with Galiza.²⁴

At the end of January 1854, the situation seemed stabilized. In a report sent to the Public Health Council, the delegate of public health was demonstrating to be informed of the sanitary situation in Galiza, saying, however, that, officially, he was informed of only one incident of cholera case in the city of Tuy, when later he knew that, in fact, there were forty three cases registered. This episode comes, at last, to corroborate the idea that the Galician authorities were omitting or distorting the real dimension of the problem, which was reinforced the necessity of maintaining the sanitary cord.²⁵

The cases of cholera that were felt in Valença, at the end of 1853, though sporadic and quickly controlled, led the sanitary and administrative authorities to be preoccupied and endow the councils with structures for the treatment of cholera patients, which is an example the construction in the fort of Novelhe, in Vila Nova de Cerveira, of an intern *lazareto*,²⁶ which started functioning it the beginning of February 1854, destined not only for the patients of cholera, but also to provide lodging for individuals who for one reason or another should be subdued to a sort of quarantine. This institution would be endowed with a doctor, a pharmacist, two servants and an outdoor policeman.²⁷

The county communities nearby Galiza were on alert and frightened by the possibility of penetration of cholera through the frontier. In March 1854, the council administrator of Ponte da Barca and the community *regedor* of Lindoso, knowing that cholera was developing gradually in Galician lands, a few *légoas*²⁸ away, asked the help of the health delegate, in order to obstruct the entrance of the disease in their territory. The health delegate proceeded with the necessary diligence, and officially consulted a vice-deputy in Tui and the doctor in charge of the cases of cholera

23 Ibid.

24 Ibid.

25 Ibid.

26 Lazareto – Building for quarantines.

27 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.10-1, not paginated.

28 Légoa – Ancient unit of itinerary measure, measuring five kilometers.

on the side of the frontier, in order to certify themselves of the presence of the illness in the Galician region. As a response he obtained the confirmation that, in fact there were cases of the disease happening in the province of Ourense.²⁹

The sanitary cord will be maintained during the next months, involving 30 to 40 policemen of the customs, 16 soldiers, and some police officers, that had the mission to guard the frontier from Caminha to Melgaço.³⁰ However, it will not be enough to avoid the reappearance of the cholera evil, between 5 and 14 of May of 1854, in the council of Valença. Such situation happened after a market took place, in the city of Tuy, where inhabitants of the council of Valença had gone, not respecting the sanitary cord, later four individuals perished.³¹ Again, the entrance of the epidemic was registered through the border, which demanded the increase of the warnings regarding the neighbour Galiza, from where it was known beforehand, that it wouldn't be given any cooperation.

In the 9 of May 1854, after having the news of a propagating cholera outbreak in Valença, the city hall of Monção met the council administrator and the doctor of the party, in order to adopt immediate measures to obstruct the entrance and propagation of the cholera virus in the council. It was then decided to reestablish the cut of all communications with Galiza and to interrupt the contacts with Valença; it was determined the withdrawal of all boats at half a *légoa* of distance of the river Minho and the destruction of all the vessels that were not respecting this resolution; a hospital was created for the treatment of cholera patients, with the capacity to receive between 20 to 30 patients, benefiting from the financial support of the brotherhoods and of the *Misericórdia* of the village, especially in the support of goods for the patients and for the nurse's salary.³² The city hall compromised itself to deal with the other expenses. On the other hand, people coming from Galiza would remain for a determined time in a certain place, in a kind of quarantine, before coexisting with the remaining members of the community.³³ Simultaneously, the administrative and sanitary authorities reiterate the importance of the cleaning of the public spaces and of the elimination of all the possible focuses of infection, as well as the necessity of improvement of the life conditions for the most in need, especially what concerns food and clothing, as these were the most fragile ones, they

29 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.10-1, not paginated.

30 Telly Cyrne, Francisco, "A cólera-morbus no distrito de Viana do Castelo (Apontamentos)", *Arquivo do Alto Minho*, 4.º vol. Tomos III e IV, (1955), p. 113.

31 Esteves, Alexandra, *Assistência às vítimas de cólera no Alto Minho na primeira metade do século XIX*. (in press).

32 Misericórdia – Lay brotherhoods that at the Council of Trent obtained the privilege of "immediate royal protection". These brotherhoods practiced the fourteen Works of charity and became the most important institutions of charity in Portugal.

33 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.12.12, not paginated

would be more exposed to get infectious diseases, that could be avoided by preventing them.³⁴

In Caminha, the council administrator, after having been notified through a circular of the civil government of Viana do Castelo of the existence of cholera in Valença, he explains the preventive measures applied in his district, regarding, the interruption of the connections with Galiza, the realization of domiciliary visits, the checking of the cleanliness of the houses of the residents in the councils, and the creation of a hygienic commission composed by health professionals and a priest. To refer also that this commission asked the council administrator to notify the civil governor in order to get authorization so that the town of Caminha could spend money from their safes with the necessary investments in order to guard themselves properly, if the cholera emerges.³⁵

In July 1854, due to the rumors of the persistence of cholera in Galiza,³⁶ the civil governor of Viana do Castelo put in charge the council administrator of Caminha in order to know the truthfulness of those rumors that were alluding to the presence of the disease in Pontevedra and Ourense. However, such information was contradicted by the vice-deputy of La Guardia, who guaranteed he would communicate any incident.³⁷ Afterwards, by the end of August, several cases of cholera occurred.

In September of the same year, the health delegate of Viana do Castelo informed the civil governor that the cholera developed gradually in the province of Ourense, up to four *légoas* of distance from the frontier, though the vice-consul of Tui gave no knowledge of this event, considering that this neglected act would put in risk the public health in the county of Viana do Castelo.³⁸ Also the council administrator of Vila Nova de Cerveira announced to the civil governor the existence of cases of the disease in Galiza.³⁹

Regarding this situation, in September 1854, it is ordered to the council administrator of Melgaço to he shut down immediately all communications with Galiza, through the dry line, as the Galician frontier was considered dirty recurring for that to armed forces. At the same time, it is reiterated the importance of the help commissions that had to exist in all the villages.⁴⁰

Facing the aggravation of the situation in Galiza, in September of the same year, the Public Health Council ordered the shutting down of communications with all of Spain, with the exception of the entrance of cattle by water and fish, through a

34 Ibid.

35 Ibid.

36 Ibid.

37 Ibid.

38 Ibid.

39 Ibid.

40 Ibid.

fiscal point in each council, at the administrator's choice.⁴¹ The news from the province of Ourense, was not particularly encouraging, noticing the death, on the 15th September, of five individuals, and, the next day, other three deaths, in the above-mentioned province.⁴² The rumors of the existence of an outbreak of cholera in Spain intensified through people who were coming to the councils of the Alto Minho to treat business or were going to health-resorts in Monção.

In October 1854, the Health Council launches a new edict with measures that should be applied in all councils, to avoid the penetration and propagation of the cholera disease. In the council of Monção, all communications with Galiza were suspended, with the exception of the entrance of cattle by water and fish, according to the established by the Public Health Council in the previous month.⁴³ However, the administrator declares the embarrassment caused by the sanitary cord and the difficulty in preventing people from crossing the border, because many inhabitants of that council needed to move to Galician territory in order to guarantee their subsistence.⁴⁴

The council administrator of Caminha, also noticed the difficulties in imposing a sanitary cord and in making sure of the cut of communications with Galiza, especially, due to the resistance of the inhabitants of the riverside community of Seixas and Lanhelas, very poor villages, that were living only from the fishermen's activity and to secure their subsistence continued to move from one side to the other of the frontier, through the river Minho.⁴⁵ On the other hand, the imposition of measures of prevention and inspection demanded investments which neither the city hall nor the help commissions could carry out due to the lack of financial resources, because the council was being affected by a serious food crisis and people could offer nothing, as they had not enough for their survival.⁴⁶

In November 1854, in the council of Monção, edicts were stuck with regulations from the police and municipal postures, in which the awareness of the populations was directed to the importance of the cleaning their own houses and shops of commerce, the prohibition of selling foods in bad condition and the beginning of the establishment of cutting all communications with Galiza.⁴⁷

Also in Caminha, after the official knowledge that Galiza was infected with *cholera-morbus*, through the circular of October 1854⁴⁸, as well as in the other councils belonging to the county of Viana do Castelo, the council of public health deter-

41 Ibid.

42 Ibid.

43 Ibid.

44 Ibid.

45 Ibid.

46 Ibid.

47 Ibid.

48 Ibid.

mined that the following measures were put into practice: cut of communications with Galiza; sending the heat-resistant to the fort of Novelhe and, subsequently, handed to the public prosecution service; convocation of the help commissions to enter the service; elaborate the principles of the medical policy for the council; choosing the appropriated place for the establishment of the hospital for cholera patients; division of the council in sanitary counties; instructions to the *regedores* to announce the doctors any case of cholera that they knew of; the doctor should immediately go and meet the patient, in a rented mount, accompanied by a nurse; direct the stray and the discriminated people attacked by the disease to the hospital created for this act; daily sending, for each one of the doctors, to the city hall's doctor or surgeon, a report of the cases of cholera when they took place in the respective sanitary county; elaboration by the doctor or city hall surgeon, of a general report based on the partial reports sent by the counties doctors, and afterwards sent to the delegation of health of the county; realization of domiciliary visits by the doctor or surgeon of the party;⁴⁹

In spite of the established alarm, the cholera did not reach the county of Viana do Castelo in 1854, but it was felt in the autumn of the next year, when it attacked with particular severity in Viana do Castelo, Caminha and, with less intensity, in Ponte de Lima. In the summer of 1855, the authorities became aware that this evil was already affecting the nearby cities⁵⁰, and therefore, became necessary to endow the county with the necessary ways to avoid its penetration, or, if that was not reached, try to reduce its effects. The cholera arrived again through Spain and North Africa. The measures then adopted were similar to those who had been ordered by the public health council in 1854, and that were based on the creation of determined structures, like, for example, hospitals for cholera patients and help commissions, and also the cleaning of the public and private spaces.

In the meantime, we can consider that, along the XIX century, the different epidemic outbreaks, not only of cholera, but also, for example, of the yellow fever, associated to new bourgeois values, like the importance of the bath and other intimate hygiene practices, and to a new medical mentality, had a strong impact in the development of the public and private hygiene. The water turned into an essential element for the cleaning of the streets, houses and bodies. The hygiene is not simply connected with the mere cleanliness or with demands of aesthetic order, but also with health. In order to guard himself from possible illnesses and diseases the individual should wash himself.⁵¹

We cannot categorically affirm that a generalized change of behaviours has happened. We presume what the hygienic and sanitary concerns were intensified espe-

49 Ibid.

50 Ibid.

51 On this subject consult Vigarello, Georges, *O limpo e o sujo. A higiene do corpo desde a Idade Média* (Lisboa, Editorial Fragmentos, 1988), pp. 141–150.

cially by the approximation of the epidemic outbreaks, though it is recognized, obviously, the importance of the cleaning of the public spaces and the necessity of instilling in the people private hygienic habits.⁵²

In the summer of 1855, facing a new sanitary crisis that was coming near the county of Viana do Castelo, the health delegate alerts for the necessity of putting an end, once and for all, to the burials inside the churches.⁵³ The public authorities moved in order to adopt preventive measures to preserve the city's public health, like the visits to the pharmacies and to the points of sale of edible goods, as well as in fund raising to help the poor patients by the help commissions created in the parishes.⁵⁴

In spite of the measures taken, the cholera reaches the city of Viana do Castelo again, and at end of September, counted already 74 dead. In the same month, the disease reaches Caminha, registering, between October and November 158 cases, some of them mortal.⁵⁵ The community of Seixas, also affected, had months before another epidemic, which had sacrificed 30 individuals. According to the health delegate, such a circumstance was connected with the fact of being a fishermen's community, very poor and without hygiene habits.⁵⁶ On a national level, the outbreak of cholera felt in 1855 caused 8710 deaths.⁵⁷

After this outbreak, which was felt in the Alto Minho between 1855 and 1856, the cholera will return to Portugal in 1865. At this time, in the county of Viana do Castelo there was already written press, which let the population know, sometimes in a dramatic way, the impact this illness was causing in different regions of Europe, presenting also medicines and home-made medicines that were considered miraculous to avoid or cure the disease. But, the newspapers started to be, especially, a way of denunciation and protest against the non-existence of a public hygiene policy in the city of Viana do Castelo, thought to be of primordial importance to avoid the explosion of infectious pathologies.

52 According to the teacher José Júlio Rodrigues, the city of Lisbon only woke up for the sanitary and hygienic concerns in vespers of new outbreak, after years of accumulating insalubrities and filth, where the presence of organic debris in the streets were still constant. Rodrigues, José Júlio. "Lisboa e o Cholera", *Biblioteca do Povo e das Escolas*, n.º 88, (1884), pp. 4–5.

53 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.12-1, not paginated. In the district of Coimbra, region in the center of Portugal, similar measures were equally taken in order to stop the development of cholera, like the suspension of market fairs, the inspection of food supplies, material and spiritual help, sending doctors and the installation of infirmaries and hospitals for patients with cholera. To be confirmed read Roque, João Lourenço, "Epidemias no distrito de Coimbra no século XIX (1830–1870)", p. 81.

54 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.12–7, not paginated.

55 Esteves, Alexandra, *Assistência às vítimas de cólera no Alto Minho na primeira metade do século XIX*. (in the press).

56 AHGCVC, received Correspondence of the health delegate, n.º 1.13.6.12-1, not paginated.

57 See Cascão, Rui, "Demografia e sociedade" in Mattoso, José dir., *História de Portugal*, vol. V (Lisboa, Círculo de Leitores, 1993), p. 432.

In August 1865, after the knowledge of several cases of cholera in Spain, it is ordered, again, the imposition of a sanitary cord with the nearby country.⁵⁸ The public health council determines the establishment of measures to control the cholera: the cleaning of public spaces, the whitewashing of particular houses, removal of mud, rotten materials and of all the filth susceptible to be turning into infectious focuses, destruction of dunghills and deposits of filth water that are in the patios or in the back yards, and prohibition of circulation of dirty animals in the city.⁵⁹

Meantime, the cholera is developing gradually in several regions of Europe, such as Turkey, Prussia, France, Russia, Italy, Austria, England and Spain. This news took the city council of the city of Viana do Castelo, in session on 26 of August of 1865, to release 900.000 réis⁶⁰ destined to the built of preventive actions, especially in the neighborhoods of the suburbs of the city, where the most poor families were concentrated, as well as assuming the payment of medicines for the poor people attacked by the epidemic.⁶¹

In October 1865, the cholera reaches Portugal, provoking deaths in Elvas. According to the local newspaper *O Vianense*, its arrival in national territory was predicted a long time ago, because of the contacts maintained with the infected nations and since the public hygiene was too far behind. It considered essential the elimination of all the focuses of insalubrities, public and individual, that existed in the city of Viana do Castelo, as well as an effective inspection of the public cleanliness. The same newspaper points out that it's not only necessary to clean the streets, but also to move the deposits of filth far from the villages and create a medical police who watches and supervises the foods exposed in the different posts of sale of the city.⁶²

However, the press does not stop praising the action of the civil governor, whose initiative was crucial for the establishment of a set of measures of preventive character, soon after the knowledge that cholera was developing gradually in Alentejo. In August, this authority sent to all the councils administrators the instructions received from the health council, in order that they are distributed by the *juntas de paróquia*⁶³, *regedores* and doctors, and recommended to the city halls proper application of the municipal postures, namely what concerns the cleaning of the councils.

In October, the civil governor ordered to the councils administrators the application of the arrangements predicted in the decree of 3 rd January 1837, which were determining the announcement of the detected cases of cholera to the superior

58 *O Vianense*, 29 de Agosto de 1865, n.º 1117.

59 *O Vianense*, 7 de Setembro de 1865, n.º 1121.

60 Réis – Ancient monetary unit.

61 *O Vianense*, 9 de Setembro de 1865, n.º 1122.

62 *O Vianense*, 21 de Outubro de 1865, n.º 1140.

63 Paróquia –Part of the territory of a diocese trusted to the direction of a priest who has the name of “pároco”, a parish priest. Parish.

authorities in charge of the conservation of the public health. On the other hand, it was recommending, that the doctors send monthly a list of the treated patients to the health delegate, specifying the illnesses.

With permit of the same date, the county council authorized the city halls, *juntas de paróquia* and places of piety and kindness to come forward with the sums of which they could dispose for the development of preventive measures against cholera, or, if that was the case, for the treatment of the poor patients.

The Carmo's Third Order hospital was mobilized to receive infected patients, and it was necessary to provide it with clothes, *enxergas*⁶⁴, among other things. In October, the civil governor met the military forces parked in that city, the provider of the city's Santa Casa da Misericórdia, the superior of the Mental Hospital of Hampered of the Charity and the delegate of the health council and the civil and military doctors of the city, to obtain support for the installation and functioning of a hospital for cholera patients and for the improvement of the medical services available in case of epidemic. At the time, the city had only 3 civil doctors for nine thousand inhabitants, fact that took the civil governor to look for support among the military doctors, asking them for help in case of epidemic.⁶⁵

After the situation in Elvas was controlled, in January 1866 there is notice of some cases of cholera in Freixo de Espada à Cinta. However, in February 1866 the situation seems controlled, not being noticed any case in the Alto Minho region⁶⁶.

Cholera and other epidemic outbreaks contributed so that in Portugal, and in the particular case of the Alto Minho, questions like medical policy, public and private hygiene were in the centre of the preoccupations and were discussed, not only by the administrative and sanitary authorities, but also by the general population. The newspaper is turned into a kind of a spokesperson of these problems, denouncing the deficiencies and the lacks of a very incipient public health system. The *Vianense*, on 23rd August 1866, was denouncing this situation, telling that, from the biggest city to the small parishes, were not noticed any tracks of *medical police officer and public hygiene*, the health council was rarely noticed and its representatives at the local scale, the county's health delegate or the council's sub-delegated or parish's agent, were showing passivity that was only awakened to declare quarantines and to announce infected ports, during the cholera outbreaks.⁶⁷

The Newspaper *The Lethes*, published in the village of Ponte de Lima, was denouncing the lack of care and the negligence in which the cleaning of streets concerned, which seemed deposits of garbage, and of the houses which, according to the newspaper were shared by filthy animals.⁶⁸ However, when cholera began to

64 Enxerga – Small straw mattress.

65 *O Vianense*, 21 de Outubro de 1865, n.º 1140.

66 *O Vianense*, 3 de Fevereiro de 1866, n.º 1183.

67 *O Vianense*, 23 de Agosto de 1866, n.º 1266.

68 *O Lethes*, 15 de Agosto de 1865, n.º 57.

spread in Elvas, the newspaper gives equally count of the council's administrator action, who was tireless in order to recommend to the *regedores* of all the villages of the council to make disappear possible focuses of infection.⁶⁹

Cholera, which will return to national territory in 1884⁷⁰, however without causing any victims in the Alto Minho, not only allowed some progresses in terms of the public health, but it also made possible a clear intervention from the authorities, and also of the bourgeois mentality itself, in the heart of the poorer classes, in terms of the mentalities, and lifestyle.⁷¹ The society turns to its base, moved by the philanthropic feeling, being prepared for a possible help to the poor patients of cholera, or by the fear that the disease inspires, being conscious that the poor people are the most affected, for what it was contributing, decisively, the absence of basic cares of hygiene and the habitability conditions of their houses.

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69 O *Lethes*, 31 de Outubro de 1865, n.º 79.

70 On the different outbreaks of cholera consult Ferreira, F. A. Gonçalves, *História da Saúde e dos Serviços de Saúde em Portugal...* p. 179.

71 Consult Arnold, David, "Cholera and colonialism in British India", in *Past and present*, Oxford, n.º 113, 1986, pp.119–151.

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A Century of Social and Economic Change – Its Impact on Health and Welfare (Poland between 1815 and 1914)

Elzbieta Kaczynska

Question Posed in This Paper, the Sources Used

This paper is not the fruit of separate, dedicated research; rather, it aims to collate and summarise the results of my previous works on the history of Poland in the 19th and early 20th centuries published in book form or as articles and/or presented as reports and lectures during an assortment of conferences held over the past few years.

Historians studying Poland in the 19th and early 20th centuries face something of a unique problem posed in the absence of political or territorial stabilisation. Albeit the period of 1815–1914 was one of relative stability in terms of political borders (apart from the adjustment in 1909), the lands of the old Republic of Poland (as the country was known before definitely losing its independence in 1795) were partitioned among three occupying powers; what's more, the Russian part of partitioned Poland was further subdivided into two territorial units – the Kingdom of Poland and the lands directly incorporated into Russia proper. This political division entailed differences in the legal constitution, in the civil and criminal law systems, in the judiciary, in internal administration, in education, etc. This, of course, also meant that there was no single authority which would collect, and report statistics subject to any cohesive set of rules. As a result, studying the history of Poland during this period is a study in the history of three different countries. This tends to be something of a daunting task for any individual researchers and, accordingly, a certain academic specialisation has developed: True to this, as it were, division of labour, my paper will concentrate on modernisation and its effects as observed in the Kingdom of Poland – a part of the Russian domain within partitioned Poland.

The Kingdom of Poland (alternately known as the Congress Kingdom, or Congress Poland) established at this time enjoyed a certain autonomy within Russia as a whole, although this autonomy was curtailed following the rising of 1830 and gradually smothered altogether following another uprising in 1863, with the last inde-

pendent institutions closed down in 1876. In comparison to the other areas of the old Poland now partitioned among Russia, Austria, and Prussia, this small country was the one with the highest degree of industrial development, and also the site of the fastest social transformations (even though ethnic Poles living in the Russian domain were worst off in terms of their political and legal situation).

Works dealing with the history of health and with the sanitary and medical situation are not plentiful, and only a handful of new ones have been published over the past decade. Most of these deal with the history of institutions rather than with the living conditions or with the societal context of disease. This, by the way, follows from the objective obstacle comprised in lack of sources. The Polish archives have been ravaged by the two wars of 1914–1918 and 1939–1945 to the point where files of the local authorities, courts, and the sanitary inspectorates survive in vestigial form only. Even where these remnants do contain any information of use, such information adds up to isolated shreds the collation of which would require years of painstaking work by a larger team of researchers – with no guarantee of success. Publication of periodicals (especially local ones) during the period under analysis, meanwhile, was impeded by censorship by the occupying powers and by lack of any wider readership base; to consider specialist and professional periodicals, in any given discipline we discern only two or three titles which were active for more than a few years. Official reporting, finally, was fragmentary at best, and until the end of the 19th century there was practically nothing in the way of organised statistical registration.

In relative terms, the largest amount of surviving statistical data is from the Austrian domain, although these statistics are highly detailed and have been processed only in part.¹ Much like the Austrian statistics, the Russian statistics are characterised by a predominance of figures concerning the finances of the health care system. It would appear that the issue foremost on the relevant officials' minds was that of legitimising costs, especially those incurred in relation to hospitals. Thus, we have the number of hospitals and the number of beds in each one, patient headcounts and the dates on which they were treated, and the attendant costs. Apart from that, there are mortality rates for various diseases – since the 1830s and 1840s, increased interest in hygiene and preventive medicine was driven by epidemics, primarily cholera but also typhoid fever, dysentery, and a host of similar diseases. There are no disease incidence coefficients or mortality coefficients, however, and the demographic statistics make no mention of age groups, let alone of social or economic status. A sequence of tedious calculations could probably yield an approximate age pyramid for certain periods, survival probabilities, etc, but even these would have a large margin of error and would be far from systematic. Even

1 The most important publication concerning Galicia – the documents collected by Piotr Franaszek, *Zdrowie publiczne w Galicji w dobie autonomii* (Kraków 2001).

the basic statistic of infant mortality was kept in a manner which must strike us as somewhat odd. In some instances, only infants are taken into account, in others – all children below the age of five; sometimes, premature births are counted in the statistics, at other times – exclusively live births. Such inconsistencies abound. It should also be borne in mind that, even towards the end of the 19th century (although less frequently, given increased police surveillance and denunciations – the latter being quite frequent in police statistics!), it was a known practice in rural areas that a deceased newborn was not registered at all so as to economise on the expense of baptism, the trip to the relevant registry, etc.

Seeing as matters concerning deaths, spreading of contagious diseases, and the sanitary condition of places associated with food production (especially slaughterhouses) rested within the ambit of the police, local police reports provide a source of statistical data, and they sometimes include descriptions of sanitary conditions at workplaces, schools, and in specific localities. Another source of information is comprised in the reports of the Head Council of Public Charity and of its subordinate Specific (i.e. local) Councils as well as in the fragmentary reports by the physicians' departments of the gubernatorial administration. Yet the information offered by these sources is limited; apart from elaborate financial reports, they contain little other than a simple register of the number of hospital beds and of patients, staff levels, and maybe deaths. An important source, albeit limited to only one category of the population, lies in the reports of the Factory Inspection active since the last decade of the 19th century; even these archives are incomplete, however, in that the Factory Inspection only occupied itself with those industrial establishments which employed at least 15 workers and which used mechanical devices of some sort (steam engines or, later on, electrical engines).

Finally, any systematised comparative research spanning longer periods of time is rendered impossible by the poor quality of statistics maintained by the tsarist authorities. In France, population files and registers after a standardised form were maintained as of 1792; these served as the model for the system introduced in the Kingdom of Poland in 1808 (with actual implementation proceeding as of 1810). The years of 1812-1818 can nonetheless be written off as “statistics-less”. Following the Congress of Vienna, population books were introduced in 1818, but it was only in 1825 that standard forms for birth certificates, death certificates, and marriage papers were drawn up. Also in 1825 were parish priests obligated to maintain registers of their flocks; no analogous duty existed for Jews, so such figures as are available are spurious and, most probably, too low (until 1825, the Jewish population was tracked by Catholic priests, leaving Jews loath to report births and deaths). A decision obligating the local administration to maintain separate books for Jews was

passed in 1830.² It was also not uncommon for impecunious peasants to themselves pronounce the baptismal formulas over their children, dying soon after birth, so as to avoid the costs entailed in baptism and in drawing up the appropriate documents.

In 1824, the Statistical Office, established by earlier decisions, commenced its operations. Apart from that, statistical data was also collated by different civilian and military authorities. These sets of data conform neither one to another. The population registers only made note of those born in a given area; accordingly, they took no account of migration. Furthermore, the year of 1847 saw the introduction of an amended standard form, making the comparison of some data more complicated. It was only in 1861 that three separate registers (in three copies) were introduced for tracking permanent residents, residents who – while not permanent – spent most of their time at the given locality, and persons arriving from without (*yavochnie*). Jews were entered in separate books. The military poses another problem as far as population statistics go in that the head-counts of garrisons were included in the general registers in some instances and omitted from them in others. As a result, for a combined population of some 6,300,000–6,500,000 people, the discrepancies between different accounts reach a quarter of a million people. The Central Statistical Committee of Russia began to publish collections of data in 1887, and the Warsaw Statistical Committee – in 1889, yet the quality of source materials relied on by both these institutions left much to be desired. The results of the first census, carried out in 1897, were published eight years later, and only then were the figures verified, whereupon it transpired that there are actually 125,700,000 people in Russia, as opposed to the 126,400,000 spoken of in the first edition. The Central Statistical Committee reported that, in 1912, there were 12,776,000 people living in the Kingdom of Poland. Its subordinated branch, the Warsaw Statistical Committee, gave this figure at 12,782,000, and the physicians' reports spoke of 13,275,000 people.³

The information about nutrition and living conditions are mainly descriptive and limited in their scope to individual cases; Warsaw was the only city whose authorities drew up (in 1891) a list of residents and published several studies about living conditions in the city.⁴ Resort to the general and uncertain data on consumption in the Kingdom of Poland as a whole is made difficult by the lack of borders

2 Grigorij Simonienko, *Sravnitel'naja statistika Carstva Polskogo i drugih evropejskich stran* (Warszawa 1879), 47–90; Adolf Rozanski, "Dzialalnosc statystyczna w okresie Krolestwa Kongresowego", *Przeglad Statystyczny*, II, 1 (1932), 58–75.

3 Stefan Szulc, *Wartosc materialow statystycznych dotyczacych stanu ludnosci b. Krolestwa Polskiego*, (Warszawa 1920), 24–25.

4 Especially: Jan Cegielski, *Stosunki mieszkaniowe w Warszawie w latach 1864–1964*, Warszawa 1968 i M. Ciemniowski, "O mieszkaniach ubogie. j ludności w Warszawie na podstawie rezultatów spisu mieszkań z roku 1891", *Zdrowie* X (1894), 34–41, 87–100, 143–159.

separating Wielkopolska from other parts of Germany or the Kingdom of Poland from the rest of Russia, and also by the fact that farmers and their families accounted for up to 70% of the population; analysis of changes in average consumption, let alone the social structure of use of specific products (alcohol included), remains elusive.

To summarise, the condition of the sources – damaged archives, lacking statistics kept during the period under analysis, absence of professional associations or societies (which were largely banned by the occupying powers for political reasons), and the convoluted history of political and internal administrative divisions – conspires against application of scientific methods to simple numerical illustrations (which hardly qualify as statistics). Also, such descriptions as are available to us are probably slightly skewed. Health and hygiene and living conditions among the poor were the object of interest for social workers, moralisers, and political activists (especially as the 19th century drew to a close) who, when they wrote, tended to dwell on the darker aspects of things. Many of the surviving memoirs are by physicians with a passion for social work.

Late Modernisation and Its Characteristics

The approximately 100 years spanning the Congress of Vienna (1815) and World War I may be referred to as a period of modernisation, even if this modernisation was initially quite cumbersome and proceeded on a top-down basis. The concept of modernisation is usually understood to comprise changes precipitated by industrialisation and by development of the markets – popularisation of education, democratisation, urbanisation, secularisation, and professionalism. One element of modernisation is presented in the development of public health care and of hospitals. Some changes of this sort could be brought about irrespective of industrialisation or its absence, on the strength of state policies alone. In Galicia, we are looking at modernisation of the public institutions, and in Wielkopolska – at modernisation of agriculture (along with a certain development of petty industry associated with farming) and modernisation of political and administrative institutions lagging behind that in Prussia. In the Kingdom of Poland, transformation proceeded in leaps and starts, with the first acceleration of changes occurring after 1832 (when, following the failure of the uprising, the territory's autonomy was scaled back and the customs border between the Kingdom of Poland and other parts of the Russian realm was eliminated) and the next one after 1850. The most dramatic changes affecting production processes in industry occurred over the period of 1850 - 1885, first in textile weaving, then in sugar processing and distilling, and finally in the

metal and heavy industries.⁵ It was at this time that there arose three industrial districts – the Dąbrowa area with its heavy industries and mines, the heartland of the textile industry centring on Łódź, and the Warsaw district with its metal, clothing, and foodstuffs industries. Major transformations of agriculture and of the agrarian structure came to pass only after 1885.⁶

The Polish case does not quite conform to any one of the more well known modernisation models – not with the Marxist one, and not with those of Rostov, of Gerschenkron, or of Wallerstein.⁷ The unique characteristic of modernisation processes in Poland lies in the fact that, the nascent national consciousness of Poles notwithstanding, they came to pass by different ways, and at different rates, in various areas (for the reasons adumbrated above). Also, there existed within the Kingdom of Poland identifiable centres of anti-modernisation sentiment: it was nothing unusual for even the best solutions to be rejected and for reforms to be boycotted for the simple reason that they were imposed by an alien power. On the other hand, the authorities – especially in the Kingdom of Poland – did much to curtail the possibilities for building up social institutions. Polish attitudes towards modernisation were fraught with at least as many paradoxes as in other countries, and more. Apart from that, the process of modernisation was far from harmonious (with areas of progress and of stagnant decrepitude abutting on each other). It would be accurate to speak here of an induced process, one which has been put in motion from above and would stall and start in reflection of the meanders of the tsar's policies. Even the comparatively small area of the Kingdom of Poland manifested considerable differences between its regions.

At the administrative level, change proceeded very slowly, this due to lack of political independence and to remaining within the despotic system of tsarist Russia. It is a telling fact that Russian official discourse did not use the word “citizen” (which would be applied, at the very most, to a landowner) – the default designation was that of “subject”. This is not an issue of pure linguistics; it bears testimony

5 Elzbieta Kaczynska, “Zagadnienie dynamiki gospodarczej ziem polskich w latach 1815–1914”, *Historyka* XV (1985), 69–81 and “Tzw. przeżytki feudalne i kapitalizm w Królestwie Polskim w drugiej połowie XIX w.” in Janina Leskiewicz, eds., *Miedzy feudalizmem a kapitalizmem. Księga pamiatkowa ku czci Witolda Kuli* (Wrocław 1976), 263–276.

6 Juliusz Lukaszewicz, ‘Drogi rozwoju rolnictwa na ziemiach Polskich’, in Stefan Kieniewicz, eds., *Polska XIX wieku. Państwo–społeczeństwo–kultura* (Warszawa 1977), 13–55 and *Kryzys agrarny na ziemiach polskich w koncu XIX wieku* (Warszawa 1968).

7 Walt Whitney Rostov, *The Stages of Economic Growth. A Non-Communist Manifesto*, (Cambridge, Mass. 1960); Alexander Gerschenkron, *Economic Backwardness in Historical Perspective* (Cambridge, Mass. 1962) and *Europe in the Russian Mirror. Four Lectures in Economic History* (Cambridge, Mass. 1970); Immanuel Wallerstein, *The Capitalist World Economy. Essays*, (Cambridge, Mass. 1980) and *Geopolitics and Geoculture. Essays on the Changing World System* (Cambridge, Mass. 1991) also *The Modern World System. The Origin of the European World Economy*, vol. I–II (New York 1974); *The Politics of the World Economy. The States, the Movements, and the Civilisations. Essays*, (New York 2nd ed., 1991).

to the very nature of the system, to its lack of civic institutions and to its inability to nurture that creature of which so much has been written in the West-civil society. The inhabitants of the Kingdom of Poland (and also of Lithuania) were subjected to new repressions after the rising of 1863. From 1861, which brought the first patriotic manifestations, through until World War I, Russian-occupied Poland remained under an interminable “special state” akin to martial law which, on occasion, assumed quite severe forms.⁸ State invigilation of the populace was considerable; not only was the development of associations smothered, charity work (a major factor behind advances in health care) was also hemmed in by close supervision and a regime of administrative directives. Education was also stunted (for one thing, Polish-language instruction was banned), with the effect that, come the late 19th century, illiteracy in the Polish-speaking domain of Russia was higher than in Russia proper, making for a significant obstacle to improvement of hygiene, to preventive care, or to resort to medical care.

Improving Quality of Life⁹

It is clear to the historian that the demographic explosion beginning (in the West) in the 18th century, with a decline in mortality coupled with a constantly high level of births, owes more to modernisation of farming and the improved nutrition which it enabled than to development of microbiology or medicine. The same held true for Poland – a clear predominance of births over deaths preceded the general availability of social care and, especially, of public health care. Specialists take the position that improvement in the general level of health was signalled by the falling number of deaths caused by communicable disease (as a proportion of all deaths of sickness and old age). Medicine became clearly better qualified to deal with conditions caused by bacteria, parasites, or nutritional failings than with chronic, debilitating diseases – this was a global trend.¹⁰ More accurate statistics taking into account the cause of death were maintained in Galicia and in Prussia, but not in the Kingdom of Poland. In the case of the latter, if the cause of death was recorded at all, it was noted for patients dying in hospital; seeing as hospitalisation extended first and foremost to those afflicted by contagious disease, the breakdown of deaths in hospital will not correspond to that for the population as a whole. The data from Galicia for the period of 1876–1893 has been collated and processed, but it does not indicate this shift.¹¹

8 In 1881 new law on martial law (with three degrees) was promulgated.

9 This paragraph and three following are a result of personal investigation of the Author, basen on different sources (see *Reference List*).

10 Magdalena Sokołowska, *Granice medycyny*, (Warszawa 1980) 9.

11 Piotr. Franaszek, (eds.), *Zdrowie publiczne w Galicji w dobie autonomii* (Krakow 2001).

Until the year 1860, average annual increases of the population were subject to considerable fluctuation; there arises the suspicion that this is due not so much to factors such as armed conflict, political migration, or cholera outbreaks as to imperfect registration. Over the period of 1860–1870, the average annual increase was 11.5‰ in Galicia, 13.8‰ in the Grand Duchy of Poznań, and 14.4‰ in the Kingdom of Poland. The 1870s brought significant improvement of living conditions due to a drop in grain prices caused by competition in the market by importers from America. The drop in prices of bread was soon followed by downward movements in the price of other staples (potatoes, sugar, meat). Also, development of the railway infrastructure and of factories as well as a general construction boom in the 1880s contributed to a robust labour market which offered good wages.

All the research to date suggests that – especially as the 19th century moved into the 20th – there occurred a significant increase in earnings and improvement of living conditions in general. As much is borne out by studies of health care coverage funded by the large industrial enterprises and of factory-sponsored housing for workers. The last 30 years of the 19th century also brought installation of sewage and water networks and of lighting in towns of various sizes, although in the case of the Kingdom of Poland such initiatives were hobbled by lack of local self-government.

This may be associated with the considerable increase of the population (greater longevity and reduced infant mortality) noted in the final decade of the 19th century. While the Grand Duchy of Poznań's population increase over the period of 1881 - 1890 was 16.3‰, the next decade (1891–1900) brought a figure of 19.4‰; in Galicia, the population increase for these two periods was, respectively, 11.3‰ and 14.5‰, and for the Kingdom of Poland – 14.4‰ and 15.6‰. Overall analysis of the improvement in living conditions from the late 19th century onwards suggests that it was brought by an increase of individual consumption (rather than collective consumption) and by economic progress and philanthropic efforts by the bourgeoisie (rather than initiatives of the state).

Thanks to the factory inspection records and to studies conducted among workers, we can reconstruct the daily fare of a poor day-labourer in the Kingdom of Poland in the first half of the 19th century as consisting of *aqua vitae* (crudely distilled vodka at 80°) consumed twice a day, one quart (approximately ¼ of a litre) at a sitting, along with sour rye bread (not always thoroughly baked) and, on a better day, a bowl of hot soup. Meat was a luxury reserved for holidays; lard or animal fat was added to the basic meal once per week. The basic staples comprised gruels, beans, and cabbage. It was not only the poorest who ate modestly; there is much to suggest that qualified workers, the petty bourgeoisie, and – most importantly – the peasants also followed diets which, while more plentiful, were equally monotonous. Recent Polish studies exploring culinary traditions in various regions point to an appalling paucity of the rural diet; even the Prussian landowners, it seemed,

favoured the peasant fare, introducing some variety only to mark a major festival or to honour a guest.

The attempt by Tadeusz Sobczak to assess consumption of foodstuffs has yielded modest results. Sobczak took the available data as a starting point for verifying the extent to which average consumption in the Kingdom of Poland may have corresponded to the theoretical recommended level of 3,550 kcal “properly” broken down into protein, fats, and carbohydrates at, respectively, 10%, 30% and 60%. Of course, this hypothetical diet is quite an optimistic one – it would be sufficient for a grown man engaging in physical labour. The data assembled by Sobczak suggests that, in the 1850s, factual consumption (assuming, of course, that the data used is correct) covered 83% of the required daily protein intake, 33% of the fat intake, and 65% of the required carbohydrate intake. By the 1880s, consumption of these nutrients increased to, respectively, 102%, 49% and 130% of the required intake, and the daily energy requirement of 3,550 kcal was slightly exceeded.¹² If nothing else, Sobczak’s calculations confirm the results obtained by other means according to which consumption increased during the second half of the 19th century, especially after 1880.

The less than wholesome traditions and habits concerning food and nutrition were deeply ingrained; in their efforts to eradicate them, physicians and charity workers concentrated mainly on nutrition of children, specifically on milk consumption. It should be borne in mind that, while 19th century advances in organic chemistry and medicine continue to reflect upon modern ideas as to the correct diet, many of the recommendations propagated at the time were different from those heard today. For example, an increase in consumption of sugar and of meat was hailed as a public health success.¹³ The nutritional improvements which could have contributed to better health among the general population comprised higher calorie intakes by the poor as well as gradual introduction of variety in the diet and compensating for protein deficiencies.

State Activity Regarding Health Care

State regulations concerning health care were introduced rather slowly in the Polish-speaking areas, particularly in the Kingdom of Poland. In Wielkopolska and Galicia, social care institutions were put in place subject to the same rules as, respectively, in Prussia and in Austria. The system in place in Galicia was changed in 1870 on account of the introduction of autonomy; the relevant statute (supple-

12 T. Sobczak, *Przełom w konsumpcji spożywczej w Królestwie Polskim w XIX wieku* (Wrocław 1968), 251.

13 Elzbieta Kaczynska, “Zdrowe jedzenie’ – zalecenia i polska rzeczywistość w XIX i XX wieku” *Roczniki Dziejow splecznych i gospodarczych*, LIX (1899), 127–154.

mented in 1876) put the autonomous authorities of Galicia in charge of preventing contagious diseases. In 1891, a nationwide law regulating health care in local communities and on manor lands was enacted, and establishment of a public hospital network was commenced.¹⁴

The worst situation persisted in the Kingdom of Poland (and, indeed, in the Russian Empire as a whole). The institutional solution resorted to here was something of a curious hybrid, comprising a network of institutions subordinated to the Head Council of Public Charity (established in 1832) as well as of Specific Councils (1842 witnessed the promulgation of a new law on organisation of the Councils and on hospitals). These Councils supervised a network of shelters, nurseries, orphanages, and hospitals funded by charitable contributions augmented with state funds. In 1870, the Councils were disbanded, and charity and its institutions were placed within the ambit of the Ministry of the Interior. Now, head physicians as well as directors of individual hospital wards were appointed by a state official – the civilian hospitals inspector.¹⁵

In this way, the state used private contributions to address the issue of public health care without resolving the problem of general health insurance. That said, the state did introduce a duty (at the formal level – in 1886, in factual terms – as of 1892) to contribute to insurance funds which disbursed benefits to workers of the larger industrial plants and to their families in the event of death or illness, and also obligated factory owners to make available outpatient clinics or factory hospitals. Supervision over these private hospitals was entrusted to the Factory Inspection, a state body. The year 1903 saw the introduction of mandatory accident insurance; again, however, this duty applied only to the larger factories falling under the jurisdiction of the Factory Inspection. There was also a state authority which stepped in when there arose the threat of an epidemic; cholera outbreaks would occur in Russia well into the early 20th century, and the situation in this respect in the 1890s was nothing short of catastrophic.

Charity Work in the Area of Health and Social Care

In all European countries, first and foremost in England, the role of public charity during the first phase of industrialisation and general modernisation was a very significant one, not only because there was still no legislation in this respect and no

14 Piotr Franaszek, *op. cit.*, 16.

15 See: Zofia Podgórska – Kławe, *Szpitala warszawskie, 1388–1945* (Warszawa 1975) and “Warszawskie Towarzystwo Dobroczyńności i jego Wydział Sierot i Ubogich Dzieci (1814–1914) in *Warszawa XIX wieku*, vol. I (Warszawa 1970). The older book: Waclaw Meczkowski, *Stan i potrzeby szpitali Królestwa Polskiego* (Warszawa 1905), and the new one: Elżbieta Mazur, *Szpitala w Królestwie Polskim w XIX wieku* (Warszawa 2008).

government or local self government bodies which could attend to these matters, but also because charitable work was an important factor of social life, a means of bettering one's own station. The slogans of the Enlightenment, exhorting that alms be substituted with the provision of possibilities for earning a decent living, exerted a considerable influence on the development of charitable works in Poland. Changes in this respect mostly comprised combining private initiatives with aid from the king or tsar, with the supreme authorities granting privileges and financial assistance to the charities.

In Poland, the impetus for development of charity came with the social changes in the 2nd half of the 18th century, during the period of growing awareness of real political danger. Poland was passing through a tremendous political crisis. Some political and intellectual circles tried to draw attention to the necessity of reforming the socio-political system, also as regards solving the existing problem of poverty, the growing number of *declassés*, vagrancy, abandoned children etc. Between 1772 and 1795, there were founded some important institutions based on charity and helped by the state, as the Hospital of the Child Jesus and the reformed asylums.

In the backward countries, industrialisation and urbanisation - once started - were nearly always rapid, and connected with the development of big business enterprises. This was also the case in Russia and - especially - in the Kingdom of Poland. The discrepancy between economic and social modernisation grew: social legislation did not exist (the first laws in this area came in the 1880s) and, in consequence, it was up to commercial circles to take the initiative. The factory organisation of social insurance, health care etc. became the most developed form, but these seem to belong to the realm of philanthropy because only at the turn the century was there implemented a set of laws (proclaimed in the 1880s and 1890s) concerning the public health system. This process was influenced also by the illegal workers' movement, which demonstrated relative power since the end of 19th century. The late 19th century witnessed the establishment of many public health care institutions financed by the bourgeoisie.

Modernisation of the state brought with it reforms of the fiscal system, the development of legislation in areas hereto ignored by the lawmakers, and the streamlining of state administration and professionalism of social services. This led to increased involvement on the part of business owners who, by bankrolling the construction of residential facilities, hospitals, bath house, canteens, etc could reduce their tax burden as well as gaining better, fitter workers by improving their quality of life. In the Russian Empire, charity formed part and parcel of the patriarchal social order and, accordingly, there was little which would inhibit it. A clear bureaucratisation of charity was taking place.

In the Prussian part of partitioned Poland and in Galicia, the initiative was taken by the higher classes or by the Catholic Church. In consequence, Christian-populist organizations of artisans, with an ideological tinge, were of considerable signific-

ance. Such grassroots activities appeared outside industry - mainly in commerce, but in the Kingdom of Poland they remained extremely limited in comparison to the Grand Duchy of Poznań or to Galicia.

In Russia, the role of the Orthodox Church remained unchanged - relatively weak; in Poland, the Roman Catholic Church became impoverished, and was regarded with mistrust. Thus, during the period discussed here, the Church - neither Orthodox nor Roman Catholic - played any important role in the organisation of social help.

In 1819, Jewish commercial men in Warsaw established fraternities modelled on the guild organization. They did not play any important role. Jewish artisans organized self-help fraternities, so-called *khevras*. In 1853–1855, in order to escape the threat of high prices, several salesmen founded a fraternity which was voluntary and independent of the employer (but not registered until 1860). In 1867, this was transformed into a Mutual Benefit Society for the Salesmen of the Mosaic Faith, and originally had 127 members. The number of members peaked at 264 in 1888.

In 1884, upon the initiative of the Office of the Elders of the Tradesmen Union in Warsaw, a similar society was organized for Warsaw salesmen regardless of their religious convictions. Integration, however, failed and the fund was formally divided: 90% was earmarked for Christian members and 10% for the Jews. We do not know any further examples of such funds.

The late 19th century witnessed the establishment of many public health care institutions financed by the bourgeoisie. One of the most sweeping projects was that for construction of residential developments for Warsaw's city poor financed by the Wawelberg family, a local – and much more modest – version of the French *HLM - Habitations de Location Modérée*. These developments were designed in reliance on the recent sanitation advances and with the intent to provide the inhabitants – much like in factory dwellings – with all amenities from birth clinic to morgue, with a nursery school, school, out-patient clinic, wedding house, and store thrown in. Warsaw and several other cities also saw the establishment of playgrounds named in honour of Dr Jordan, the organisation of summer camps for children, and the launching of “drop of milk” initiatives. At the behest of the medical community, of philanthropists, and of the boards of some industrial and railroad associations, efforts were launched towards the provision of baths and showers at the factories and of bathing facilities for the general population.

The beginning of factory social services

As we can see, in the Kingdom of Poland the seeds of social insurance appeared in the mines and other heavy industry enterprises, in large part belonging to the state, although until the end of the period under discussion the mutual benefit societies

emerged primarily due to the initiative of entrepreneurs. Such societies were best developed in those areas of the economy which required specialization and which had traditions dating back to the guilds (e.g. type-setters); they were either totally or partially connected with cash funds, and the workers were organized into corporations. The members were skilled workers more often than unskilled, and almost exclusively men with steady employment. The majority were heads of families and, again, most were male, even though women constituted about 20-25% of all employees.

In 1866, the Ministry of the Interior issued an ordinance obligating factory owners to provide their workers with free medical care (if the malady in question was not the result of negligence or ill will on the part of the patient), but there was no possibility of putting this law into practice. A similar legislative effort was undertaken in 1887; this time around, industrial operations employing between 50 and 500 people were obligated to set up out-patient clinics, and the larger ones (employing more than 500 workers) – sick bays with at least one bed per 100 workers and a doctor available on the premises every day. As far as the Kingdom of Poland was concerned, implementation of this ordinance did not commence until the 1890s, and it was the norm for a visiting factory inspector to find that “the regulations are being ignored and that the level of health care is lacking”. The *de facto* commencement of the factory laws’ application in the Kingdom of Poland was in 1896, and it concerned only the enterprises which employed over fifteen workers or used mechanic power. The duty of insuring workers against illness was introduced by law in 1895 but, again, no provision was made for the actual enforcement of this rule. None of the legal instruments applied to all industrial operations on a uniform basis, and none extended over all the provinces.

In the last three decades of the 19th century, when the tempo of development of industry and the increase of the proletariat reached a very high level, funds were established upon the initiative of business owners in a completely arbitrary manner. Some of the basic principles recurred because the models were taken from the same institutions as previously, but in many respects the differences were fundamental. Neither in the Kingdom of Poland nor in any other partition were mutual benefit societies the effect of grassroots endeavours, of a spontaneous initiative from below.

The law coincided with the outset of a long-term favourable situation in all domains of economic life. The years 1886 - 1901 were an era of the greatest investment movement in Russia and in the Kingdom of Poland in industry and in construction, of progress in agriculture imposed by the competition of cheap American grain, a rapid rise of migration and urbanization, and of expansion of wide-range urban infrastructure: the railways, telephone-telegraph communications, etc. The real wages of the workers climbed, and the living standard of the heretofore handicapped lower strata improved. It became apparent that such improvement of living conditions favoured social activity and the presentation of greater demands to the

employers. The last two decades of the 19th century witnessed the emergence, albeit underground, of almost all the more important parties which were to play a great political role for a long time to come. This was also the era of mass-scale social movements whose peak was the 1905 revolution.

The basic problem which absorbed the public opinion of the time (with all the reservations as regards adequacy of the term “public opinion” in reference to the Russian Empire) was the absence of a clear responsibility for unfortunate accidents. There was no distinction between them and illnesses from other cause nor was there any official concept of professional ailments. The first law about the responsibility of enterprises for accidents at work, as long as the victim was not obviously careless and was abiding by applicable rules, was issued in 1903. It pertained only to those enterprises which were subjected to factory inspections, i.e. those which employed over 15 workers or which used mechanical equipment (with the exception of mines and metallurgy). It was only advised to resort to accident insurance.

However, after 1903, the big entrepreneurs themselves began to pay contributions to the insurance societies. Small firms with low profits, whose number was by no means little, were unable to afford to do so at any level of consistency, and their workers had slight chances for winning compensation even if the accident was clearly the fault of the factory. In bankrupt firms, the workers could not make any claims. Not until 1908 was it announced that workers must be insured in one of the private insurance societies, but in reality this directive could not assume legal force, and hence it was not observed by all firms.

From 1912, mechanised enterprises with at least 20 workers (if not mechanised - with 30 or more workers) were obliged to establish funds. The law determined the payments made by the workers as three-fifths, and those paid by the employers as two-fifths, of the general fund. Basically, employees of medium-sized enterprises which were not mentioned in the law about medical help and obligatory insurance did not have mutual benefit societies. Even in the mining and metallurgical industry, only 59% of the 22,700 employees in 1898 benefited from the funds (all from the single region of Dąbrowa).

All the funds were organized and managed from the top - there was no self-government. The workers did not participate in the funds' administration - members of the boards were officials. Not until 1900 did the government issue a decision providing that the board should include at least one workers' delegate. The boards, in turn, were not obliged to keep statistics, and documents were prepared in an arbitrary ways. Actually, the manager of the fund was the director of the factory. The best known is the activity of some of the biggest enterprises. Medical assistance was provided by all the mines and metallurgical plants in the Dąbrowa district, by it through their own hospitals or by renting beds in those operated by other entities; they would maintain out-patient clinics and had their own physicians and junior physicians.

Health of the Population

This paper has already made mention of the population increase resulting from a surplus of births over deaths. At this point, I would qualify that information with some additional comments. This major shift in natural tendencies in population size has been likened to a “big bang”; given, however, that the trend first observed in Western Europe towards the end of the 18th century is still in evidence today, and that it proceeded in at least two stages, “demographic transition” would be the nomenclature of choice. The first of these stages (subdivided, in turn, into phases of its own) comprised a drop in mortality rates due to growing life expectancy and lower infant mortality coupled with a birth rate holding steady at a very high level. The second stage, particularly in the 19th century, comprised a precipitous drop in the birth rate, with life expectancy continuing to grow and the global population continuing to increase, with the net effect that the Earth’s population was now doubling in ever-shorter cycles. Demographic fluctuations can be ascribed to a variety of factors; for instance periods of larger-than-usual drops in the mortality rate were associated with a marked increase in agricultural production enabled by crop rotation or by large-scale introduction of DDT. Spikes in births usually followed after major wars (the “compensation wave”).

In the case of Poland, the jury is still out as to the period during which the transformation actually took place. The answer is far from unambiguous; the data is incomplete, incohesive, and ill-suited for comparison. Some maintain that the years 1807–1840 were a preparatory period, and 1840 - 1870 an interim period. Others prefer to place the beginning of transformation in the last 15 years of the 19th century, and others yet – at the turn of the 19th and 20th centuries. This last view seems to be gaining the upper hand.¹⁶ Be that as it may, we are looking at a delay of at least 30 years as we consider the major demographic shift in Poland vis a vis that occurring previously in Western Europe. Krzysztof Zamorski has emphasised that a uniquely Polish phenomenon is comprised in only minor shifts throughout the preparatory stage. The slowing down and delay of the transformation means that, once it does arrive, it breaks out suddenly and unfolds rapidly; given the meagre development of industry and services, this results in overpopulation of rural areas (especially in Galicia – Wielkopolska seems to have coped better). This overpopulation in the villages was one of the factors driving the mass waves of economic migration to other European countries and to the New World. As far as the Kingdom of Poland is concerned, much has been written about the *exodus ruralis* during the last 20 years of the 19th century when many people left for the larger towns and industrial districts; in the end, this actually led to a labour shortage in the villages.

16 Kazimierz Zamorski, “Specyfika transformacji demograficznej. Historyczna reinterpretacja znanej teorii demograficznej” in: *Celem nauki jest człowiek... Studia z historii społecznej i gospodarczej ofiarowane Helenie Madurowicz – Urbanskiej* (Krakow 2000) 373–385.

The *exodus ruralis* brought about a situation where, all of a sudden, the industrial boomtowns in the Kingdom of Poland or Upper Silesia suddenly came to have centres of stark poverty, inhabited by people struggling to adapt to the new type of work and way of life. Initially, these new arrivals would dwell in hovels and barracks in which two or three workers working different shifts would take turns sleeping on the same bunk. Social care, including medical services, was non-existent, and the nature of their work left these people prone to accidents; conditions in the large industrial centres were grim indeed, bringing to mind the proverbial fires of hell – much like England at the outset of industrialisation. This was grist to the mill of socialist propaganda – it is no coincidence that socialism took root among the Polish working class in the last decade of the 19th century. Yet people continued to stream into the industrial districts, gradually achieving a modicum of stability in their lives, improving their living standards. The historian is thus left with a large collection of contradictory accounts which he must carefully analyse with a critical eye.

Population increase, however, is not a sufficient indicator of improving health, especially when one tries to consider shorter periods; it is better to rely on more direct signs of change. However, an attempt at drawing up statistics of infant mortality and of the average life expectancy meets with failure; such calculations would have to be preceded by a thorough analysis of all the records, with all their different versions considered and weighed against one another. As to sketch out a general picture, we could mention that, in 1895, a male infant could expect to live until the age of 31. In 1880, the same indicator for Sweden was almost 47 years, for Denmark 46, for England and Wales 42, for France 41, for Germany 36, for Italy 34, and for Austria 31 (i.e. the same as in Russia in 1895).¹⁷

A sensitive indicator of physical health of the population is presented in mortality among infants aged less than one year. This is calculated in reference to the number of live births; then again, the number of stillbirths manifested a downward tendency as obstetric care improved and pregnant women were no longer assigned to heavy work. For a number of European countries, the data on infant mortality is fairly good, going back to the early 19th century and becoming reasonably reliable since the 1850s. We also have sets of data for approximately 20 cities, including Warsaw. Infant mortality rates for the Kingdom of Poland or for Russia as a whole, meanwhile, are little more than rough estimates, and even the information for Warsaw gives rise to certain doubts. While the loose scraps of data pertaining to specific localities are now being analysed, it is already clear that they will not amount to foundations for a proper set of statistics. It appears that even hospitals and maternity wards neglected to keep accurate records of births or of infant deaths.

17 Alan S. Milward, S.B. Saul, *The Development of the Economies of Continental Europe 1850–1914* (Cambridge, Mass. 1977), 135.

It is generally accepted that, around 1820, for every 1,000 live births in Western and Central Europe, approximately 240 babies died in the first year of their lives. More detailed data from the middle of the 19th century suggest that this may actually be a conservative estimate.¹⁸ To the end of the 19th century a mortality rate of 260 for every 1,000 live births subsisted in many areas, although a consistent drop in infant mortality is to observe in several countries (even to 95). European Russia was still afflicted by infant mortality in the range of 260–280, but if the Kingdom of Poland and Finland are left out, the lands of Russia proper held the inglorious infant mortality record of 296‰.

At the eve of 20th century in Warsaw infant mortality was 194 for every 1,000 live births, so Warsaw could be situated among the retarded cities, however not at the worse position. Please bear in mind that this data should be regarded more as a general indication, and that it gives rise to serious questions upon closer analysis. It would appear that more methodical organisation of the health care services and of statistics gathering led to an increase of all variables, those concerning deaths and incidence of diseases included. In other words, we may well be dealing with a certain paradox which might be summed up in the words the more doctors, the more diseases.

It could be added, that contemporary Polish figures paint a bleaker picture than those from developed Western European countries for analogous periods (in which infant mortality after 1960 generally fit within the 10 - 30‰ range). After World War II, infant mortality in Poland was 120‰ in 1946 and 111‰ in 1950. It then began to drop sharply (falling to 55‰ in 1960), especially after peasants were exempted from social insurance contributions and included in the free health care system (attaining 37‰ in 1970 and 26‰ in 1980). The most recent Polish infant mortality figures are in line with the European average - 19‰ in 1990, 14‰ in 1995.

All these juxtapositions, incidentally, do not take into account the discrepancy in infant mortality among children born to married couples and out of wedlock. Throughout the 19th century and even later, this difference was a dramatic one; in some industrial cities after World War I, for example, 240 out of 1,000 children born to married couples died before their first birthday, up to 330 per 1,000 children born to single mothers.

Data published by the Medical Inspection point to a markedly higher incidence of disease in Russia as well as the Kingdom of Poland between 1894 and 1904, more

18 There are a lot of works about; for example: J. C. Chesnais, *The Demographic Transition* (Oxford 1992), D. J. Kerzer, M. Barbagli, eds., *History of the European Family*, vol. II (New Haven – London 2000) etc.; see also P. Szukalski, *Plodnosc i urodzenia pozamalzenskie w Polsce* (Lodz 2001), the data in periodic *Zdrowie* (1895) The data from about 1870–1880 r. sometimes are drastically different, but after this period we can observe the conformity.

so in the larger cities than in small towns and in the countryside.¹⁹ Would this be indicative of a factual deterioration of the population's health during what was a very good time from the economic perspective, with a general improvement of living standards? This would be a premature conclusion; come the late 19th century, statistics of illness began to be kept, the registers – at least in larger cities – were maintained with a new accuracy, and the public health care network grew denser.

The state of the public's health as perceived by medical practitioners, nonetheless, was not satisfactory. Over the years of 1890-1900, some 12.7% of army conscripts were permanently demobilised on account of illness or disabilities. In the year 1902, 94,700 conscripts were listed for the draft; of these, 13% was sent home immediately on grounds of lacking health, and some were referred for further examination or hospitalised. The draft board examined 78,500 men, of which 7.3% were found unfit for service due to spinal problems, joint damage, and other afflictions (this figure does not include those sent home due to insufficient height). In 1904, 8% of conscripts were demobilized.²⁰

An intriguing analysis of medical examinations of conscripts into the Russian army, replete with a methodology presentation, is offered by Michał Kopczyński in the recently published work entitled "Big Transition".²¹ Medical records drawn up the draft boards account for a significant pool of information, although it may be considered representative primarily for the lower social strata. As much arises from the rules governing compulsory military service; the annual draft in tsarist Russia extended to men aged over 20 and less than 30, provided that they did not belong to a privileged class (landowners, clergy, certain professional groups) and did not qualify for exemptions on family or health grounds. So much for the broad strokes; to consider its details, the conscription system was very complex, and the long and short was that it was primarily members of the lowest social classes who actually appeared before the draft boards which verified their suitability for service, mainly as measured in height and in overall health. The height standard in force as of 1874 (expressed in the Russian units *vershki*) translated into just under 154 cm, down from the almost 156 cm enforced previously. In other European countries, by comparison, the minimum height for a soldier varied between 154 and 158 cm. Those who passed muster in medical terms were then subject to a lottery to determine who was actually sent to the ranks. Unwilling conscripts disposing of the necessary

19 *Otchet o sostoianii narodnogo zdravia* (St. Peterbourg 1905, 1906); Władimir Esipov, *Otcherk zhizni i byta Privislinskogo Kraja* (Warszawa 1909).

20 The calculations on the base of the quoted sources; also see: Adam Zakrzewski, "Wzrost w Krolestwie Polskim. Przyczynek do charakterystyki fizycznej Polaków", *Zbior Wiadomości do Antropologii Krajowej*, XV, part II (1891), 1–39.

21 Michał Kopczyński, *Wielka transformacja. Badania nad uwarstwieniem społecznym i standardem życia w Krolestwie Polskim 1866–1913 w świetle pomiarów antropometrycznych poborowych* (Warszawa 2006).

means could “buy themselves out” by finding – for the appropriate fee – another man to take their place. Until 1873, service in the Russian army lasted for 20 years. In 1874, the “buy-out” proviso was repealed, and the scope of professional exemptions was narrowed down (although teachers, artists, clergymen, physicians, and veterinaries still benefited, as did scions of aristocratic families). At the same time, the duration of service was shortened to 15 years, comprising 6 years of active service plus 9 years in the reserves.

Having conducted a critical analysis of the results of medical examinations by Russian draft boards (i.e. of data pertaining to men eligible for the draft, but not yet inducted into the army), Michał Kopczyński concludes that, over the 47-year period of 1866–1913, the average height of persons from the lower social classes increased by 2.8 cm. The largest changes in this respect was noted over the 20-year period between 1882 and 1902, during which the average height jumped by 2.4 cm. Kopczyński explains this result (which, by the way, is consistent with the observations by Krzysztof Zamorski already cited above) by higher nutrient consumption, especially by persons born between 1867 and 1881. Let us recall here that the rules governing extension of land ownership rights to peasants were promulgated in 1863 and that the 1870s brought an agrarian crisis when food became plentifully available and, thus, inexpensive. The average height of the rural population increased, and differences in this respect between craftsmen, field workers, and landowners were equalised. The figures for small town residents improved even faster, although they were initially lower than those for rural residents. Draftees from larger towns were generally taller. The notable exception to this latter rule was that of Warsaw. Kopczyński explains this in reference to poor sanitary conditions prevailing in that city, but the situation in this regard generally improved after 1880, so the results for Warsaw’s unfavourable statistics in all and sundry areas (including incidence of assorted social pathologies) probably have more to do with the rapid influx of destitute people from the countryside. Michał Kopczyński also noted above-average height measurements among draftees who, today, would be called white-collar workers. Lesser variations of height were to be found among draftees of Jewish origin, what’s more, young men with a Jewish background remained consistently short during the period under analysis. The most general conclusion would be that the case of the Kingdom of Poland does not depart significantly from the rules posited in 1955 by Simon Kuznets and subsequently verified in reference to England by Jeffrey Williamson.²²

Even today, the opinion that inhabitants of rural areas are healthier and live longer than city dwellers runs strong. This is “folk sociology”, a deduction from the fact that the countryside generally has better air and more wholesome food. In real-

22 M. Kopczyński, op.cit., 189–191; Kopczyński quoted Simon Kuznets, “Economic Growth and Income Inequality”, *American Economic Review*, vol. XLV (1955) and J. Williamson, *Did British Capitalism Breed Inequality?* (Boston 1985).

ity, already in the second half of the 19th century did data on mortality and incidence of disease in various countries begin to indicate that it was only in the first stage of urbanisation that living conditions in the cities were worse than in the countryside. Towards the end of the 19th century, also in the Kingdom of Poland did the industrialised regions have quality of life indicators more favourable than those for agricultural regions. Examinations of conscripts from the countryside yielded alarming results – the young men from the villages were “barbarously unkempt”, with the skin on their bodies hardened by dirt and that of their feet peeling, covered with eczema and scabies. They would report before the draft board in clothes which had never been washed; many were short and puny, plagued by illness and acquired afflictions, including amateurishly treated syphilis. Asked about their diets, they would reply that, since childhood, they have eaten nothing but potatoes or noodles (from flour and water) with cabbage, sometimes gruel and bread; they would readily admit that they never wash their necks or private parts²³.

Physicians practising in specific localities ascribed the generally poor state of health prevailing among their charges first and foremost to poor living conditions, superstition, and bad habits. Tuberculosis – while it was receding in the early 20th century, it was still the most dangerous disease of the time – was normally diagnosed in every seventh patient examined, with the Kingdom of Poland faring somewhat better on this count. In some environments, tuberculosis ran rampant in excess of any standards.²⁴ The physicians would also find that some 17% of men and 23% of women seeking their assistance are afflicted by nothing save hysteria, which they have come to regard as an illness in its own right. The women were much the worse for frequent pregnancies, and even the well-to-do suffered digestive problems because they would alternate between strict fasts and unmitigated holiday feasting. Illnesses of the urinary/genital tract were common because “lack of cleanliness, early sexual transgressions, and indulgence in liquor” went hand-in-hand with deeply rooted superstitions concerning personal hygiene and treatment of such ailments.²⁵

23 *Biblioteka Warszawska*, IV (1902), 603–604.

24 WAP Białystok, archives of the *Rząd Gubernialny Łomżyński, Wydział Lekarski* (Dept. of Medicine), 340, 469, 638, 641; *Kancelaria Gubernatora Łomżyńskiego, Referat II*, 483; *Otchet o sostojanii narodnogo zdravija* (St. Peterbourg 1905, 1906); *Zdrowie*, 6 (1914), 481.

25 Władysław Meczkowski, Antoni Ambroziewicz, “Wyniki spisu jednodniowego chorych w szpitalach prowincjonalnych Krolestwa Polskiego”, *Ekonomista*, III (1914), 179–213; W.Swiatlovskij, *op.cit.*, and of the same author: “Tkackoje prozvodstvo w sanitarnom otnoshenii”. (Po povodu tak nazyvajemogo “infilatora” F.Trubinskogo), *Warszawskij Dniewnik*, 205 (1887); see also *Voprosy obshtchestvennogo zdorovia* (Warszawa 1891).

Conclusion

The political situation prevailing in Poland caused any activity in the area of medicine to assume a political, even an ideological aspect. During periods of stepped-up repression and of active anti-Polish policy, as inevitably followed after any armed effort, the “organic labour” became a surrogate of sorts for the independence struggle, with improving quality of life meant to stir and inculcate national consciousness. Practitioners of the liberal professions, oftentimes hailing from the low and middle-level gentry, displayed the greatest levels of commitment in this area.²⁶ Thus, physicians were social workers whose work in the physical sphere was to augment that of teachers in the spiritual one in making the people. The medical profession was associated with strong social commitment, so the state of general health suggested in memoranda addressed by the medical community to the authorities, in appeals to the public, or in memoirs may be slightly exaggerated.

Paradoxically enough, the greater the work done in the field of hygiene and health care, the criticism became more alarmist, and the number of patients per capita increased. Was this a deterioration of public health? It was actually an improvement of visibility – as diagnosis, statistics, and classification improved, more and more patients had their conditions recognised and entered the medical system. During the first half of the 19th century, the police recorded many deaths of homeless people succumbing to the cold, to malnutrition, or to poisoning; in the second half of the century, such cases became less numerous rather than increasing.

Thus, there are grounds for stating that there was a correlation between modernisation and improvement of the material standard of living and health. If we study the question diachronically, the results yield a positive trend. If, however, we compare the changes in Poland to those in Western Europe, the former lags behind, the changes are lesser in scope, and an underdevelopment of institutional security provided by the state becomes manifest.

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Translation from Polish into English: Bartłomiej Świetlik.

²⁶ See: M. Hanecki, “Z dziejów warszawskiej służby zdrowia w latach 1863–1900”, *Studia Warszawskie*, vol. II, 99–158; M. Lyskanowski, *Zapiski warszawskiego konsyliarza*.

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State's Medical Experts in Local Practice Provincial Doctors View of Themselves as Public Health Promoters: an Example from the Swedish Countryside, 1880–1920

Anna Prestjan

Introduction

Even if the Swedish welfare state made its breakthrough and really was expanded in the 1930's and 1940's, the first steps were taken at the end of the 19th century. These early welfare strivings were mainly expressed through public health care measures, and public health care has since then been a prioritised part of the welfare state.¹ From now on, a national system for public health and medical services was established, and the role of medicine in social planning increased.² Medical science developed, medical care conformed to governmental administration and medical services expanded quantitatively concerning medical professions, specialisation, institutions and beds.³ From a perspective of professionalisation, this meant that trained experts, the professional medical agents, came to play an increasing part in the Swedish state's efforts to solve different social problems, and that profession became more important than class.⁴

Many scholars have pointed out that Sweden, in an international perspective, distinguishes itself in the early organizing of a public health care project with medical legislation, public medical authorities on a central as well as on local level, and a

1 Esping-Andersen in Thullberg & Östberg (eds) 1994, pp. 79–85, Sundin in Carlsson & Arvidsson (eds) 1994, p. 77, Lundqvist 2001, p. 754, Erikson 2003, p. 221, Sundin in Sundin, Hogstedt, Lindberg & Moberg (eds) 2005, p. 365, Bernsen in Ervik & Kuhnle (eds) 1993, pp. 72, 80–83, 99–100.

2 Seip 1984, pp. 12–13, Åmark 2005, p. 26, Berge 2007, p. 13, Sundin 2005, p.397, Qvarsell 1991, pp. 166–167, 173–174.

3 Palmblad 1990, passim, esp. pp. 9–12, Clark Nelson in *Att se det osedda : vänbok till Ann-Sofie Ohlander* 2006, pp. 98–113, Qvarsell & Torell in Qvarsell & Torell 2000, p.9.

4 Perkin 1989, Eklöf 2000.

system in which the majority of all medical professionals were state employed.⁵ These measures were foremost justified on the basis of contemporary ideas of the unhealthy and dangerous city, in some parts based on real needs demanded by the industrialization and urbanisation of the growing cities. Research, then, also focuses how public health reforms were put in to practice in Swedish *cities*, not in the countryside.⁶ City or countryside, it has been noticed that we have comparatively little knowledge of the citizens' encounter with the welfare state, that is, of the citizens needs for, use of and benefit of the welfare services.⁷ Even though the importance of the local perspective has been pointed out,⁸ as well as the importance of the local, individual agents to the development of public health,⁹ research on how public health care was practiced and on what effects public health care policy had on a local level is scarce.¹⁰

By studying the provincial doctors as the state's medical experts in local practice, one can produce knowledge on a) how (in the meaning when, to what extent and in what ways) public health as policy and practice was implemented in the Swedish countryside communities, and b) on the part played by the experts as agents in the development of the Swedish welfare state. This article is based upon a case study of a small and sparsely populated medical district in the middle of Sweden, the Sveg district, during the period 1880–1920.

The Local – Central Perspective

One way to approach the problem – how public health care policy was realised in local communities – is to analyze these communities as medical marketplaces,¹¹ where different kinds of health and medical services are offered and used in a geographically limited area. It has, though, been claimed that physicians in Sweden, where the private practitioners have been comparatively few in an early state regulated medical sphere, don't have had any reason to guard their own interests in

5 Ling 2004, pp. 23, 25, Sundin, Hogstedt, Lindberg & Moberg 2005, p. 24–26, Kearns in Clark Nelson & Rogers (eds) 1989, pp. 7–81, esp. p. 24,

6 Sundin 2005, pp. 400–403, Sköld 1996, p. 94–95, Edvinsson 1992, Nilsson 1994, Edvinsson & Rogers 2001, pp. 541–564.

7 Erikson 2003, pp. 221–222.

8 Qvarsell 1994, p. 105, Sköld 1996, pp. 94–95, Larsson 2004, p. 40.

9 Sundin, Hogstedt, Lindberg & Moberg in Sundin, Hogstedt, Lindberg & Moberg (eds.) 2005, pp. 19–34, Edvinsson & Rogers 2001, p. 543.

10 Sundin in Carlsson & Arvidsson (eds.), p. 70.

11 According to the British historians Mark Jenner and Patrick Wallis, this perspective is rewarding, presupposed that the concept of medical market(place) is properly defined in every specific case, Jenner & Wallis 2007 (eds.), p. 3.

competition with others on a market.¹² Anyway, even if more or less state regulated, the Swedish medical market never have been fully monopolized by the public health system and its agents. For example, Swedish historians Motzi Eklöf and Sofia Ling have used the medical market terminology to point out that medical pluralism, in spite of early state regulation, has been a fact in Sweden even until today.¹³ As long as there is a choice, supply and demand, there is a market. I suggest, then, that the terminology and concept of medical marketplace can be used to analyse what happens when ideas of public health confront reality in local societies, and that the welfare state's public health policies can be expressed as a striving towards domination and control of *all* Swedish medical marketplaces, meaning that all citizens should get access to, but also *chose* and *use*, the public health and medical care instead of other options.

The term medical marketplace also stresses the study's focus on local societies. The relation and interaction between the local level and the central plays an important part in this study. This relation shall be understood as both analytical and geographical. Analytically, the relation is between structures and practices. Professional and political interests are expressed through medical legislations, recommendations and instructions. This composes a framework – a structure – intending to regulate the practices of the medical agents – here, the provincial doctors as represents of a public and centrally organized health care system. The provincial doctors were expected to perform their duties in accordance to this framework: to pass on medical science and health care policies to the local community and turn it into practice. On the other hand, obviously the provincial doctors had to adjust their practice to the specific conditions of the physical place.¹⁴

The local-central-relation is also a geographic relation between the Swedish cities as political, academic and cultural centres and “the rest of Sweden”, in a period when the absolute majority of the Swedish population still lived in rural and sparsely populated areas. Not until the 1950's, more than half of the Swedish population lived in cities. Still around 1900, about 80 % lived in the rural areas.¹⁵ It is to notice that Swedish public health care policy was motivated out from the idea of the alarming health situation in the *cities*, in a time when this alarming health situation was a problem to only a minority of the Swedish people. Research on Swedish public health care reforms has to some extent investigated the performance of state policies in local communities, but in *cities*, and has confirmed them, in the late 19th century, as indeed unhealthy places.¹⁶ A shift in ideas has been made a point of: in

12 Sundin 2005, p. 385–386.

13 See for example, Eklöf 2000, Ling 2004.

14 An interesting question, not to be answered in this context, is if the experiences of the local medical agents may have had impact on the framework and possibilities to change it.

15 Sköld 1996, p. 94–95, Ivarsson 1988, p. 4.

16 Sundin 2005, Sköld 1996, Edvinsson 1992, Nilsson 1994, Edvinsson & Rogers 2001.

turn-of-the-century Sweden, the city was seen as an unhealthy place, while the countryside was idealized as natural and healthy,¹⁷ but in the 1930's, the countryside was revealed as underdeveloped and unhygienic in the shadow of the welfare state's advance in the cities.¹⁸ This is interesting. Did the Swedish welfare system never really reach the Swedish countryside and, hence, the majority of the Swedish citizens? Was public health reforms maybe never designed to fit the rural Sweden? The question to what extent – and when, and how – public health care reforms were realized in the Swedish countryside, here stands out as a relevant one.

Questions, material and disposition

This study aims to say something about conditions and prerequisites for the impact of public health reforms in the Swedish countryside, in a period of time when the first steps were taken to create the Swedish welfare state. Now, the public health care system expanded – with national ambitions, but motivated by urban problems. The question to be answered in this essay is: what was the provincial doctors' own view of their possibilities, as the state's medical experts, to promote public health care in the district?

The main materials used for this study are the provincial doctors' yearly reports to the National Medical Board in Stockholm. The reports have been used in several contexts, principally in “traditional” medical history studies or local history studies. The reports' value as empirical sources has been confirmed, according to their possibilities to give information not only on specific places and individual physicians, but also on public health conditions and the province doctor as a profession.¹⁹ From a choice of reports from the 19th century, Swedish historian Ylva Sjöstrand points out some interesting aspects on the provincial doctors' view of the modern and the traditional. A common feature of the reports studied is the physicians' generalized descriptions of the locals from a “from above” perspective. According to Sjöstrand, the physicians did share some common, but contradictional, ideas of the locals. The provincial doctors seem to have had an ambivalent attitude to the locals

17 The idealization of the countryside in turn-of-the-century Sweden has been discussed and analyzed by for example Martin Stolare and Nils Edling, Stolare 2003, Edling 1996.

18 Edvinsson & Rogers 2001, p. 562, Edvinsson 1992, p. 10. The uncovering of the Swedish countryside as underdeveloped and filthy was manifested in a series of reports in Swedish national public radio in 1938, titled *Lort-Sverige* (Dirty Sweden), documenting the very poor standards of housing and living in the Swedish countryside. The report series was produced by journalist and writer Lubbe Nordström, who also wrote a book with the same title.

19 Swedish historian Karin Johannisson has distinguished three types of history of medicine: traditional, social and critical. Traditional history of medicine is, Johannisson says, written from the perspective of physicians and medical science, often anachronistic, and takes the objectiveness and “truth” of medical knowledge for granted, Johannisson 1990, pp. 13–20.

citizens in the rural districts. While the physicians sometimes picture themselves as the modern society's represents and the advocates of sense, rationality and science, in other contexts, aspects of the same modernity is described as something bad in contrast to the idealized traditionalism represented by the "good farmer".²⁰ This ambivalence can maybe be explained out from the provincial doctors' double roles and loyalties as at the same time the state's represents and the local society's.

The reports were based upon standardized forms. The physician should describe the incidence of different diseases and complaints and the number of children born, but also the "common health condition" in the district on the basis of different factors as, for example, housing conditions and fresh water supply, the local authorities actions in health issues, the number of medical agents practising, ceremonies as forensic medicine autopsies and scientific observations. The yearly reports, then, provide broad information about a region and its population, and not only on health matters.

The reports as a source of primary information do of course have its limitations as well. The information given is always a selection, made by the individual physician. The content of the reports is then not only a matter of what the National Medical Board wished to know, but a matter of what the doctor found worthwhile to tell. The individual character of the reports also results in differences in quantity. Of the 40 reports used for this study, the majority are very detailed, but there are also more moderate writers among the physicians. A lack is that the reports tell very little about the people in need of medical health care. The patients, or presumptive patients, do only occur as numbers in statistic information on diagnoses.

After a brief overview over the provincial doctors' Swedish history and earlier studies of it, the medical district of Sveg 1881–1920 is presented. The study then focuses the prerequisites for public health advances in the district, called attention to and discussed by the provincial doctors' themselves in their reports.

The provincial doctors – earlier studies and background

Swedish historical research has described the medical profession as one of the most successful ones of the 19th century. The physician's status grew and the physicians increased their influence over the developments of modern society. The physician had the role of medical expert, impartial represent of science and truth teller.²¹

Swedish historical research on occupations in the care section has mainly focused women dominated occupations, and the physician, from a gender perspective, have

20 Sjöstrand 2003, pp. 139–161.

21 This view is common in many studies, as for example Palmblad 1998, pp. 35–37, Johannisson 1991, pp. 150, 155, 170, Björkman 2001, pp. 90–95, Ling 2004, pp. 33–34, Arvidsson 2002, pp. 75–77 and Edvinsson & Rogers 2001, pp. 548, 562.

been seen as a masculine profession with supervision over midwives and nurses. Mostly, studies in medical history points out physicians as a male collective with power over women, both other professional groups and patients.²²

Physicians, then, have been pictured as a homogeneous group, whose power and independency increased rapidly from the end of the 19th century. Beside this picture, anyway, is another, contradictive one. Studies show that physicians did *not* have that significant power, in society or even over their own professional conditions. The differentiation between the physicians contradicts the image of physicians as a homogeneous collective. No one can question the fact that the profession for a very long time was an exclusively male one – but there are gender history studies that give a balanced picture of the expected patterns of subordination and superiority. For example, female professions as the district nurse often had an independent and important position in relation to the local physician.²³

When it comes to the provincial doctors, studies are predominantly biographical or local. The harsh working conditions of the provincial doctors are often called attention to, and the province doctor is described as a hero, observing and supervising the local society from a professional, “outsiders” view. The physician here is the represent of progress and development. Interestingly enough, many studies show how the state employed physician competed with other medical agents, and how the physician’s personality and social interaction were more important factors in the competition than professional and official authority.²⁴

In the 18th century, the Swedish state took the first steps towards a system of state employed physicians. Sweden was divided into medical districts, and a physician was stationed in each of them, a “province doctor”.²⁵ “Province” here refers both to the fact that the system built upon marked off areas, districts or provinces and to the important notion of that this was something that indeed included the rural and sparsely populated areas of Sweden, the provincial Sweden. Or, at least, was meant to.

The motive behind the system was not only that the state should better provide for the citizens’ health, but also that the physicians should report back to the state authority, the National Medical Board, about all conditions that concerned the citizens’ state of health.²⁶ From the very beginning, then, the provincial doctors were

22 Öberg 1996, pp. 90–91, 95, 304, Andersson 2002 pp. 168–172. See also Milton 2001, Nilsson 2003.

23 Arvidsson 2002, pp. 57–58, 66–67, Qvarsell in Sjöstrand (ed.) 2003, p. 16, Emanuelsson & Wendt, pp. 10–12, 14–15, 18, 85, 186.

24 Abukhanfusa 1994, pp. 34–40, Abukhanfusa in *Källor till den svenska historien* (Årsbok för Riksarkivet och landsarkiven), 1993, pp. 132–142, Nilsson 2002, pp. 121–127, Appelqvist & Nilsson 2005, pp. 95–113, Sjöstrand 2003, Järnankar 1997, pp. 33–43.

25 Bergstrand in Kock (ed.) 1963, pp. 120–124.

26 Ibid.

double agents. As medical experts, they were supposed to supply the local society with public health care and supply the state with information and knowledge of local conditions.

The provincial doctors' working conditions were regulated in a specific instruction. The first instruction was appointed in 1744, but the most important one was that from 1822, which outlined the provincial doctors' conditions until the 1960's. According to the instruction, the physician not only should give medical care and advice to all members of the district, but among other tasks work for preventative medical care, fight epidemics and sexual transmitted diseases, instruct and supervise vaccinators and vaccination against small pox, supervise the district's midwives and dispensers and perform forensic examinations and autopsies. In short, the province doctor should act in every local medical and health issue possible.²⁷ The instruction was renewed several times during the 18th, 19th and 20th centuries, but the main themes remained the same.

The province doctor had a yearly salary combined with a rate system for medical services. A problem was that physicians stationed in very sparsely populated areas naturally earned less than their colleges in more urban districts. This was regulated in 1890 through a so called service benefit, intending to guarantee a certain income for the physician. The medical district of Sveg was one of the districts where the physician was guaranteed such a benefit.²⁸

In 1880, the provincial doctors organized themselves in Swedish Provincial doctors' Association (Svenska provinsläkarföreningen). A change in the instructions in 1890 gave the provincial doctors extended social and political influence as they now became obligatory in the newly established Community Boards of Health, municipal authorities with the task of supervising certain health issues in the local societies. From the end of the 19th century, then, the provincial doctors' possibilities of local influence increased.²⁹ But times were to change. During the 20th century, the system of provincial doctors lost importance in relation to the expanding system of public hospitals and the increasing number of hospital physicians. When physicians became more specialised, the province doctor profession, bound to local practice, lost status.³⁰

27 Ibid.

28 Svensk Författningssamling 1890:59, *Taxa för arfvode åt visse i civil tjänst anställda läkare för enskild sjukvård och för intyg, meddelade på enskild begäran, äfvensom för tjensförrättningar, verkställda enligt gällande instruktion eller myndighets uppdrag.*

29 Kock 1962, p. 125.

30 Kock 1962, p. 157.

The Medical District of Sveg: Population, Industries, Communications

The medical district of Sveg 1880–1920 was part of the Härjedalen province in Jämtland County. The district consisted until 1898 of six smaller municipalities, and after that of five.³¹

Even if the population of this part of Sweden was very small, it increased, especially in the 1880s and the 1910s.³² In the Härjedalen province, the population growth was especially remarkable after 1900, in particular in the village of Sveg.³³ In the district as a whole, the population grew from about 6000 inhabitants in 1881 to more than 9000 in 1920.³⁴ Health matters were an issue for the Municipal Boards of the district until 1909, when Sveg had become a society big enough to have a Community Board of Health of its own.³⁵

1880–1920, agriculture and animal husbandry was the dominating industry in the county. At the beginning of the 1880's, almost 90 % of the population were peasants, the majority self depending farmers and crofters. At the end of the 19th century, a new working class emerged, farmhands of both sexes and forestry workers. Until the turn of the century, farming in the district was limited to self support and for a long time unmodern.³⁶ An important additional source of income was forestry. The forestry had an impact on the social structure and the population of the district as hundreds of workers came to stay during logging and rafting seasons. This social group of outsiders, young, single men with no families and a non-resident lifestyle, can be expected to have had an impact on the district's health conditions: the workers as carriers of diseases into the district, them passing on venereal diseases, or the forest workers' communities as breeding grounds for epidemics. But surprisingly enough, this is only mentioned once in the provincial doctors' reports, when the doctor claims that the forestry workers' drinking habits has a bad impact on the locals' ditto.³⁷

The fact that almost all of the local men also worked in the forestry industry and stayed away from home for long periods is never mentioned in the reports, and neither is the fact that the women too lived away from home during summer, living with the cattle in the pasture lands. This special social structure, where either the man or the woman in the family staying away from home most part of the year, is

31 Provsialläkarrapport Svegs distrikt 1908 (Provincial Doctor's Report Sveg District: from now on is referred to PDR) Based upon archive studies of all PDR 1880–1920.

32 Rolén (ed.) 1990, pp. 22–23.

33 Bromée 1974, pp. 122–123.

34 PDR 1903.

35 PDR 1908.

36 Rolén (ed.) 1990, pp. 22–29.

37 PDR 1882.

mentioned by the priest as having an impact on morality, family bonds and parents' control over their children, but never by the province doctor.³⁸

In the district, there were no cities – only small villages, some of them only with a couple of small farms, spread with miles of forests between them. To communicate with and travel to other places was time demanding. In 1889, the district got a telegraph station. The province doctor in charge at the time called this epoch-making, as the district eventually was connected to the “civilized Sweden”.³⁹ The following year telephone connection was the happening of the year. Telephone, the doctor said, was “invaluable” to health care work.⁴⁰ In the beginning of the 20th century, the district got railway connections to other places in Sweden. The railway improved the communications of the district, but also the food prices and the population's social structure as a new category, the navvies, became part of it during the period of railway building, 1901–1924.⁴¹ In the reports, the navvies, as well as the forestry workers, are seen as a group separated from the locals, with their own health problems connected to their bad housing and nourishing conditions, but not as having any impact on the district as a whole.

Prerequisites for Public Health

The State's Experts

During the period 1880–1920, nine provincial doctors worked after each other in the district. The physicians were all between 30 and 40 years old when they took up their duty. None of them was born or raised in the area, but came as strangers from other parts of the country. It is hard to decide if, and if so, to what extent the province doctor ever became part of the local society. Apparently, some of them did, as L. O. Svenonius (1853–1926), who married a local girl and stayed in Sveg until he died, while others never may have been more than “constant visitors”, as the doctor who had his family in the south of Sweden during his eight years of service.⁴²

The doctors' own view of themselves as the State's represents is obvious in their yearly reports. This is also a finding of an earlier study, who says that the provincial doctors seem to have applied a from-above-perspective on the locals. In agreement

38 Prestjan 2009.

39 PDR 1889.

40 PDR 1890.

41 Rolén (ed.) 1990, p. 122–125, 149–152, Bromée 1974, p. 123, PDR 1902, 1904, 1908.

42 All information on the provincial doctors are collected from extensive archive studies: PDR 1880–1920 and Chrush records, Sveg parish.

with this, the yearly reports from Sveg are filled with indignant and dejected comments about the locals' housing, eating, drinking and cooking habits, infant care, hygiene, ignorance, superstitiousness and suspicion to all that was modern.⁴³ "Cleanliness is something unthinkable", a province doctor claims in 1881.⁴⁴

In the earlier study mentioned is talked about an ambivalent attitude: even if the doctors tended to see the locals as "the others" who had to be educated, informed and supervised, on the other hand, they also had a way of defending the locals' way of living as "natural" and "healthy" in contrast to the unhealthy and deprevated lifestyle in the growing cities. Coming to the provincial doctors of Sveg medical district, anyway, there are few if any comments indicating this kind of ambivalence. The provincial doctors here never have anything good to say about the locals' way of life – which is surprising, according to the contemporary idealizing of the countryside and the farmer's healthy life style.

Needs of public health care?

Were there specific needs for public health care in the medical district of Sveg, caused by specific health problems? Aside from the very common chronic stomach and rheumatic sufferings, the district was ravaged by diseases and epidemics. Especially serious were the problems caused by diphtheria, tuberculosis and, in 1918–1919, the Spanish Flu.

Diphtheria was a serious and very contagious throat disease, and for long times the cause of a great deal of the district's infant mortality.⁴⁵ Even if diphtheria was a sphere where the province doctor – for once, at last – could prove the superiority of medical science,⁴⁶ the disease wasn't discussed in the yearly reports as causing a special need of medical expertise, apart from one or two comments about how death could have been avoided if the provincial doctor had been summoned, at all or earlier.⁴⁷ The same thing can be said about tuberculosis, a disease prevalent in the district during all of the period, or other infectious diseases.⁴⁸ Another example: severe

43 PDR 1880-1920, *ibid.*

44 PDR 1881.

45 The reports' records of how many fallen ill from diphtheria shows that the disease was occurring almost every year 1880–1920. The period 1908–1915, there were very few cases, if any, every year, but in 1916–1920, the disease was emerging again, even if it never reached the level of the 1880's and 1890's. In 1884, the province doctor reports of 30 percent mortality in diphtheria. PDR 1880–1920.

46 In 1901, the province doctor reports of a new "serum treatment" that had been found to considerably decrease the mortality from diphtheria, PDR 1901. In 1904–1905, the province doctor writes that since the locals have learnt to seek treatment in time, the state of illnesses have been mild, PDR 1904, 1905.

47 PDR 1894, 1898.

48 S. f. e. PDR 1883, 1891, 1897, 1901, 1905, 1908.

flu epidemics ravaged the district, as the rest of Sweden, in two periods, the “Russian” about 1890 and the Spanish Flu in 1918–1919. In 1890, at least 65 percent of the district’s inhabitants fell ill,⁴⁹ and in 1918–1919, the numbers of persons taken ill and died were even higher.⁵⁰ Even if the Spanish Flu was the direct cause of an exploding public health intervention in the district as well as the in county (see later on),⁵¹ the provincial doctors never discussed the epidemics as giving rise to higher needs for medical expertise.

The occurrence of diseases and epidemics may be expected to have caused the provincial doctors to point out the need of public health efforts and medical expertise in their reports – but this argument wasn’t used to advocate their own importance. Instead, it was the locals’ traditional way of life that was identified and underlined as the most remarkable threat to state of health that caused the real need of the province doctor’s expert knowledge. The provincial doctors’ opinions of the locals’ way of life was critical. The locals led an unhygienic life, and it was especially their habits of housing and eating that concerned the physicians. Almost every year, the reports mention the local eating habits. The food supplies were sufficient, but according to the provincial doctors the local women had no knowledge, nor interest, of cooking, and because of this, the locals never ate something that wasn’t rotten, rancid, sour, dried or salted.⁵² Even if the homes in general were spacious, the whole household crowded in one room, and it wasn’t until the 1910’s that the locals abandoned the tradition to live under the same roof as their cattle.⁵³ The provincial doctors’ view of the local traditions of infant care is somewhat contradictory – the mothers are said to breastfeed their children far too long, but at the same time they are accused of giving the babies potatoes, herring and porridge far too early.⁵⁴ And so on. The locals, the provincial doctors declared in 1882, ate

sour, disgusting, half-year-old milk and dried half rotten meat, sour fish, raw pork, coffee with snaps in unreasonable quantities. That this diet eventually will destroy even a harsh farmer’s stomach is obvious.⁵⁵

On top of everything, the local women were too lazy to cook:

Attempts to introduce peas, beans and grains in this diet will not succeed, as no local

49 Åman 1988, pp. 74–86, PDR 1890.

50 PDR 1918–1919.

51 Åman 1988.

52 PDR 1880-1920, the cooking and eating habits are mentioned in almost every one of the reports.

53 PDR ex. 1884, 1886, 1889, 1892, 1897, 1904, 1916.

54 PDR ex. 1885, 1893, 1907, 1913.

55 PDR 1882.

woman is willing to subject herself to the one hour's effort of preparing these food-tuffs....⁵⁶

The locals' particular partial to coffee, or the "coffee abuse", was another concern of the province doctor during the whole period. The amount of coffee consumer by the locals surprised and shocked the doctors. According to the doctors the inability and lack of interest in cooking and the opposition of using new methods of storing food resulted in chronic stomach complaints.⁵⁷

The housing habits of the locals were another thing described as a serious threat to health. In the district, the dwelling houses were spacious timber buildings, heated with a fire place in one of the rooms. The critical points were two. First, all the members of the household usually crowded in one room, where they ate, slept, cooked and worked, regardless the many rooms of the buildings. This was both a practical solution to keep the warmth in a harsh climate and a traditional way of living. Second, it was very common that part of the household, as the old people, the maids or the farmhands, had their lodging in the barn. Even if the provincial doctors through the years agree on the barns as more clean, tidy and healthy as lodging than the dwelling houses, this was found as unhygienic as the crowding problem. The problems with these traditional ways of lodging, according to the doctors, were not only the infectious risk and the problems with isolating and disinfection in cases of illness, but also that the dwelling houses were considered draughty and cold, which caused rheumatic diseases.⁵⁸ The habits of lodging existed to the end of the period, but became, to the province doctor's relief, unmodern and thereby more uncommon from the first years of the 20th century.⁵⁹

It was, then, the locals' traditional way of life that, due to the provincial doctors, made the medical experts' knowledge and advice a necessity in the medical district of Sveg – not the existence of diseases and epidemics. This was of course subjective judgements and besides that, as we have seen, possibly part of a tradition where provincial doctors used a condescending jargon to express their understanding of the locals and their way of life as conservative.

56 PDR 1891.

57 S. f. e. PDR 1881, 1885, 1887, 1891, 1901, 1915, 1916, 1919, 1920. Even if 17 (!) cups of coffee a day certainly can be seen as over-consumption, one should keep in mind that the frequently debated Swedish "coffee abuse problem" of the late 1800's and early 1900's also should be seen in the light of a tendency to, from a moral point of view hidden behind health arguments, problematize all so called luxury consumption among the lower classes.

58 PDR ex 1884, 1886, 1889, 1892, 1897, 1904, 1916.

59 S. f. e. PDR 1908, 1912, 1915, 1920.

The public health force: state authorised medical agents

In the district, there were of course other medical agents than the province doctor. Some of them can be said to have reinforced public health's position in the district, as members of a public health "force", while others meant competition and challenge. Let's start with the public health force that besides from the province doctor consisted of midwives and nurses. Midwives and nurses were, as the doctor, professionals and authorised by the state, and, even if not state employed, public employed and not private entrepreneurs. An increasing number of midwives and nurses in the district, then, mark the expanding public health care system and the medical experts' grip of the medical marketplace.

In the Sveg district, there were at the beginning of the period 1880–1920 only three midwives. The lack of educated midwives concerned the provincial doctors. Giving birth should be supervised by medicine. But as the cost of a midwife was a municipal responsibility, not all municipals could afford, or prioritized, this service. Information on the numbers of childbirths assisted by a midwife can only be found in reports from the years 1886–1889, and varies between 40 and 50 percent. The low number of midwives in the district, the far distances and the bad communications were not, anyway, the only reasons to the locals to not chose one of state's medical experts when giving birth. According to the province doctor, the locals preferred to engage help women or help men rather than the local midwife, even if the latter lived closer. This is an example of how there was a lack of confidence in the public health care, and a higher confidence in the traditional resources, independent of availability.

Until 1901, the provincial doctor was the only deliverer of public health care in the district, assisted by the midwives and the small pox vaccinators. With the opening of a small cottage hospital in Sveg village – the result of private fund raising and persuasion of the municipalities to make contributions – a professional nurse was engaged by some of the district's municipalities, who eventually had agreed to pay for this service.⁶⁰ The cottage hospital was the very first institutional effort of the district, and it is important to notice its half-public, half-private character. The cottage hospital nurse reinforced public health's force of medical experts, but any remarkable reinforcement didn't take place until the years of 1918–1920, when a fast expansion occurred. This was the result of the meeting of direct needs – the influenza epidemic of 1918–1919 – and of renewed public reactions to an old problem – the tuberculosis.

1918, a municipality nurse was engaged by the Sveg municipality, with economical contributions from the forestry companies. Two years later, three of the district's six municipalities had their own nurse. 1918 was also the year when the

60 PDR 1901–1920.

influenza epidemic called the Spanish Flu ravaged Sweden. The Sveg district did not escape its advance, and almost a third of the districts' inhabitants fell ill. This year, no less than nine extra nurses and two help nurses did service in different areas of the district, and temporary epidemic hospitals were set up.⁶¹ The same year a tuberculosis clinic, a so called *dispensär*, with a tuberculosis nurse, was arranged in Sveg village. In the district, tuberculosis was common from the beginning of the period.⁶² People died from tuberculosis every year – in 1889, 10 percent of all deaths were the result of tuberculosis.⁶³ The tuberculosis situation in the district was not especially alarming in 1918 compared to earlier years, and the *dispensär* reform was rather the result of contemporary medical progress in the field as well as increased social interest for tuberculosis as a problem than of an alarming situation. The aim of the national *dispensär* activities was mainly preventive measures to prevent spreading of the infection and increase resistance to it, and its activities were mainly based upon philanthropy. The *dispensär* nurse visited all parishes of the district at some times of the year, to deliver information on the disease and the contagiousness, and assist with care and hygiene in the homes. The system was, though founded in philanthropy, part of an early, public non-institutional care system, where medical professionals practiced in local societies and implemented public health care.⁶⁴

Competition

The public health reinforcements then reached the medical district of Sveg district late. Until 1918, the province doctor was all alone, besides from the very few midwives and vaccinators. The midwives, anyway, weren't always the doctor's allies, they could also be challengers. In 1897, the province doctor for the first time mentions a midwife, who "pretty much is engaged outside her profession"⁶⁵ and a few years later, he is really upset over the enterprising midwives:

...the midwives are engaged to cure all kinds of complaints that do not have anything

61 PDR 1918. Margareta Åman has written about the Spanish Flu in Sweden and Jämtland County. The flu came to Sweden summer 1918. Östersund, the one city in Jämtland County, was one of the most stricken Swedish cities with extremely high mortality rates, Åman 1988, pp. 74–86.

62 PDR 1886.

63 PDR 1889. See also PDR 1884–1889, after this year, the tuberculosis patients are reported separately and do not appear in the yearly reports of the provincial doctors.

64 PDR 1918, 1919. See Sundin 2005, pp. 405–406, who points out that the public and the private initiatives often were each others' complement and supplements during the period, and Seip 1984, who defines 1870–1920 as a period of cooperation between public and private and a forerunner to the welfare state thinking of the 1930's and on, when public responsibility increased, Seip 1984, pp. 12–13; Beskow & Wiman 2006, pp. 1229–1230.

65 PDR 1897.

to do with their profession... I say, the midwives of Lillherrdal and Ytterhogdal have the functions of ordinary nurses, nota bene: who also prescribe the treatment. But what to do? The public want it that way, as the midwife in their opinion always is a kind of doctor.⁶⁶

Not only factors connected to the presumptive patients' preferences and the suppliers of medical health care are of importance when it comes to what extend public health care can succeed in a local society. Another thing important is the relation between different medical agents. This relation is usually expressed as competition, between qualified and un-qualified healers,⁶⁷ or between different professions,⁶⁸ but can also be about cooperation, dependence or complement – something that has been established by for example Swedish historians Agneta Emanuelsson and Rig-mor Wendt concerning the relation between provincial doctors and district nurses.⁶⁹ As we have seen, there are possibilities to inquire into the provincial doctors' relations to, for example, the midwives, who apparently could be both allied, supervised subjects and competitors. In this study, though, the relation focused is the competition between the province doctor and the quack.

The disobedient midwives were not a major problem to the provincial doctors in Sveg district. They had more serious competitors in the local quacks, or, rather, The Local Quack. In the district, one man, mill owner Anders Wallström, practiced medicine during the whole period 1880–1920. The history of this business is enough for a book of its own, and much has been written about Wallström and his feats. He is still today kind of a local historical hero, and the province doctor are in these stories the narrow-minded, ridiculous man who tries to charge Wallström, but always get cheated. There are several stories of how the public confidence in the medical expert was low, compared to the unlimited faith in Wallström's capacities and methods.⁷⁰

The provincial doctors' reports give a similar picture of the situation. Wallström is mentioned every single year. There were other medical swindlers as well, as masseurs, hypnotizers and homeopaths,⁷¹ but even if they too indeed were seen as competitors by the provincial doctors, they were nothing compared to the miller.

In some cases, the province doctor admitted the value of the unauthorized healers. The acceptance of quacks was of course also due to the doctor's attitudes. Some of the quacks so were judged reliable and useful, and even a valuable resource, as they limited their practice to their own village and cooperated with the

66 PDR 1900.

67 See for example Eklöf 2001, Ling 2004.

68 See reference 25.

69 Emanuelsson & Wendt 1994, t. ex. s. 10–12, 14–15, 18, 85, 186. Se också Jenner & Wallis 2007, s. 14.

70 S. f. e. Wahlqvist 2003.

71 S. f. e. PDR 1889, 1900, 1909, 1910, 1917, 1920

physician.⁷² Axel Möller (1853–1924), province doctor of the district 1884–1892, wrote:

I personally consider humans masters of their own bodies, and that they have the right to ask anyone they wish for advice when these bodies let them down or cause them pain. I therefore do not attach any importance at all to Wallström's appearance as a doctor.⁷³

The district was large, the communications few and so the public health resources, he wrote:

Here, where the doctor is far off, [the quacks] are necessary and often even useful, especially as they do request alarming cases to the physician.⁷⁴

For the most part, though, the provincial doctors, and even Möller, agreed upon Wallström as a greedy, overestimated, self-righteous and dangerous charlatan. Wallström did not limit his practice; on the contrary he extended it and treated patients even in other districts.⁷⁵ His practice included writing of prescriptions (accepted at the district pharmacy), production and selling of his own patent medicine, purchasing medicaments directly from his own illegal storage and all kinds of treatments, from internal to chirurgic.⁷⁶

The provincial doctors' discontent with Wallström rose from two contexts: the quack's trespassing into the areas of the authorized medical experts, and the public's unlimited confidence in and support of the quack. The trespassing could be met with legal measures, as there were laws against illegal trade with pharmaceuticals and unauthorized medical practice.⁷⁷ Wallström was reported and put on trial, and even judged a few times, but his outstanding reputation was always an obstacle to his accusers. Wallström extended his practice. In 1889, Wallström was engaged as "district medical officer" in one of the district's parishes. The municipality payed Wallström to hold regular receptions in the parish four times a year. According to the province doctor, people flocked in large numbers, sick or healthy, to see Wallström. The business was a very profitable one: each patient payed a fee, divided between the quack and the municipality.⁷⁸ Wallström's receptions went on until at least 1920, and through the years, he extended his business to other parishes inside the district.⁷⁹

72 PDR 1885, 1890.

73 PDR 1886.

74 PDR 1885.

75 PDR 1885.

76 PDR 1881–1920.

77 Ling 2004, *passim*.

78 PDR 1895.

79 PDR 1903, 1915, 1920.

This was, of course, a defeat to the province doctor of the district. In the 1890's, the province doctor's possibilities to outreach work and extended public health services improved. If a parish wished regular, local receptions of the province doctor, the municipality had to pay for wood, make premises available and pay a reasonable compensation to the doctor for travel expenses. The fact that a municipal committee rather paid for the services of a quack than for the authorized physician's, and even payed the quack more, was unconventional and of course a struck to the doctor's professional pride.⁸⁰

In 1892, anyhow, one of the district's municipalities made an economical agreement with the state, and the province doctor from this year on held regular receptions there.⁸¹ In 1898, the province doctor made efforts to hold receptions in "Wallström parish". The province doctor found these receptions very important, as the locals of this parish were "more than usual prejudiced and ignorant in health matters". By then, the communications were improved as a new main country road was prepared.⁸² The province doctor established that his receptions not at all had had any effect on the quack's popularity, but that the public health's efforts were necessary as a counterbalance.⁸³ In 1909, the province doctor could extend his activities with regular receptions to two more parishes of the district. But by this time, Wallström the quack had had his receptions in these places for several years.⁸⁴

According to the provincial doctors, the Wallström problem had three explanations: the insufficient legal means,⁸⁵ the disregard of the local authorities,⁸⁶ and the locals' ignorance and stupidity.⁸⁷ It was very easy, was a province doctor indignant statement, to accuse and convict a legitimized physician, but very hard to achieve any legal consequences when it came to the quack and his activities.⁸⁸ And when Wallström eventually was fined, the public raised funds to pay his penalties.⁸⁹ The confidence in the quack seems to have been astonishing – even if there were several cases where Wallström's mistakes led to complications, invalidity and even death, the locals kept their confidence, probably maintained by the man's almost mythological status.⁹⁰ During the whole period the locals' ignorance is a recurring theme in the provincial doctors' reports. The locals are called naïve, foolish, superstitious

80 PDR 1895, 1898.

81 PDR 1892.

82 PDR 1895, 1898.

83 PDR 1898, 1899.

84 PDR 1903.

85 PDR 1886, 1889, 1910.

86 PDR 1886, 1905, 1908.

87 PDR 1897, 1906, 1915, 1916, 1919, 1920.

88 PDR 1905.

89 PDR 1895.

90 S. f. e. PDR 1903, 1916.

and stupid, something that appears to be the most important reason to Wallström's success.⁹¹

Public Health in the District of Sveg 1880–1920: Summary, Conclusions and Discussion

Even if public health care in Sweden expanded fast in the period of 1880–1920, in Sveg medical district, there was no noticeable development of public health until the very end of the period. The district went through several changes: the population increased, the communications improved and the railway and forestry industries grew more important. But it was not until the last years of the period that any remarkable increase in the reach of public health took place. This sudden expansion was then the answer to one new and one old problem: the Spanish flu epidemic and the renewed interest for the tuberculosis problem.

The provincial doctors, anyway, from the beginning of the period saw considerable needs of medical expertise in the local society. Those needs were not, as may be expected, related to the geographical place's specific demographic and social structures, or to the occurring of serious diseases and epidemics. Instead, the provincial doctors justified their presence as medical experts and public health agents referring to the locals' way of living and their ignorance of scientific principles for hygiene and medicine. The most common complaints of the district, stomach problems and rheumatism, were directly connected to the locals' lifestyle. The provincial doctors' role in local society in reality, then, seems to have been wider than experts in strict medical matters – they seem to have taken the responsibility of teaching the locals a modern way of living. Almost everything in the locals' way of life had, according to the provincial doctors, effects on their state of health. This is something that stands in accordance with the contemporary way of translating all social matters into science, preferably medical science. The definition of “medical matters” then was widened.

According to the provincial doctors' yearly reports, there were several thinkable obstacles to public health's and the medical expert's problems with getting a grip of the medical district. The army of medical expertise was small, the communications of the district was bad and people were poor. But it seems as if lack of confidence in authorized medicine and its represents was the most important explanation to public health's deficient successes. The consumers' demand for medical services is depending on need, purchasing power and confidence.⁹² Confidence is something

91 PDR 1897, 1906, 1915, 1916, 1919, 1920.

92 S. f. e. Kearns, Lee, & Rogers in Clark Nelson & Rogers (eds.) 1989, pp. 9–81, Eklöf 2001, pp. 36–45.

that is created between the medical agents and the consumers of their services, and is by Swedish historian Motzi Eklöf called "a decisive prerequisite" for a physician's success in a local society in competition with other physicians and practitioners.⁹³ The question of confidence is connected to the constant presence of a mighty competitor: the local quack. Even if the medical district of Sveg was gifted – or cursed – with a quack of mythological status even in his own time, the continuing presence of other unauthorized healers stood out as a general problem to the provincial doctors. The locals' confidence in the quacks corresponded to their lack of confidence in the province doctor. Poor access to public health – bad communications and few medical experts – might be an explanation. This is contradicted, though, by the fact that an un-authorized healer often was engaged even if there was an authorized one at hand.

Why, then, this lack of confidence in the state's medical expert? The consumers' confidence in a medical agent can be based upon the agent's medical knowledge, professionalism and successful treatment results. Eklöf, however, emphasizes personal qualities and reputation as very important to confidence,⁹⁴ and British historians Mark Jenner and Patrick Wallis in the same way point out the importance of the medical agents' integration in local social networks.⁹⁵ As we have seen, the provincial doctors in Sveg district don't seem to have looked upon themselves as part of the local society, but rather as more or less temporary visitors, and ambassadors of modern and civilised Sweden. The yearly reports picture the doctors as persons in authority, with a distinct from-above-view of the locals. In this way, the province doctor cultivated his own role as medical expert and state represent, and created a distance between him and the inhabitants of the district.

Finally: how important was the province doctor as the state medical expert to local implementation of public health? The material used for this study can only give a notion of how the provincial doctors *themselves* felt in this matter. The provincial doctors 1890–1920 seem to have shared the understanding of themselves as representatives of medical science and the Swedish state. The provincial doctors' real influence and power to carry out public health reforms and special public health efforts, is harder to analyse. The provincial doctors seem to have agreed upon their important assignment, and upon their importance in modernizing the Swedish countryside, but there is also an agreement upon the limited possibilities of implementation.

The question of the medical experts' significance in the development of public health at the Swedish countryside remains here unanswered, then, until new source materials can shed light over the issue. Here, materials as for example the Local Health Board's records, local press and the provincial doctors' own periodical *Eira*,

93 Eklöf 2001, p. 36.

94 Eklöf 2000, p. 37.

95 Jenner & Wallis 2007, *passim*.

certainly will constitute a base for a following study. So far, one can establish that yes, there were competitors to the state's medical expert in the medical district of Sveg, *confidence* stands out as the most important factor in public health strivings to dominate the district's health care and no, in 1880–1920, the implementation of public health in the district did not follow the district's societal development.

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“Matters of Life and Death” in a Mediterranean Port City Infrastructure, Housing and Infectious Disease in Patras, 1901–1940

Panagiotis G. Eliopoulos

Patras, the fourth largest Greek city and a major port, underwent a great deal of change during the first half of the 20th century, especially after the currant crisis (1890's) the trade of which Patras controlled and depended on to a large extent¹. The 20th century, a period that perhaps has preoccupied Western Europe urban historians less, since the urban process there has been completed, constitutes nevertheless the great urbanization period for Greece.

At the turn of the century, Patras, while actively trying to fight off the unhealthy factors of its urban environment, continuous and spontaneous expansion meant that these efforts could bear little fruit, especially to the ones living at its outskirts. Up to the 1940's epidemics and disease will repeatedly carve their own print on the city map and decimate the young populations. Medical institutions still, at that period, supported by philanthropic effort and local authorities, will not be able to provide healthcare to meet the city's needs. The arrival of thousands of Asia Minor/Pontus refugees, and the following frequent epidemic outbreaks, made it clear that new initiatives should be undertaken regarding the public health sector, from both local authorities and central government.

1 The rise and fall of the Patran Currant empire is well known and sufficiently present in Greek and international historiography. A sample of the essential works on the subject include: Franghiadis A, *Peasant Agriculture and Export Trade: Currant Viticulture in Southern Greece, 1830-1893*, doctoral thesis, European University Institute, (Florence 1990)., Θ. Καλαφάτης, *Αγροτική Πίστη και Οικονομικός Μετασχηματισμός στη Βόρεια Πελοπόννησο*, 3 vol., (Athens 1990-1992). S. Petmezas, “El comercio de la pasa de Corinto y su influencia sobre la economía griega del siglo XIX (1840-1914)” in J. Morilla, J. Gomez-Pantoja y P. Cressier (edit.), *Impactos exteriores sobre la Agricultura Mediterraneo*, (Madrid 1997), pp. 523-562. Π. Πιζάνιας, *Οικονομική Ιστορία της Ελληνικής Σταφίδας, 1851-1912*, (Athens 1988)

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During the 19th century 20 census were run, from 1821 up to 1896. In the 20th century however they become more scientific and richer in published results. However, the census themselves were not saved, meaning census personal and family cards, and only general information tables the Statistical Service chose to publish exist. For this presentation, we are going to use the ones of 1907, 1920, 1928, and 1940. The census of 1907 is used as a starter point, but we work primarily on the ones of 1920 and 1928. The census of 1928 is richer in published results (tables), while results of the 1940 census were never published due to warfare, except tables regarding population size.

Another source we used is the Vital Statistics for which data exist for the periods 1860–1885 and 1921–1937. The extracted information can only be used to illustrate the actual population progress as well as an expected population progress of a city, though it cannot give an interpretation on issues concerning population inflow or outflow since migration related catalogues were not used by authorities. The most useful source for this study however was the civil registry's archive of Patras after thoroughly indexed more than 45.000 Death Records, but having faced the complexity of working on different methods of registration in a 40 year period. Up to 1919 there does not seem to be a standard system of registration and depending on the care of each clerk, we may or may not find exact data on a person's place of birth, occupation, cause of death etc. The uninterruptedly recording of deaths (contrary to the registration of marriages and births starting only after 1925) – even if incomplete – is due to the fact that a death certificate was necessary to obtain an interment permit. It is after 1919 that all data becomes available after the adoption of national register methods. The use of the Death Records, will show the frequency and course of epidemics and disease (smallpox, typhoid, Dengue, tuberculosis, syphilis, Spanish influenza) and are crucial in calculating mortality rates.

The 1921–1925 Statistics of Death were useful in helping me forming broad causes of death categories and to compare local to national experience.

Matters of life...

Hygiene issues troubling Patras during the 19th century, were common for most Greek cities of the time with most not resolved until mid 20th century, although some improvement was made. By the end of the 19th century the unpopulated maritime lower part of the city, was transformed from a theatre of swamps to the quarters with the best gridiron and sewage. Problems still existed due to its proximity to the sea, in the form of standing water masses at the extremes of the city during summer. In a fast expanding city, water supply was inadequate for several quarters, with water running a few hours during daytime and then collected and

preserved in jugs with whatever hygiene risks this entails especially during the warmer months.

A lot of effort was made by social institutions in fighting disease comprising a danger to public health and social coherence. To all these efforts, private initiative will fill in for state indifference and/or volition, in the form of charity, a not so local experience, since the erection and equipment of health institutes in Athens, Piraeus and Syros was accomplished through private funding².

Starting from the last quarter of the 19th century, the city is being equipped with a new hospital (1872), Almshouse (1876), Nursery (1899), Asylum for the Insane (1900); all built through generous donations of prominent Patrans. The maintenance costs of these philanthropic establishments are covered through municipal budget funding, assisted by private initiatives and to a point Prefect administration. The adding of a new aqueduct, cemetery, avenues and plazas, all contribute in making the city more hospitable for its residents and thought partly responsible for the drop in mortality.

By 1928 the city is struggling for its modernization, so it can reach the living standards achieved in other European cities. This struggle will be consistent with the will of the Greek State to undertake the refugee restoration, with the creation of hygienic infrastructure, to control and confine infectious disease, as well as to organize medical and pharmaceutical treatment. Furthermore the Greek State is called to care for the planning and development of water and sewage system of cities, population and size of which are rapidly increasing during the 1920's³. Cementing of the streets around the city centre is continued and the Council strives for ways to enhance the aqueduct's reserves, although this would not be made possible for many years to come.

“...residents will be able to get cool water at any time, meaning the coming end of ice.”⁴

Improvements seldom reach out to the whole city. On the occasion of the Dengue epidemic and while seeking the causes of its rapid spread, *Neologos* gazette started an extensive inquiry on the sanitary conditions in every district of the city with its reporter accompanied by both a City Councilor and the Chief of Police. The results were published in a series of articles headed “Our districts. A true Augean ordure” – a comparison to the mythical Herculean task – painting a vivid picture of the city

2 Μαρία Κορασίδου, *Οι Άθλιοι των Αθηνών και οι Θεραπευτές τους, Φτώχεια και Φιλανθρωπία στην Ελληνική Πρωτεύουσα τον 19 αιώνα* [The Miserable of Athens and their Healers, Poverty and Philanthropy in the Greek Capital in the 19th Century], (Αθήνα 2004), pp 77–81.

3 Γιάννης Κυριόπουλος, “Οι Πολιτικές Υγείας και Ασφάλισης στην Ελλάδα υπό το Πρίσμα των Διεθνών Εξελίξεων την Περίοδο του Μεσοπολέμου” [Health and Social Security Politics in Greece Under the Prism of International Circumstance]

4 *Νεολόγος*, Tue. 28 Aug. 1928.

and the living conditions of its residents. It became apparent that besides the central quarters, few other areas of the city retained even a minimum of hygienic living requirements. For most sections problems were common like, absence of sewers (Map 1, Areas: 1,2,6,8,25,26), standing waters (Areas: 1,2,4,6,12,21,25,26), open ditches passing through the quarters carrying impurities and becoming sources of infection during summer (Areas: 1,2,3,5,6,7,9,10,26).

Map 1 Area 5 ...a ditch carrying every impurity dropped in by soldiers. I have been informed that by that ditch's foul and germ filled water, surrounding gardens are watered. I am utterly horrified and my horror is aggrandized when a resident hinting the condition tells us in brag: "If only you knew what... nice vegetables grow in these gardens"⁵

City cleanliness issues for streets (Areas: 14, 20), plazas and open markets (Areas: 18, 22, 23) and the lack of a timely unstopping of drains (Areas: 4,9,11,13,14,20,24), were more than common, with narrow streets, preventing the passing of the maintenance-cleansing department carts (Areas: 8,12,14,20,24). Many other hygiene issues derive from the operation of tanneries (Areas: 12,14) and stables (Areas: 9,15), as well as from daily residents' unethical practices like the use of open spaces as lavatories "by people not respecting one's self"⁶ (Areas: 6,12,17,19,20,22,25) and the need for further sanitation in existing public lavatories (Areas: 16,17) and houses (Areas: 8, 14) .

More problematic appeared to be sections outside city limits until recently, gradually incorporated by continuous city plan expansions. The search for cheap housing, and anarchic building, continues to create new small quarters away from city centre and the possibility of quality housing. Interwar Europe cities were being subjected to rationalization regulations with overwhelming urban planning bills⁷, but despite the 1923 "Of Urban planning etc" Bill, urban sprawl continued in many Greek cities⁸ as it did in other cities of the Mediterranean⁹. The State indirectly supported such practices, legalizing illegal constructions as a means to inte

5 *Νεολόγος*, Fri. 14 Sep. 1928.

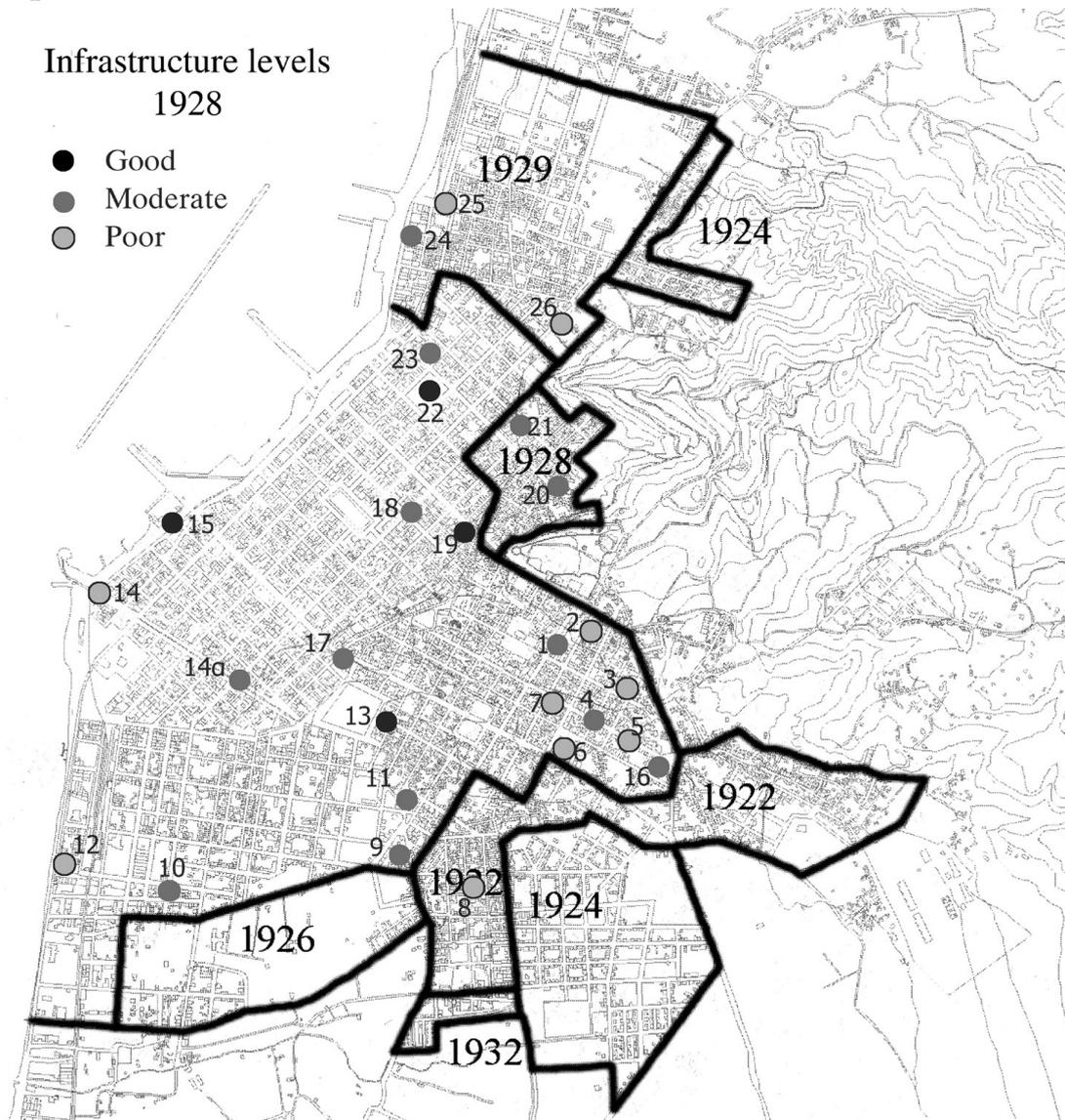
6 *Νεολόγος*, Mon. 17 Sep. 1928.

7 Mark Mazower, *Η Σκοτεινή Ήπειρος. Ο Ευρωπαϊκός Εικοστός Αιώνας*, (Αθήνα 2001), p. 98.

8 Βίλμα Χαστάογλου, *Βόλος, Το Πορτραίτο της Πόλης, από τον 19 Αιώνα έως Σήμερα*, (Βόλος 2007) 2nd ed., p.96.

9 Lila Leontidou, *The Mediterranean city in transition: social change and urban development*, (Cambridge 1990), p. 12. Also Δ. Οικονόμου, "Σύστημα γης και κατοικίας στη μεταπολεμική Ελλάδα", pp. 57–114 in Θ. Μαλούτας και Δ. Οικονόμου (edit.), *Προβλήματα ανάπτυξης του κράτους πρόνοιας στην Ελλάδα*, (Αθήνα 1988).

Map 1. Infrastructure condition of 1928 Patras by districts.



1. Marked areas are approximately set, they do not cover the extent of every quarter but an estimated central point.
2. The area surrounded by districts 15,17,19,22 constitutes the original new part of the city (mid. 19th cent.) and would be marked as good.
3. The area surrounded by districts 17,19,13,1,2 is the traditional old part of the city and would be marked as moderate.
4. Areas 1,2,3,4,5,6,7,9,10,11,12,14,14a,22,23 were de facto engulfed in the city plan between 1890–1920.

Sources: (1) Districts' hygiene and infrastructure levels *Νεολόγος*, 14–19 Sept. 1928.

(2) City plan expansions map used here is taken from N. Μιτζάλης, *Η Μεσοπολεμική Βιομηχανική Ανάπτυξη της Πάτρας και οι Μεταλλαγές στον Αστικό Ιστό της Πόλης* [The Interwar Industrial Growth of Patras and the Transmutations in the Civic Web of the City], (Πάτρα 2007), Map 3, p. 140.

grate the working classes and to bind them to State paternalism, functioning as a safety valve against social conflict pressures¹⁰.

Ten years later (1938), the same gazette will publish a follow-up regarding the sanitary conditions found in the working class quarters, focusing on infrastructure (roadwork, water supply, school buildings etc.) and housing quality in which it becomes evident that public and sanitary works start from the city centre and slowly expand to the periphery. Essential problems of the workers quarters in 1938 include water supply, still insufficient according to needs, pollution produced from various nearby industries and narrow unpaved neglected streets. Housing is poor nearly for every lower class quarter and although some new and bigger houses exist, most are small in terms of size and in relation to the number of occupants, with many of them described as shanties. In refugee settlements infrastructure does not vary from lower classes' quarters, but housing is in many cases better due to the active state involvement.

On the poor conditions at those peripheral lower classes quarters, fingers were pointed to their residents by local journals and authorities alike. Their “liability” lies in their very choice of building houses at those remote areas (North South and East), attracted at first by the abundance of cheap land, but then demanding from Civil authorities to fulfill their needs. If living conditions at the slumps were disappointing this was not the case for the city centre, where the main concerns are now limited to secondary issues (boulevards, aesthetic of light poles, band exhibitions at plazas¹¹).

According to the descriptions given for every district, I ranked them both in terms of infrastructure and housing to good, moderate, bad and the results are shown on the following map.

The poor dwellers of those distant quarters will not have a representation in published sources. Information about their numbers and their survival techniques are drawn indirectly from articles concerning philanthropy and city life. During the 1917 blockade, the destitute attending soup kitchens were estimated to be 21.000 (39% of 1920 city's population), while in 1928 over 4.100 (6% of populations) were attending philanthropic soup kitchen on a daily basis.

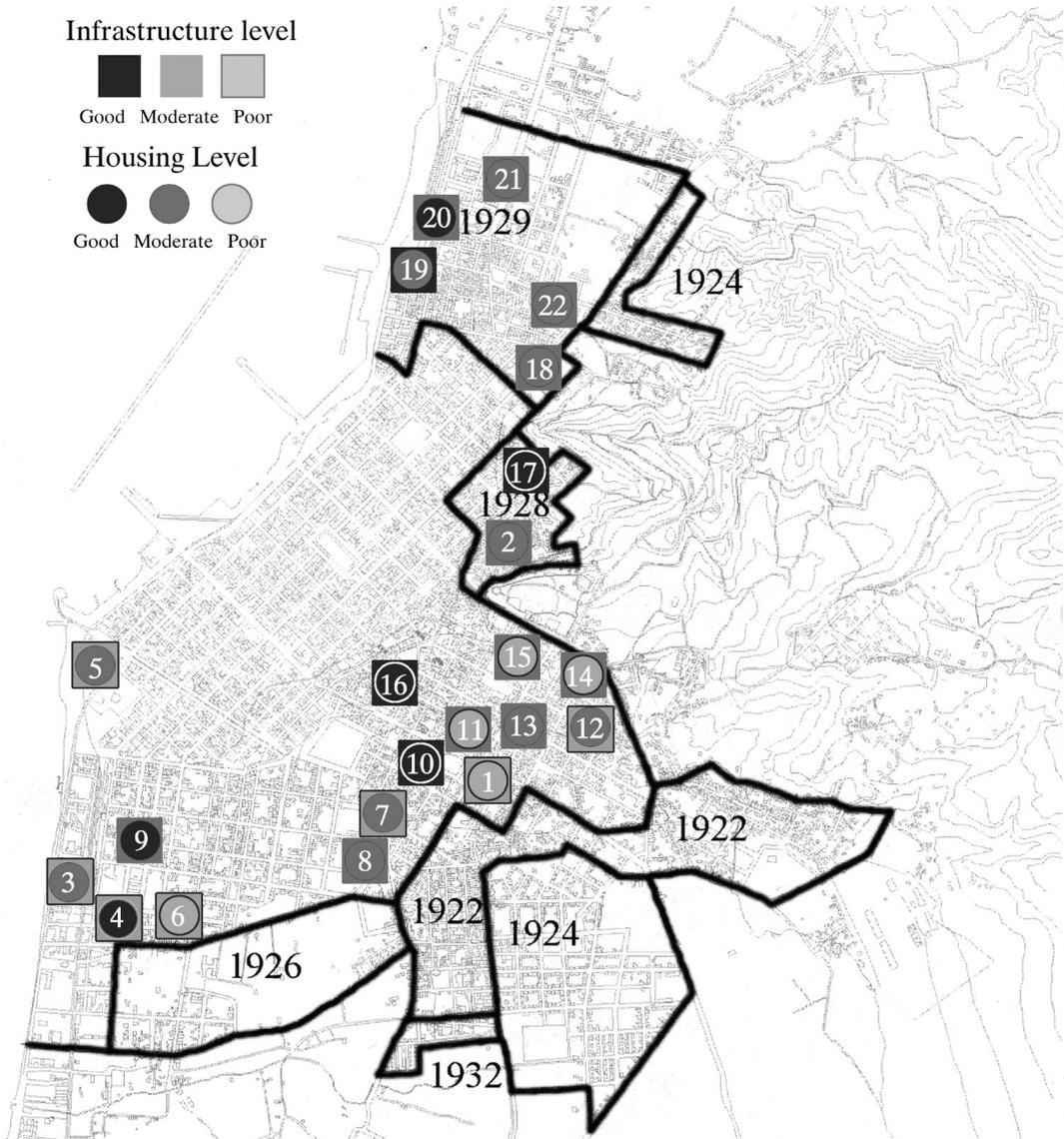
In 1938 4 different daily soup kitchens are still organised at working class quarters with an unknown number of beneficiaries, poor students are given free milk¹² and attend school soup kitchens. The need to support the poor and to expand free school meals is highlighted, especially because of the poor health of the young, caused by malnutrition and showing signs of physical weakness, inability of

10 Λίλα Λεοντίδου, *Πόλεις της Σιωπής, Εργατικός Εποικισμός της Αθήνας και του Πειραιά, 1909–1940*, 2nd ed. (Αθήνα 2001), p. 238.

11 *Νεολόγος*, Tue. 17 May 1938. Also Jun. 2, Jul. 29 and 31, Aug. 2, Nov. 29.

12 *Νεολόγος*, Sun. 16 Jan. 1938. Also found in Fr. 1 Apr. 1938 issue.

Map 2. Infrastructure and Housing levels by quarters, Patras 1938.



The area inside the 5,16,19 triangle is considered good both in terms of infrastructure and housing.

Sources: (1) Information on housing and infrastructure *Νεολόγος* 11 Dec. 1938- 10 Jan. 1939.
 (2) City plan expansions map N. Μιτζάλης, *Η Μεσοπολεμική...*, p. 140.

attendance in class, fainting etc¹³. These provisions are intended only for the city's poor with outlander mendicants or even temporarily unemployed immigrants facing forced transportation¹⁴, to ensure social order within the city¹⁵.

13 *Νεολόγος*, Fr. 1 Apr. 1938.

14 Athens police arrests idle people, perhaps seeking and not finding work, declares them as a public enemy and banishes him! Where? To Patras (215 Km)! And the poor soul comes here on foot from Athens with military escort! He is then confined in the Police or Divisional hovel! Then another trek, another fast,.. to Pirgos(100 Km)! He was banished there for Patras police and so on... Αλέκος Μαρασλής, *Ιστορία της Πάτρας. Η Εξέλιξη μιας Πρωτοποριακής Πόλης. Εικόνες και Γεγονότα από τη νεώτερη πολιτική, κοινωνική και πνευματική ανάπτυξή της* [Evolution of an Avant Garde

...and death

By the end of the 1920's, mortality in Europe and its urban centres is not solely connected with the size of the cities. In most cases public works regarding hygiene are directed to bigger cities, making their population more resistant to certain types of disease. There also seems to be a geographic mortality pattern running from North to South of Europe with three distinct mortality zones and cities found in each sharing common characteristics. A low mortality zone (less than 12‰), found in most cities of Germany, Belgium, Switzerland and the Netherlands. An average mortality zone (12–15‰), affecting England, most of France, North Italy, Austria and part of Poland. The third – high mortality zone (>15‰) – surrounds the cities of Spain and Portugal, Mediterranean France, Italy (except Rome) and Greece (Athens, Sallonica and Piraeus)¹⁶.

Mortality of Patras, estimated by Vital Statistics, for the period 1921–1937, fluctuates between 14,71‰ (1937) and 22,27‰ (1928), while mortality calculated upon Registry's archives on census years, is shown in the following table:

Table 1. Mortality of Patras (‰), 1907–1940.

| Year | Patras Population | Death Records | Mortality ‰ |
|------|-------------------|---------------|-------------|
| 1907 | 51,932 | 1036 | 19.95 |
| 1920 | 53,255 | 1049 | 19.70 |
| 1928 | 66,809 | 1450 | 21.70 |
| 1940 | 79,570 | 1028 | 12.92 |

Sources: (1) Statistical Service of Greece, Census Results 1907, 1920, 1928, 1940.

(2) Mortality estimated using Civil Registry Archives, Death records for respecting years.

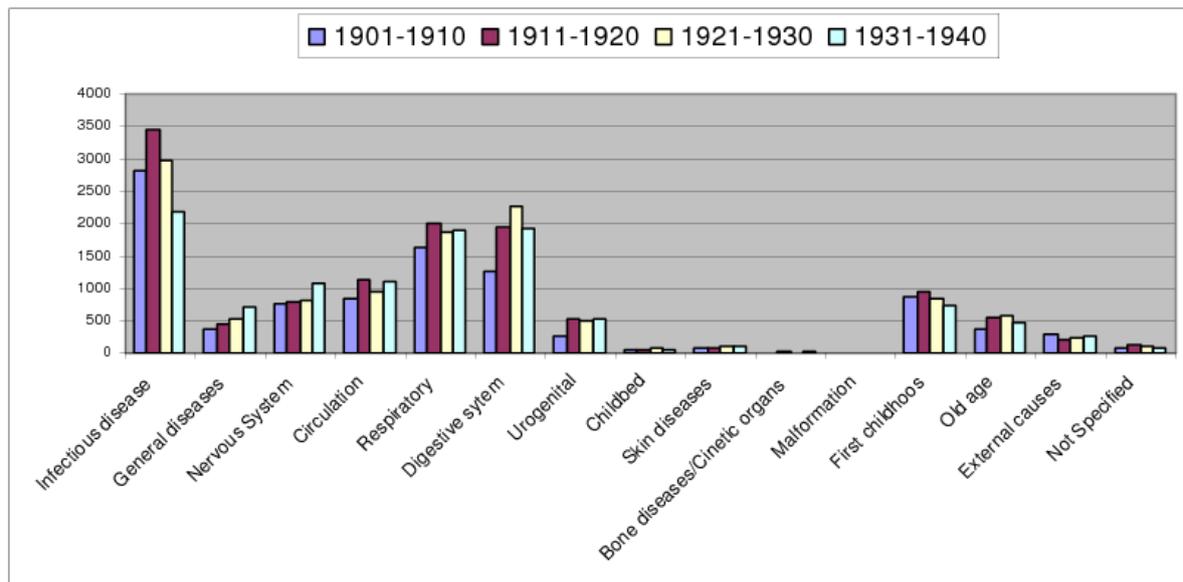
Either from the Vital Statistics data or from calculations on mortality on census years from the Death Records we may conclude that Patras follows the high mortality Mediterranean pattern, with mortality declining only well in the 1930's. To the contributing factors of this drop we should include the existence of an improving water supply and sanitation system, school education on personal hygiene, a rise in living standards for a large portion of the population in Greece and a newly organised pharmaceutical and medical system. If one would argue that this decline might have appeared earlier in the 1920's if the refugee repatriation had not slowed down the process, we should bear in mind that these same major improvements funded by the State, had only been made possible because of its efforts to succeed in the refugee restoration issue (as mentioned earlier).

City. Pictures and Facts from her Modern Molitical, Social and Intellectual Development], (Πάτρα 1983), p. 300.

15 *Νεολόγος*, Fr. 18 Feb., Wed. 9 Mar. 1938.

16 Jean-Luc Pinol, Francois Walter, *Η Σύγχρονη Ευρωπαϊκή Πόλη έως τον Β' Παγκόσμιο Πόλεμο*, (Αθήνα 2007), pp. 112–114.

Figure 1. Causes of Death by Broad Categories, Patras 1901–1940.



Source: Civil Registry Archives, Death Records, 1901–1940.

Infectious diseases hold the first place among causes of death throughout the 1901–1940 period¹⁷. Some as tuberculosis are permanent threats to public health until 1940 while others only occasionally will they strike upon the city. Until 1930, every preceding decade is marked by at least one epidemic, of a greater or lesser scale. Only after 1930 is the city, able to fight off infections on the instance of their appearance, since after that year I could not trace an able number of deaths from infectious disease that could constitute an epidemic.

One of the main reasons of the development of single cases to full scale epidemics, was the refusal of the patients to come forward, afraid of the isolation the medical authorities would enforce. Instead, they would prefer treatment in friendly grounds, even if this meant treatment away from medical supervision, if the latter would entail the quarantine of the patient. During spot tests for carriers of infectious disease, it was not uncommon for patients' families to make a stand against authorities. This refusal was related with the quality of medical services administered during therapy period. Quarantine would often be provided in hospital barracks-outbuildings, sometimes lacking window and door frames, maybe even a roof, heating or medical care.

Smallpox which often visited the city in the 19th century will continue to trouble health authorities up to 1923, when the last epidemic was reported. According to

¹⁷ The categorization followed is the one also used by Death Statistics including: typhoid, Malta (and other) fevers, malaria, smallpox, measles, Scarlet fever, whooping cough, diphtheria, influenza, cholera, dysenterial catarrh, plague, leprosy, erysipelas, encephalitis, cerebro-spinal, malign fevers, anthrax, rabies, tetanus, all tubercular infections, syphilis, all cocciases, septicemia, scrofula, Leishmaniasis.

death records, smallpox will claim 169 lives in 1905 (32 per 10.000), 27 in 1906, 47 in 1913, 50 in 1914 and 78 in 1923 (13 per 10.000 population). For several other years, occasional smallpox deaths are witnessed, but will not, in any case, constitute an epidemic. Remarkably not only have I not encountered an instance of vaccine shortage in the local newspaper *Νεολόγος* (Neologos), but instead there were many a time where large vaccine commissions were published or advertised by civil, prefecture authorities and pharmacies alike. Vaccination to smallpox was compulsory, but unfortunately sources, do not give out any information regarding the way they were organized, the massiveness of which we can only suspect given the volume of vaccine orders, sometimes surpassing 10.000. Therefore, the continued smallpox epidemics in the first quarter of the 20th century must be related to the relative effectiveness of vaccination against the disease, as well as to vaccination system deficiencies, as it had been pointed out for Piraeus at the beginning of the century¹⁸.

Typhoid deaths are also not uncommon until WWII. In the death records of 1913, and only after careful indexing, would a terrible epidemic of typhoid be revealed. With an impressive total of 432 victims, this epidemic remarkably never really affected the city's population and in fact remained invisible to official statistics, since 419 of the victims were prisoners of the Balkan wars. Generally not much care was taken in the registration of prisoners' deaths and more than 30 deaths could be registered on a single record, not giving out any data except names and age of the deceased.

Table 2. Decennial average of typhoid deaths, Patras 1901–1940.

| Decade | Annual deaths average | Per 10.000 deaths |
|-----------|-----------------------|-------------------|
| 1901–1910 | 19.8 | 204 |
| 1911–1920 | 18.2 | 145.6 |
| 1921–1930 | 14 | 117.9 |
| 1931–1940 | 5 | 44.7 |

Note: The 419 prisoners of war deaths are not included.

Source: Civil Registry Archives, Death Records, 1901–1940.

Much progress has been made in the fight against typhoid in the 1920's and in fact this reduction is even more impressive than numbers suggest, since 1922–1923 were years marked by the arrival of thousands of refugees, a population more prone to infection because of their settlement conditions. In Belfast, typhoid seems to have

18 Γιάννης Γιαννιτσιώτης, *Η Κοινωνική Ιστορία του Πειραιά, Η συγκρότηση της αστικής τάξης 1860–1910* [Social History of Piraeus, The Composition of the Middle Class 1860–1910], (Αθήνα 2006) p. 269.

been dealt with since the turn of the century and by 1911 typhoid cases had been “quite rare”¹⁹.

Having been spread throughout Europe, probably by American soldiers, Spanish influenza will concern local journals on a daily basis, with commentaries on the course of the disease, warnings to the townsmen and advices on the protection from the disease. Death Records show 233 influenza deaths for 1918 (44 per 10.000 population), while other sources calculate deaths to 496 (95 per 10.000 population)²⁰. The absence of conformity between the numbers of sources derives from the fact that medical authorities would also count deaths due to other influenza complications, while my figures are extracted from the number of the death records that explicitly state influenza as the cause of death.

Mayor and Prefect put some effort in prolepsis and fighting of the epidemic ordering the disinfection of centers of pollution, repairing of streets where water stagnated, hiring 4 additional doctors to undertake the free examination for the poor and offering medicine and milk to the needy. The Ministry also decreed the assignment of 4 civilian and 10 military doctors to cover needs, but against the Prefect’s decree only 10 out of 45 doctors recorded new cases, to aid statistics regarding the course of the epidemic. Civilians were charged with the cleansing of streets and houses where hygiene conditions were thought not to be proper. At a Mayor’s inspection tourney in the parish of St. Dionysius, the most heavily struck by influenza (58 dead in 2.500 parishioners or 2,32%), things seemed to get out of control:

...they were filled with horror from the shabbiness and foulness of most ground and basement residences. In some of these houses they witnessed the gloom scene of dead alongside dying patients. Eleven cleaning carts were assigned exclusively for the refuse collection of house impurities at St. Dionysius parish.²¹

City Councilor (and M.D.) Topalis published his Influenza Death Statistics, calculating the number and age of victims and distributing them by parish.

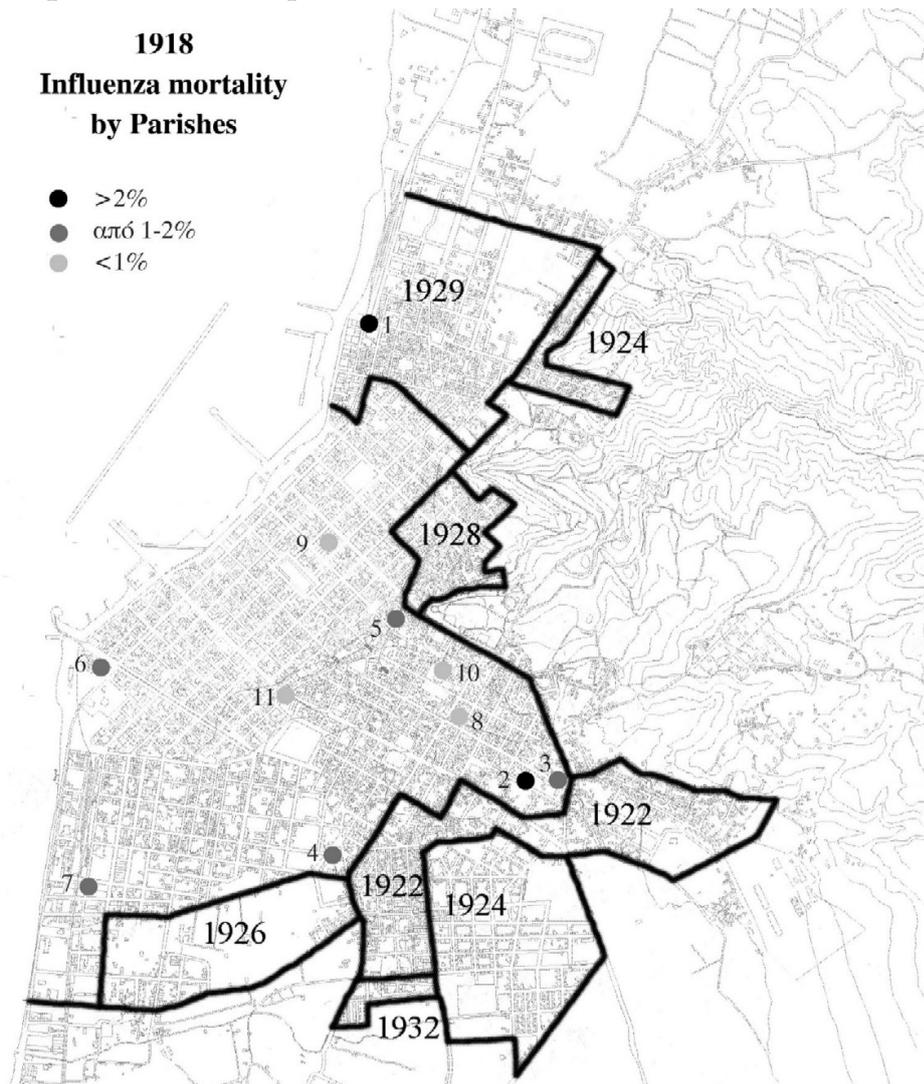
Comparing this map with Map 1 and 2 from 1928 and 1938, it may be argued that the areas with the highest influenza mortality rates in the 1918 epidemic are also the worst in terms of infrastructure and housing even up to the late 30’s. This converse relation between quality housing, infrastructure and mortality, during the Influenza epidemic, is in reality a relation between income and achieved health level, for the various economic strata of the city’s population.

19 Blaney R., “Belfast: 100 years of public health” p. 127 in Frederick Boal and Stephen Royle (ed.), *Enduring City, Belfast in the Twentieth Century*, (Belfast 2006).

20 *Νεολόγος* 4 Nov. 1918.

21 *Νεολόγος* 21 Oct. 1918.

Map 3. Per Parish Spanish Influenza mortality in Patras, 1918.



Sources: (1) Νεολόγος Thu. 25 Oct. 1918.

(2) City plan expansions map N. Μιτζάλης, *Η Μεσοπολεμική...*, p. 140.

The poor, not having the ability to meet high rent prices in the developed city centre, choose to build shanties at the city's outskirts that cannot provide even a minimum of living conditions in terms of sanitation, especially when those areas have hardly any sewerage or water supply. Their frail economic condition also means their diminished capacity in search for medical assistance in times of illness (besides the municipal hospital), food consumption in terms of both quality and quantity, making them more susceptible to disease.

In Ερμής (Ermis) encyclopedia, plague seems to have made its last appearance in Piraeus, and other port cities, during 1912–1915²². Μεγάλη Ελληνική Εγκυκλοπαιδεια (Great Hellenic Encyclopedia) argues that plague in Piraeus in 1912, was imported from India via contaminated sacks, while cases reported at Siros in 1915, are presumed to be nothing more than heavy cases of influenza. Greater

22 Lemma πανώλη (plague), *Encyclopedia Ερμής* (ΧΘΩΝ 2002).

care was taken in the prevention of plague introduction and precautionary measures against the plague at the time were mainly limited to disinfection from land and sea.

...provisions are taken for the dispatch of all boat rats and obstruction of their exit to the land... The duration of the imposed disinfection is set to 5–7 days, including the time of passage for ships. Passengers coming from plague stricken areas are carefully examined, placed under hygienic supervision and their luggage is decontaminated. The recording of all cases is mandatory for doctors, the medical attendance of the sick is provided by adept personnel in appointed seclusive hospitals, or where these do not exist, in secluded houses...²³

Its appearance in 1922 right after the coming of the Asia Minor refugees, contradicts the holding position that plague was vanished. Although not comparable in volume with past times pandemics, there were indeed a lot cases resulting to death²⁴. During the 1900–1940 period, Death Records register 50 plague victims, 46 of which pertain to the 1922–1929 period. Out of 36 cases where place of birth is known 11 concern refugees. These 50 deaths by far exceed the number suggested by Maraslis²⁵, whose sources rely on Medical Association statements and journals mentioning 73 cases of plague (1922–1928) with a total of 19 deaths.

Plague is mainly transmitted to man from rat parasites (less common is transmission from human parasites) and more vulnerable are populations without access to clean water or protection against verminous raids. For Patras, such populations exist among the poor and the Asia Minor/Pontus refugees, dwelling in shanties beyond city limits. Upon their arrival, refugees will stay in groups of tens and hundreds, in overcrowded and inhospitable places (26 refugee camps in 1922²⁶ found in warehouses, schools, churches, or the countryside), helping diseases to spread faster among their ranks. Refugee camps, where thought to be permanent plague centers, when the outbreak of 1924 started out from one of these temporary settlements²⁷. Plague patients' quarantine, will initially take place at the Hospital for

23 Lemma πανώλη (plague), *Μεγάλη Ελληνική Εγκυκλοπαίδεια* [Great Hellenic Encyclopedia], Τόμος ΙΘ' (Αθήνα 1932).

24 Enlightening on the course of plague in Greece, but also for the diachronic medical, social and religious discourse that the disease triggered, is the work of Kostas Kostis Κώστα Π. Κωστή, *Στον Καιρό της Πανώλης, Εικόνες από τις Κοινωνίες της Ελληνικής Χερσονήσου 14ος-19ος Αιώνας* [In the Time of Plague. Visions from the Greek Peninsula Societies 14th-19th Centuries], (Ηράκλειο 1995).

25 Αλέκος Μαρασλής, *Ιατρική και Γιατροί στην Πάτρα* [Medicine and Doctors on Patras], (Αθήνα 1978), pp. 362–364.

26 *Νεολόγος*, 30 Oct. 1922.

27 *Νεολόγος*, 28–29 Jun. 1924.

Infectious disease which for this period will be turned to a Plague hospital; two country mansions will be ordained for the same purpose soon after.

The plague alarm will cease in August 1924²⁸, two weeks after the last report of a transmitted case in the city. One could assume that infected vermin in foreign ships are responsible for the spread of plague, although it is odd that between the 26 victims for which profession is known (1922–1929), no mariner or port related professional (transportations, dockers etc) is mentioned. The first victim for whom profession is known (4th in time line) is a traveling petty merchant. His contribution to the spread of the disease could have been great, if in the meantime he had handled personal items of plague victims²⁹. Moreover the few blocks targeted focus of the disease, hints that plague may not be the result of a pest epizooty, but a case of a man to man transmission. The greater spread among refugees, in respect to the total population could also lead to a similar conclusion. According to sources, plague as well as lot other infectious disease are an inherent feature of every major population movement, may it be of economic, military or forced nature, with the translocation of refugee populations being the most distinctive type of the last category³⁰.

There is, on the other hand, hard evidence to suggest epizooty as the cause of the outbreak. Among the first victims was a young builder, having ailed after working in sewage repair works at the Paragka (Παράγκια) refugee settlement for 5 days (where plague started out in 1924), pointing to a verminous spread if not contracted by refugees. Piraeus will be stricken by plague in 1923, a year after its first appearance in Patras, counting 118 deaths until 1926. Other cities visited by plague include Thebes (1926), Chalcis (1926) Kalamata (1926,1929), Messini (1929) and Pyrgos (1929)³¹ (most of them being port cities).

The reason why local press did not pay much attention to plague at its early first outbreaks, must be associated with the presence of several other infectious diseases throughout 1922–1924 considered to be more threatening to the health of the citizens. Besides several cases of smallpox, the city was under siege from lethargic encephalitis as well as a typhus epidemic (1922–1923), for which refugees were again blamed for by parts of society and press³².

The last great epidemic to strike upon the city will be in August 1928 when the first of many cases of Dengue³³ was identified. The epidemic was carried from

28 *Νεολόγος*, 4 Aug. 1924.

29 Journals had repeatedly criticized TB victims' families for immediately using or selling a deceased's personal items without first caring for their disinfection.

30 Κώστας Π. Κωστής, *Στον Καιρό της Πανώλης...* p. 164.

31 *Τα Νέα* [Ta Nea journal] 29/01/2000.

32 At that same time typhus was also found in Corfu and many other Greek cities receiving refugees

33 Comparing the number of deaths registered in Patras to the number published in Vital Statistics, we can see that only for the year 1937 do the numbers of these sources agree. For the

Athens by travelers; by Sept. 20 there were 20 thousand cases leading to 7 deaths³⁴ and by Oct. 3 Patras counted 50 dead from the Dengue, with a lot more out of complications to vital organs, mainly the kidneys³⁵. Deaths caused by the continuous attenuation of the body, on account of the disease, being registered to other causes, were impossible to detect in the death records. By calculations more than 30.000 (44% of city's population) had contracted the disease and there are mentions of some ailing two or three times. In Athens and Piraeus 80–90% of the population had been infected³⁶ while a total of 1.419.800 cases resulted in 2065 deaths nationwide³⁷.

Besides the infectious diseases mentioned above that took the city by surprise, there were also others that had become endemic to the city and were constant threats to the health and life of its residents. Syphilis and tuberculosis are among the ones with the greatest effect upon society.

Although venereal diseases are not an uncommon cause of death in early 20th century Patras, because of its nature it seems almost invisible to detect in death records of adults, but it's well present in the death records of foundlings. Society seems to be aware of the situation with local press being filled with daily entries-advertisements for syphilitic treatments, medicines and syphilidologist doctors. This alone lets us assume, that syphilis was more common than the registry's death records let us assume.

Table 3. Decennial deaths from Syphilis, by age groups, 1901–1920.

| Year | <1 | | 1–10 | | 21+ | Total |
|-----------------|--------------------------|------------|--------------------------|------------|------|--------|
| | Foundlings- Illegitimate | Legitimate | Foundlings- Illegitimate | Legitimate | | |
| 1901–1910 | 153 | 9 | 3 | | 10 | 175 |
| 1911–1920 | 225 | 10 | 10 | | 9 | 254 |
| Per cent | | | | | | |
| 1901–1910 | 87.43 | 5.14 | 1.71 | | 5.71 | 100.00 |
| Per cent | | | | | | |
| 1911–1920 | 88.58 | 3.94 | 3.94 | | 3.54 | 100.00 |

Source: Civil Registry Archives, Death Records, 1901–1920.

rest of the years they show an average divergence of 0,67%. So it seems that mortality in Patras taken from the Civil Registry does not seem to greatly vary from published statistics, although both census results as well as the correctness of number of deaths registered have been opposed by recent research and contemporary sources as well. Siampos G., *Δημογραφική εξέλιξις της νεωτέρας Ελλάδος, 1821–1985*, Αθήνα 1973. Valaoras V., “A reconstruction of the demographic history of modern Greece”, in *Milbank Memorial Fund Quarterly*, April 1960, Vol. XXXVIII, No. 2.

³⁴ *Νεολόγος*, 20 Sep. 1928.

³⁵ *Νεολόγος* 3 Oct. 1928.

³⁶ *Τα Νέα* 29 Jan. 2000 <http://www.in.gr/Reviews/placeholder.asp?IngReviewID-22767&IngChapterID=228388&IngItemID=22841>

³⁷ Φωκίωνας Καπανάκης, *Η Δημόσια Υγιεινή εν Ελλάδι* [Public Hygiene in Greece], (Αθήνα 1933), p. 12.

Syphilis is responsible for at least 429 deaths in the first 20 year period, 92% of which are infants with congenital syphilis (on average 20 deaths annually).³⁸ Some hypotheses can be made here regarding the increased number of foundlings dying from syphilis.

Undeniably a number of the infected infants are illegitimate children of prostitutes transmitting them with the disease and then abandoning them at the Nursery right after birth. A second is that legitimate children of infected parents – afraid of the social stigma – choose to abandon the infant so as to secure their social status and existence since the infant would be recorded of “unknown identity” and the disease could not be traced back to them.

Consequently, there is an undeterminable greater number of infected women (as carriers would be a lot more than infected women giving birth every year) and a number of infected men. An adults’ attempt to conceal this social disease, minimizes rates among them, since syphilis could be a triple stigma. Besides the social stigmatization of a person, syphilis constituted a stigma for a nation since it was thought that it could be responsible for giving birth to generations of degenerate murderers. It was also seen as a stigma for the city not knowing how and where to “hide” its patients or to deal with the prostitutes transmitting the disease³⁹. This last issue had often troubled authorities of numerous cities⁴⁰ by mid and late 19th century, with suggestions made for located prostitution, later giving way to the idea of expulsion of prostitution from areas of family presence⁴¹.

Although by 1900 prostitutes were obliged to be inspected twice a week (and if one was found to be carrying a VD she was to be sent to the Syphilitic Hospital for treatment) Syphilis was still spreading. Efforts to contain syphilis included the founding of a new Women’s Infectious Disease Hospital in 1905 (with 20 beds)

38 Infection of foetus is more common when the mother is at the first stages of infection. Some infants die intrauterine and when born alive they soon show symptoms of congenital syphilis. Αντωνιάδης Αντ.(edit), *Ιατρική Μικροβιολογία [Medical Microbiology]*, (Αθήνα 2005).

39 In France prostitutes were obliged to be tested once a week. Suspicious cases were sent to hospitals, living in miserable conditions and were held captive until they were cured. Calculations suggest that during 1871–1903 725.000 women were arrested in this manner. Syphilis was also seen as an instrument of the working class against the middle class and aristocracy, since it was spread from prostitutes to men and women of the upper classes. Tilles Gerard., *Stigma of Syphillis in the 19th century France*, <http://www.bium.univ-paris5.fr/sfhd/ecrits/stigma.htm>.

40 The Common women’s Establishment. Execution of Scheme. Engineer Mr. Likoudis by order of. D. Sotiriadou, is already processing the design of an Establishment for common women...will be erected at a non-expanding section of the city...will consist from many single and independed pavilions... *Νεολόγος* 26 Oct. 1899.

41 In the 1894 “Of common women and disorderly houses” police ordinance a proven prostitute was forbidden to walk to public promenades, public squares and to enter theatres. Γιάννης Γιαννιτσιώτης, *Η Κοινωνική Ιστορία του Πειραιά...* pp. 245–255.

“..so far confined in a shanty – a real hog pen...”⁴², the Anti-Aphrodisiac Clinic in 1924, (right after an observed increase of VD, for which refugees were once more held responsible), and the “Syphilitic Infirmary for the Poor” 1936. Just 19 adults, 4 women and 15 men were declared to have died from the disease in the 1900–1920 period. Nonetheless in an advanced stage syphilis is connected with other diseases infecting the nervous system, like the case of a labourer in 1909 dying from “*paralysis (from syphilis)*”. Therefore the actual number of deaths from syphilis – as for other diseases as well – is elusive a fact acknowledged by both Director Ιω. Γ. Μιχαλόπουλος and Inspector Μιχ. Ι. Βαστάγος in the 1921–1922 introduction of the Statistics of Deaths respectively.

During 1921–1940, deaths from syphilis drop to a third mostly due to the decline of foundlings’ deaths from the disease and more information on the victims is available since death records registration is standardized (1919).

Table 4. Decennial deaths from Syphilis by age groups 1921–1940.

| Period | <1 | | 1–10 | | 11–20 | 21+ | Total |
|-----------------------|-----------|------------|-----------|------------|-------|-------|--------|
| | Foundling | Legitimate | Foundling | Legitimate | | | |
| 1921–1930 | 74 | 14 | 1 | 4 | 1 | 19 | 113 |
| 1931–1940 | 38 | 6 | 0 | 1 | 0 | 6 | 51 |
| Per cent 1921–1930 | 65.49 | 12.39 | 0.88 | 3.54 | 0.88 | 16.81 | 100.00 |
| Per cent 1931–1940 | 74.51 | 11.76 | 0.00 | 1.96 | 0.00 | 11.76 | 100.00 |

Source: Civil Registry Archives, Death Records, 1921–1940.

Of the 4 women dying from syphilis aged 35–65, only one was born in the city, the others coming from the broad periphery that supplied the migration movement to Patras⁴³. One was married and all were registered as housewives, but considering that V.D. are widely spread in high risk groups, one would expect to find some of them among its victims. Tracing some of the at least 300 prostitutes⁴⁴ (1910) among them however is impossible⁴⁵ as it is almost certain that on the instance of a prostitute’s death, her status is covered behind the – harmless for social mores – term “housewife”.

42 Εφ. Νεολόγος, 16 May. 1905.

43 For the demographic composition of Patras see αναγιώτης Γ. Ηλιόπουλος, “Δημογραφική συγκρότηση και μεταναστευτικά ρεύματα της πόλης-λιμάνι των Πατρών την περίοδο του Μεσοπολέμου”, pp 131–139 in Λυδία Σαπουνάκη Δρακάκη (ed.), *Η Ελληνική πόλη σε ιστορική προοπτική* [The Greek city in historical perspective], (Αθήνα 2005) or Panagiotis G. Eliopoulos, “Demographic composition and immigration movements of the port-city of Patras during the Interwar Period”, 7th International Conference on Urban History, Athens-Piraeus, 27–30 October 2004. <http://library.panteion.gr:8080/dspace/handle/123456789/458>.

44 City Council Meeting Proceedings 11 Oct. 1910.

45 In the death records of 1901–1940 period, there are just two records mentioning prostitutes. A “common” dying from nephritis (uraemia) in the Municipal Hospital (1911) and a disorderly house mistress aged 55 dying from pneumonia in 1926.

More dangerous to public health was thought to be the unregistered non-professional prostitution that could not be checked (numerically or medically) as the main cause of VD transmission. By calculations this unregistered prostitution was estimated to be 100 times greater than the official for Athens and Piraeus, comprising of teenagers and young women complementing their income, or trying to amass their dowry while ostensibly preserving their social status, being responsible for 75% of the total venereal cases⁴⁶. If what holds for Athens and Piraeus regarding the number of prostitutes checks for Patras, it may explain the lack of information on prostitution in the death records.

Despite its preference to lower strata, the disease concerns everyone and among the 14 male victims (7 having been born in Patras.) we find a chemist, a retired higher ranking military officer and two private employees, with just two out of the 14 passing in the Municipal Hospital.

Research on the nature of tuberculosis has much to tell of a society's structure and has been used by historic demographers as a rate for the socioeconomic state of a society. It concerns all social strata but it is particularly disastrous to the poor where it decimates the young. Until the first quarter of the 20th century, commendable cures will include aerotherapy, rest, overfeeding and heliotherapy while cough medicines, antipyretics, haemostatics for hemoptysis will be administered to relieve the symptoms. Such a treatment was inexpedient to the poor especially when hospitalization in Greek Sanatoria was a time-consuming effort⁴⁷. Tuberculosis had shown downward tendencies across Europe by the second half of the 19th century and although other respiratory disease had many more victims, authorities were more concerned with tuberculosis. This is because respiratory disease was affecting infants and the elderly while tuberculosis hit the economically active young adults that constituted the capital of a society⁴⁸.

Early 20th century Greek doctors found the causes of the infectious transmission of the disease in unhealthy and poor ventilated environment (schools, public offices, tobacco cutting factories, printeries, industries, prisons, houses), recruitments, returning emigrants from overseas⁴⁹ and the absence of precautionary measures and decontamination. Other factors thought to be predispositions to tuberculosis were the spread of syphilis, alcoholism, measles, smallpox, whooping

46 Lemma πορνεία (prostitution), *Μεγάλη Ελληνική Εγκυκλοπαίδεια Δρανδάκη* [Great Hellenic Encyclopedia], Β' έκδοσις, (Αθήνα 1932), Τόμος Κ'.

47 Γεράσιμος Ρηγάτος, *Ιστορία της Νοσηλευτικής, από τη Φιλάνθρωπη Τέχνη στη Σύγχρονη Επιστήμη* [History of Nursing, from Philanthropic Art to Modern Science], (Αθήνα 2006) p. 132.

48 Anne Hardy, "Reframing disease: changing perceptions of tuberculosis in England and Wales, 1938–1970", *Historical Research* 76 (194), 2003, 535–556.

49 When the disease progresses and they can no longer work, they return to Greece with the hope of attention and medical treatment from their families. Such a theory is confirmed for 17 dying on steamboats coming to Patras from the U.S.A. and three more where we read "arriving from America".

cough, all of which weaken the immune system making it more susceptible to infection. They considered that lack of hygiene in public and private places, but also unhealthy habits, dropped the system's defense mechanisms and led to tuberculosis, relying on the fact that just a small percentage of those exposed to the disease ailed.

For England, Sweden, France, Germany and Greece, institutionalization in hospitals and sanatoria, was the most popular practice to abolish the infectious spread⁵⁰. Once hospitalised, patients not only pose no threat, but could also find better treatment. Success of institutionalization was measured by the number of patients that could be accommodated. In 1914 Gothenburg, had 106 beds for every 100 deaths from the disease. Birmingham provided 57 beds for every 100 deaths. In the early 1930s, Gothenburg had 175 sanatorium and hospital beds per 100 deaths, while in Birmingham there were only about 60 beds per 100 deaths⁵¹. In Patras the available number of beds for pulmonary tuberculosis, did not change in the course of more than 25 years. The 18 hospital beds provided meant that there were 14 beds per 100 deaths. In 1930 the number of beds had not changed and the beds per 100 deaths ratio had decreased to 12.

The fight against tuberculosis abroad was deemed to be fought, not only in the field of curing the infected, but also in the areas of health education and the social and environmental factors that led to TB like poverty and housing⁵². For Patras however poverty and poor housing went hand by hand, especially when the idea of workers' housing schemes would have to wait since accommodation for the refugees was more pressing and health education would not bear fruits until the 1930's. The 1901–1904 tuberculosis mortality had been calculated for 12 major Greek cities (Athens, Piraeus, Patras, Corfu, Syros, Trikkala, Volos, Kalamata, Larissa, Zante, Pyrgos and Tripolis) to 16,02% with 40,2 deaths per 10.000 population and Greece having 34 deaths per 10.000 population. During the same period France and Austria would count 30 deaths according to the Berlin Sanitary Bureau Statistics⁵³ and Sweden 332 per 100.000 during 1875–1879 falling to 145 during 1921–1930⁵⁴.

50 Μαρία Κορασίδου, *Όταν η Αρρώστια Απειλεί, Επιτήρηση και Έλεγχος της Υγείας του Πληθυσμού στην Ελλάδα του 19 Αιώνα* [When disease threatens, Surveillance and Control of the health of the population in 19th century Greece], (Αθήνα 2002), p. 59.

51 Marjaana Niemi, *Public Health and Municipal Policy Making, Britain and Sweden, 1900–1940*, Ashgate, 2007 pp. 134–135.

52 Ibid., p.117.

53 Βασίλειος Πατριώτης, “Η Πορεία της Φθίσεως εν Ελλάδι, από του 1890–1905” [The Course of Pthisis in Greece during 1890–1905], Πρακτικά Ε' Πανελληνίου Ιατρικού Συνεδρίου, (Αθήνα 1906), p. 12.

54 Jan Sundin and Sam Willner, *Social Change and Health in Sweden, 250 of politics and practice*, Swedish National Institute of Public Health, 2007, p. 119.

Many doctors claimed that TB deaths were in fact more than sources recorded, especially for infants⁵⁵ and considered that ¼ of all deaths registered to asthma, emphysema, bronchitis, cerebro-spinal etc., were in reality deaths from TB. This could only be the result of massive misdiagnoses, intentional or unintended. A family losing a member to the disease, would pressure the doctor to alternate the cause of death, so they would not themselves be suspected as carriers of fear for a potential social isolation.

many a time the doctor succumbing in the persistent demand of the deceased family, declares as cause of death not tuberculosis but instead chronic bronchitis, and this for obvious social reasons...⁵⁶

This occurred against the B.Δ.(Royal Decree) 31 Dec. 1836 “Of protection against infectious disease” by which pulmonary tuberculosis was declared an infectious disease, ordering its notification (registration) and precautionary measures to be taken by doctors and relatives on penalty of 20–200dr. fine and 1–6 weeks imprisonment⁵⁷. In Britain compulsory notification of TB cases was introduced in 1913⁵⁸.

Doctors were not always responsible for this “denaturalization”, given that solvency to assure medical treatment should not be taken for granted at the time. Especially for the lower strata, a doctor may be called to issue certificates for people who he never had the opportunity to examine in life. He should then rely on the information given by relatives to understand the nature of the illness of the deceased. On the other hand fear of arrest, must have not acted in a preventive manner as to avoid the covering of causes of death that would otherwise bring unrest to the social sphere.

...The doctor is called only when the end is near, usually too late or even right after to declare the death.: This is a usual case for the elderly for who “old age melancholy” is the most common “cause” of death. Therefore doctors called to issue a death certificate to a person they have not treated, usually accept what the family tells them, without investigating further, unless the death was suspicious: They knew that nothing more was expected from them...⁵⁹

55 Γ.Ν. Μακκιάς, Πρακτικά του Α' Ελληνικού Συνεδρίου κατά της Φυματώσεως (Αθήνα 1909), pp. 137–138.

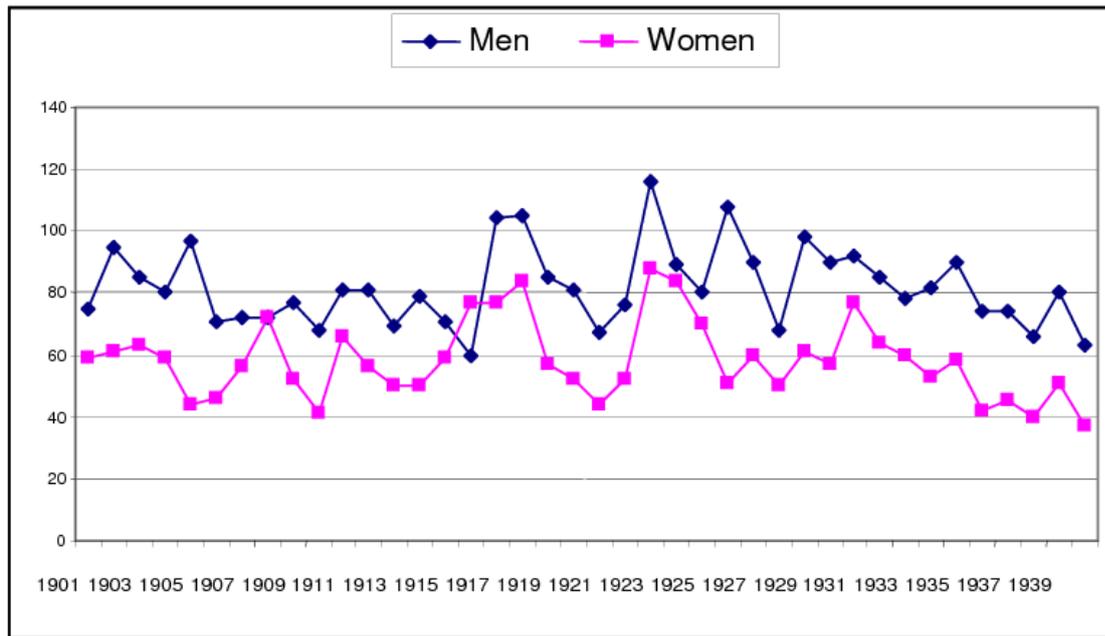
56 Π. Ροντόπουλος, Η εν Ελλάδι εκ Φθίσεως θνητοτης καθ' ηλικίαν, φύλον και επάγγελμα εν 12 πόλεις κατά την τελευταίαν δεκαετίαν 1899–1908 [The Phthisis mortality in Greece, by age, sex and vocation in 12 cities for the last decade 1899–1908], Πρακτικά του Α' Ελληνικού Συνεδρίου κατά της Φυματώσεως 1909, p. 502.

57 Β. Πατρικιός, Β' Έκθεσις περί της εκ φυματώσεως θνησιμότητος εν Ελλάδι [2nd Report on Tuberculosis mortality in Greece], (Αθήνα 1918). p.32.

58 Linda Bryder, *Below the Magic Mountain, A Social History of Tuberculosis in Twentieth-Century Britain*, (Oxford 1988), pp. 41–43.

59 Eugénia Bournova, “La mortalite en transition dans une ville mediteraneenne, Rethymno au debut du xx siecle”, *Histoire Urbaine*, vol 21, Avril 2008.

Figure 2. Number of deaths from Tuberculosis, Patras 1901–1940.



Source: Civil Registry Archives, Death Records, 1921–1940.

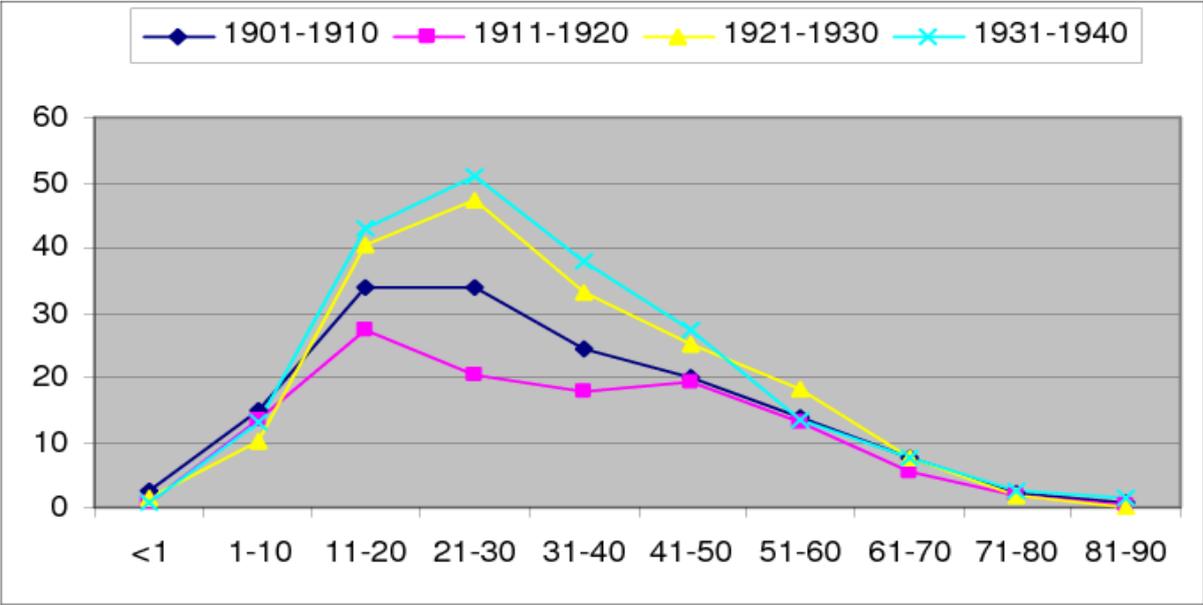
Apart from the years between the Greek involvement in WWI (1917) and the coming of the Asia Minor/Pontus refugees (1922), TB deaths show a relative stability. The increase of deaths from TB during WWI was common for many European countries due to the worsening of food consumption⁶⁰. Tuberculosis mortality slowly decreases in the 1930's although it still remains high when compared to other European cities. For 1907, census year, TB mortality in Patras is calculated to 24,65 per 10.000 population. For Mediterranean Spain in 1912 the rate for Cadiz (population 70.000) is 40,3, for Gerona 40,50, Leon (population. 11.000) 44,70⁶¹. In 1928, TB mortality in Patras is 17,66 per 10.000 population (respective rates for 1927 and 1929 are 20,4 and 23,32). For that same year Cardiff having the highest rate among British cities of the same size, mortality reached 10,1 and Swansea 10,03. By 1940 Patras' rate falls to 12,69 but still high compared to Cardiff 9,00 and Swansea 6,9⁶². Apart from the 1911–1920 period deaths from TB as a percentage to total deaths are increasing for men and women alike. Male deaths

⁶⁰ In Greece food shortages were experience even before its involvement to the war because of the blockade by the Entente Forces, resulting in 30 deaths from starvation in Patras alone according to the Registry's archives.

⁶¹ Espagne. Mortalite generale et mortalite par tuberculose dans les capitales (chefs-lieux) de provinces en 1912 (Etablies d' apres le Boletin mensual de Statistica demografico sanitaria). Office International d' Hygiene puplicue 1915 p 953. in Βασίλειος Πατρικιος, *Έκθεσις περί της εκφυματιώσεως θνησιμότητος εν Ελλάδι* [Report on Tuberculosis mortality in Greece], (Αθήνα 1917) p. 46.

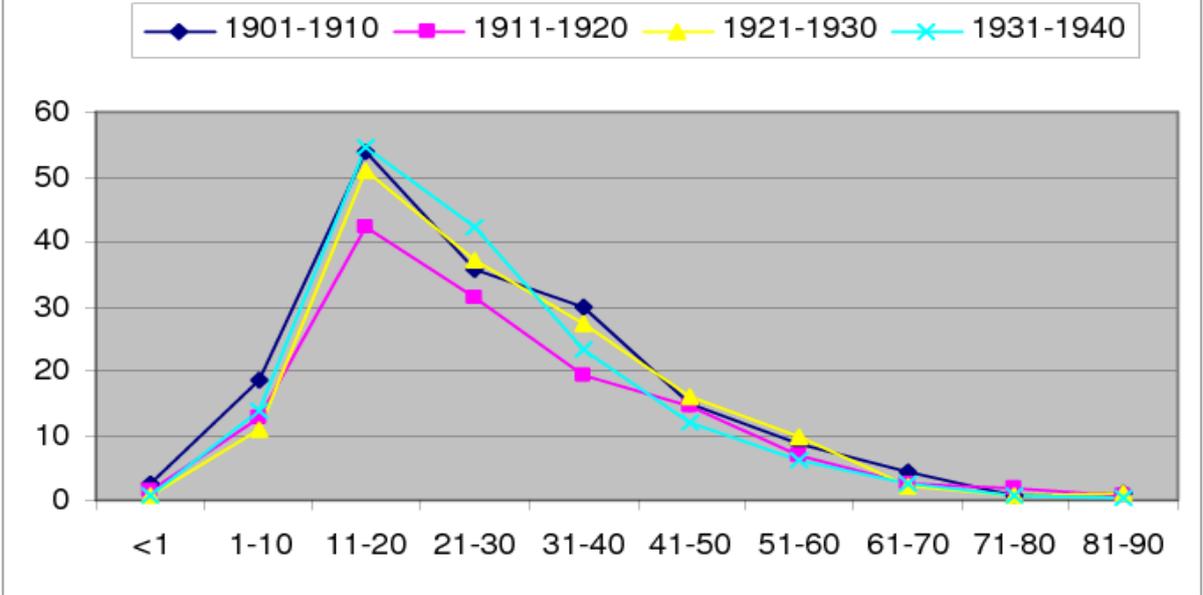
⁶² Steven Thompson, *Unemployment Poverty and Health in Interwar South Wales*, (Cardiff 2006), p. 206.

Figure 3. Decennial Male Distribution of Tuberculosis Deaths to Total Deaths by Age Groups, 1901–1940.



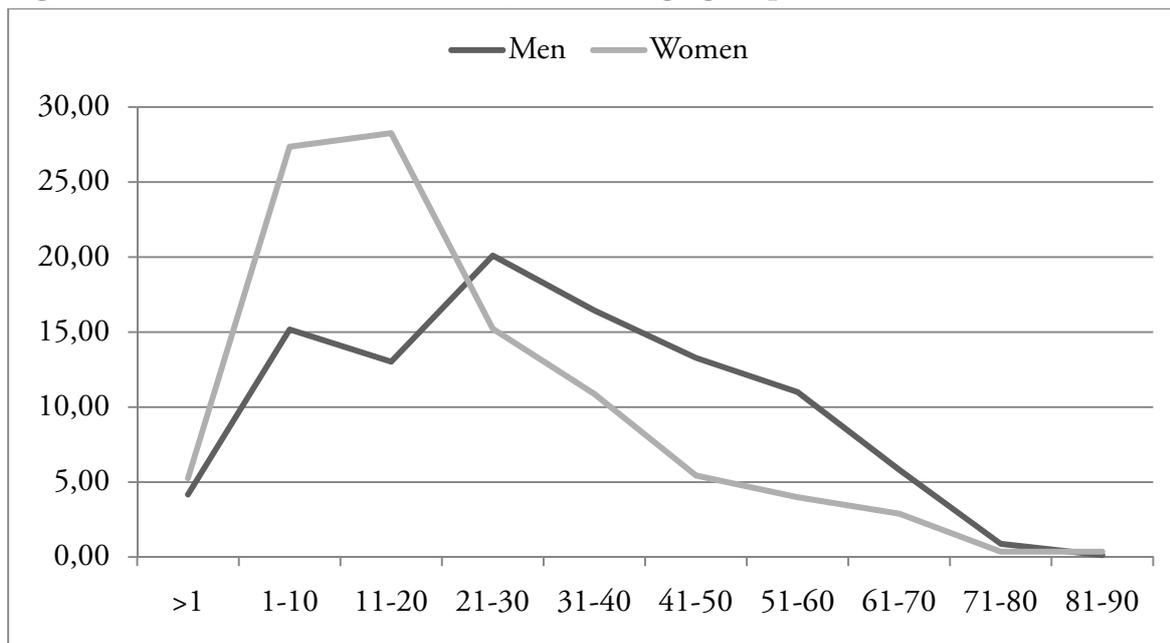
Source: Patras Civil Registry, Death Records Archives, 1901–1940.

Figure 4. Decennial Female Distribution of Tuberculosis Deaths to Total Deaths by Age Groups, 1901–1940.



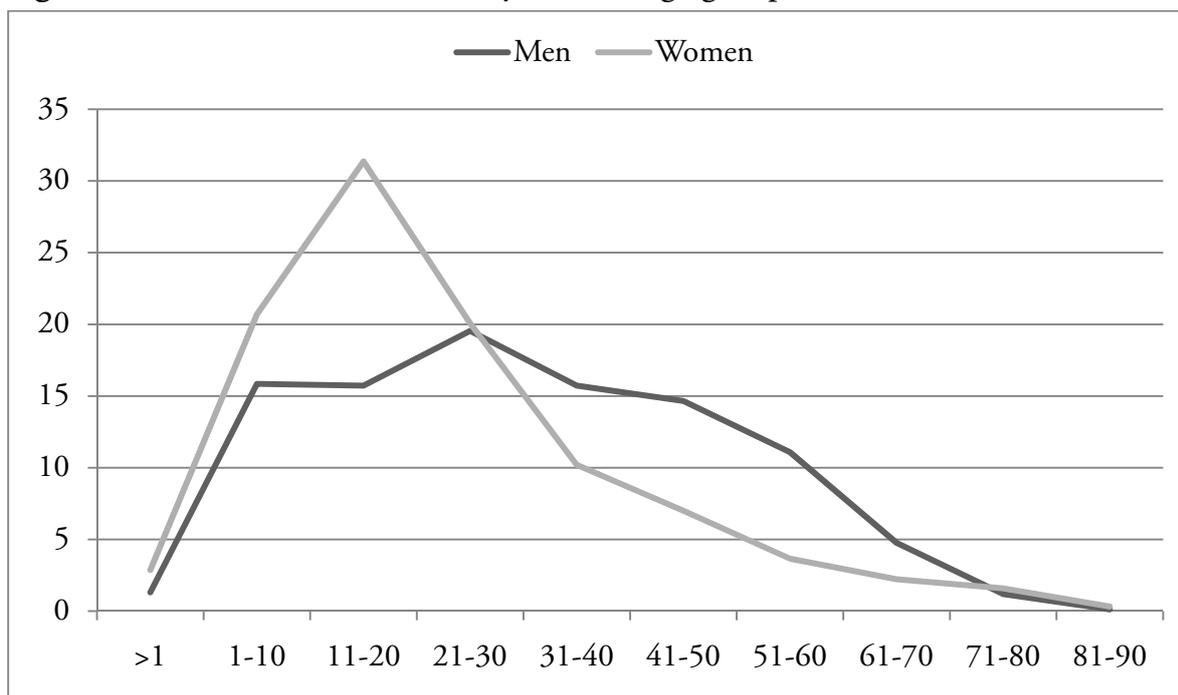
Source: Patras Civil Registry, Death Records Archives, 1901–1940.

Figure 5. TB deaths distribution by sex and age group 1901–1910.



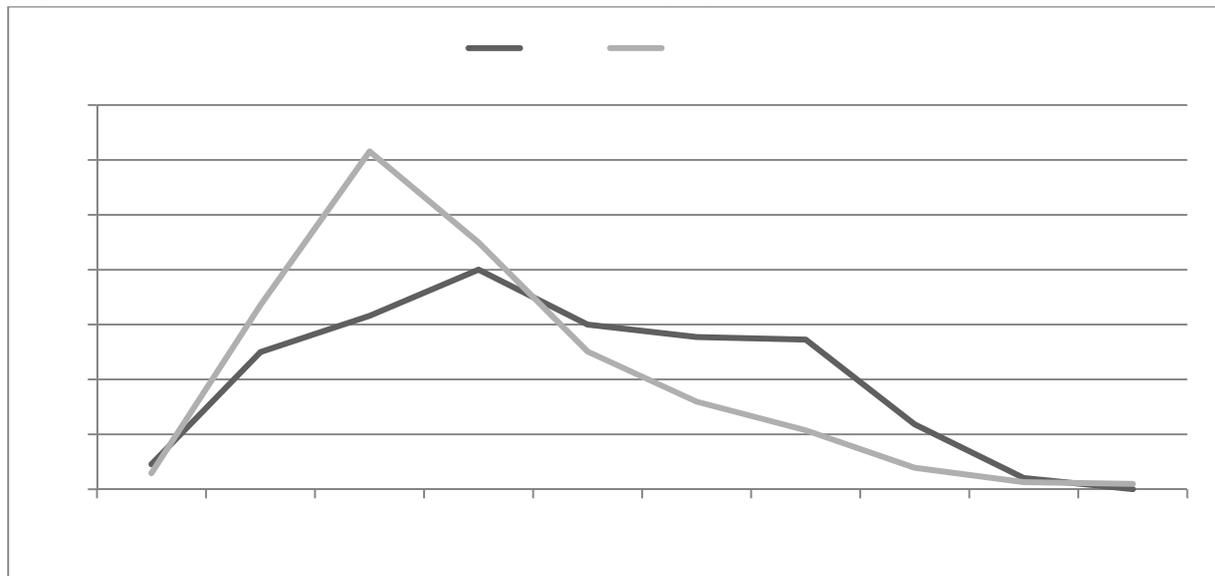
Source: Patras Civil Registry, Death Records Archives, 1901–1910.

Figure 6. TB deaths distribution by sex and age group 1911–1920.



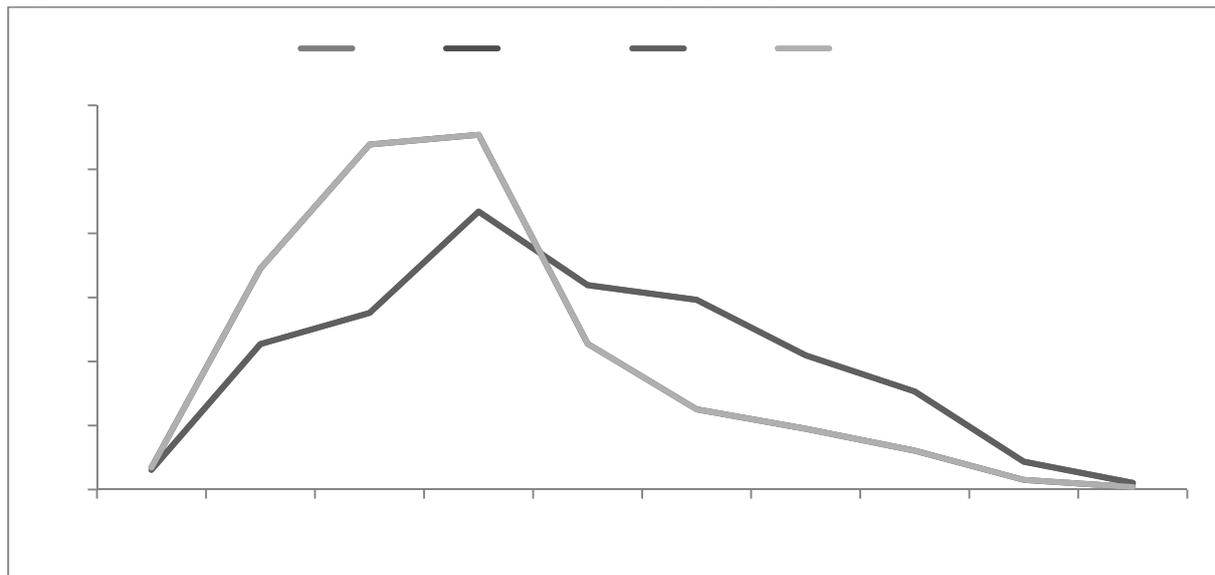
Source: Patras Civil Registry, Death Records Archives, 1911–1920.

Figure 7. TB deaths distribution by sex and age group 1921–1930.



Source: Patras Civil Registry, Death Records Archives, 1921–1930.

Figure 8. TB deaths distribution by sex and age group 1931–1940.



Source: Patras Civil Registry, Death Records Archives, 1931–1940.

from the disease are almost always more the female and it constitutes the greatest cause of death for the young and adults up to 40 of both sexes, common to many other European cities.

“..Tuberculosis constituted the first cause of death – a veritable scourge of society – in young people between 11 and 20, and adults between 21 and 40...”⁶³

63 See Maurice Garden, «La mortalité» in Yves Léquin, *Histoire des Français XIXe – XXe siècles, Un peuple et son pays*, Armand Colin, Paris 1984, pp. 287–366.

Male deaths from TB peak in the 21–30 age group, while for women this occurs earlier between 11–20. At its peak TB was responsible for more than half of deaths of both sexes, just as pre WWII Belfast where TB was responsible for half of deaths for ages 15–24⁶⁴. Worthy to note is the 1911–1920 period's considerable decline of male deaths for the 11–40 age groups and should be attributed to the continuous recruitments of the Balkan and WWI Wars, since female deaths do not show such a great decline. The also small percentage among the economically active males' deaths in the 1901–1910 period should be seen as a byproduct of overseas emigration which Patras accommodated as a major emigration port.

The two sexes were not treated equally in death. Women percentages are more concentrated to younger ages, especially towards the age of 20. For the whole 1901–1940 period, 60,87% (1901–1910) to 45,92% (1931–1940) of the inflicted will have died by the age of 20, while by 30 the respective percentages are between 76,09% (1901–1910) and 71,5% (1921–1930). Big improvement is observed for young girls (aged 0–10) with a drop from 32,61 (1901–1910) to something less than 19% (1931–1940). It follows the usual tendency for female TB mortality to exceed male during childhood and early adulthood, but male surpassing it around the age of 30.

In Merthyr and Rhondda S. Wales, young female TB mortality during 1931–1933 is also higher than male. In the 15–24 age group male mortality is 1,6 in Merthyr and 1,1 for Rhondda, while female is 2,9 and 2,65 per 1000 population respectively. In the 25–44 male mortality is about 1,45 and 1 and female 1,75 and 1,55 respectively. And again for Swansea female TB mortality will exceed male up to the 15–24 age group⁶⁵.

Research in UK, Germany and Sweden suggest that the TB preference towards young women is attributed to the better feeding of men on the expense of women. Hard work at home and constant childbearing took their toll, making them more prone to the disease⁶⁶.

...a certain amount of evidence suggests that house-wives, at their own expense, put the rest of the family first when it came to serving food. This, in combination with hard work and frequent pregnancies, could lead to a low nutritional status and reduced resistance to TB. There is, on the other hand, little evidence that children were also subjected to such gender discrimination at the dinner table, which could have contributed to the higher mortality rate among girls...⁶⁷

64 Frederick Boal Stephen Royle (ed.), *Enduring City, Belfast in the twentieth century*, (Belfast 2006), p. 247.

65 Steven Thompson, *Unemployment...* pp. 208–210.

66 W. D. Johnston, "Tuberculosis", in Kenneth Kiple (ed.), *The Cambridge World History of Human Disease*, (Cambridge 1993), pp. 1059–1068.

67 Jan Sundin and Sam Willner, *Social Change...* p. 123.

An explanation based on the stress caused by childbearing to the immune system, however satisfactory may be for most European cities, fails to do so to the same extent for Patras, since it mostly covers women already married something which before the age of 20 was not very common in Patras since the average age at first marriage (1925–1940⁶⁸) for women is 24,6⁶⁹ – a point strengthened by N. Peloponnese's low illegitimate natality of (0,007). If in fact children, regardless of sex, were not discriminated in terms of food portions, the increased concentration of younger girls' deaths must be indeed connected to other biological and social factors. Puberty and the start of menstruation increases nutritional needs and when these cannot be met, it increases the chances of infection, but to these factors we should add the impact of domestication in over-populated housing which was the case for the majority of the poor, as mentioned earlier, or the worse working conditions the female unskilled workforce faced in industry.

Men's deaths tend to be more dispersed according to age. Half of the ailed victims will have died by the age of 30 with 20% of its victims being from 21 to 30. Young boys' rates (aged 0–10) seem to improve since in 1901–1910 they represent 19,34% of the victims, but by 1940 their percentage drops to 12,9%.

Research on the relation between each occupational group's causes of death, to its representation in the city, is still ongoing and hopefully will shed some more light on the life and death issues of a major port-city in South East Europe.

Summary

Greece experienced its great urbanization period rather late compared to most European countries, for which it proved totally unprepared for. The following urban sprawl witnessed in Patras and several other Greek cities in the first three decades of the 20th century, resulted in a deterioration of living conditions and sanitation for a great part of an expanding city, given the lack of funds or the will of authorities to confront the issue.

Up to 1928 poor hygienic infrastructure had as a result the constant presence of epidemics (smallpox, influenza, typhoid, plague, encephalitis, Dengue etc.), strengthened by the thousands of Asia Minor/Pontus refugees' influx, which eventually compelled the State to intervene by funding large sanitation schemes nationwide, and resulted to an impressive drop in mortality and the eradication of large scale epidemics in the 1930's.

Other infectious diseases however had become endemic to the city, such as venereal disease and TB and would not be dealt with effectively until after WWII. Venereal disease deaths are common among the foundlings in the Municipal

68 Its only from 1925 that the Registry records marriages.

69 Calculations on Marriage Records 1925–1940, Patras Civil Registry, Marriage Records Archives.

Nursery, since most adults' deaths were more likely to be concealed in fear of a social stigmatization. The effect of TB upon mortality is rather difficult to be precisely estimated, given a large number of untreated patients, misdiagnoses and efforts to conceal true cause of death as per Venereal Diseases. TB showed a firm preference to working class young women and men and deaths from TB would start declining only after well in the 1930's.

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Χαστάογλου Βίλμα, *Βόλος, Το Πορτραίτο της Πόλης, από τον 19 Αιώνα έως Σήμερα*, 2nd ed, Βόλος, 2007 [Volos, Portrait of a City from the 19th Century to the Present].

From Warfare to Welfare

Postwar Homelessness, Dislocation, and the Birth of the Welfare State in Europe: The Case of Berlin 1945–1949

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In past years, with state funding for public health and welfare undergoing much scrutiny, historians and public health policy makers alike have proposed to study the origins of what for years could be characterized as a European welfare consensus. Was there indeed any such conversion of approaches? And if so, what caused it? Among others, the Phoenix network, a coalition of scholars studying health care and medical policies over the course of Europe's history and in its present, called for an investigation of moments in European history when thinking on public health and welfare policies converged.¹ This paper proposes that indeed there was a period in European history which generated something of a postwar convergence of approaches. The postwar period witnessed a remarkable consensus about the importance of public planning, spending, and state involvement in the health and welfare sector. By examining the case of Berlin as one immediate postwar city and situating it in the larger European context of the time, one can point to common motivations and actors involved. The root of this consensus was not any optimistic humanitarian ideology, nor even primarily a concern for public health or the spread of epidemics. Rather, it grew out of a shared setting, marked by physical destruction and political instability. As a result, profound concerns about governability and the legitimacy of any state came to the forefront. In the case of Berlin, this was aggravated furthermore by a fear of the return of National Socialism.

Following an introduction to the significance of the Berlin setting, the city's health and housing challenges will be situated in the postwar European context.

1 European Thematic Network on Health and Social Welfare Policy, Phoenix tn, "Health and Welfare: Diversity and Convergence in Policy and Practice," Athens 19–22 February 2009 University of Athens Building Kostis Palamas, Av. Akadimias, nr. 48 Athens. The author wishes to thank the Athens conference participants and the anonymous reviewers for their generous feedback.

Image 1. Ruins, puddles, and exposure to elements in the fragmented city.



Courtesy of Landesarchiv Berlin.

Next, different factors leading to the emerging state interventionist consensus will be examined. The case of housing and concerns about contagion of infectious diseases, inter-Allied competition within the realm of public health, interventionist traditions and expectations, as well as the universalist international health discourses will be examined in particular.

The focus will be on commonalities and convergence of general underlying ideas rather than on specificities of different health policies. Of course, approaches did differ. The differences, for example, in policies vis-à-vis invalids or the various Allied collaborations with international organizations such as the Red Cross, the Office International d'Hygiène Publique, the World Health Organization, or the International Labour Organization, were pronounced. Likewise, the degree to which health and welfare policies at the municipal and district level related to or

were inconsistent with statewide policy could differ significantly. The links between the levels of health and housing welfare administration were indeed manifold. Allied housing, health and medical officers stationed in Berlin operated on both the municipal and state level. They were thus closely involved in policy and procedure at the municipal and district level, e.g. overseeing the work of epidemic watch groups in their districts, monitoring and directing the resources of local hospitals, or gathering statistics on typhoid fever infection rates. At the level of the Allied Control Council, these very same officers debated national and state policy, including legislation. This paper focuses on the debate about state and governmental involvement in welfare. This, I argue, was a debate in which ideas converged. Practically all of Europe was concerned about the challenge of housing and providing for millions of displaced and distressed Europeans. This housing crisis, I suggest, was a founding moment in the history of health and welfare policy of Europe.

The sources for this study include scholarly studies about other European cities and countries; primary records including health and housing statistics; records of the International Red Cross and the United Nations Refugee Relief Organization; and a wealth of records from Allied and municipal offices concerned with housing and public health in Berlin 1945–1949, now held at Military Archives of Britain, the United States, Russia and France. Among the documents are weekly meeting minutes, decrees, law drafts, as well as internal and international correspondence with peers in Britain, Poland, Russia, Belgium and elsewhere by members of the occupying forces working in Departments of Health, Housing, and Public Safety in Berlin. In addition, correspondence between Berlin municipal welfare, health, and housing offices, their Allied counterparts, and individuals in France, Britain, Germany and elsewhere—now held at Landesarchiv Berlin, Staatsbibliothek, and in several district archives—have been examined.

Why Berlin? The case allows for an international study of the approaches to the health and housing crises. Berlin was occupied by four different military and occupation governments in the immediate postwar period. The Soviets had arrived first, in March 1945, to be joined that summer by British, US and French forces. Allies and Germans alike brought elements of the welfare and public health discourses in their native countries to the discussions. In addition, the documents suggest that the actors were keenly aware that the health and housing problems they were addressing were not unique to Berlin. They repeatedly observed the commonality of the problem and thus they present the possibility to study an international debate. The Allies themselves agreed upon the necessity of international cooperation and the exchange of ideas about these common problems. One resulting example of cooperation was an institution called the International Committee on Building and Housing. Established in the fall of 1945, its members met weekly in Berlin under alternating Allied chairmanship. Many of the meetings included

Germans as well as other European visitors. Its professed goal was the study of the common housing crisis, resulting public health concerns, and possible solutions.² Its founding members noted that not just Berlin or German cities, but cities across Europe were facing common challenges of housing and providing for the health and well-being of their inhabitants.³ The committee did not simply invoke the example of Berlin, London or Paris; Amsterdam, Warsaw, Leningrad and other cities were just as present in the debates, again for sharing similar problems. As will be shown, numerous other examples of the awareness of the Pan-European nature of the problem can be invoked, from Surgeon Generals' communications and international relief organization to the public press of the day.

Indeed, the housing crisis was one of *the* common problems in immediate post-war Europe. Wars tend to unsettle and shift populations, and create homelessness. But this war initiated by Nazi Germany, subsequent occupations, war tactics, and war-related scarcity of resources for regular construction and repairs—even in countries less affected by bombings—unsettled so much more than the wars before. The subsequent result: millions of Europeans were homeless. Countless popular publications on the problem of housing were published in the middle and late 1940s. Whether one looks at specialized publications of the time, such as the United Nations Refugee Relief organization's "Europe's Homeless Millions," communications from Surgeon Generals of various European countries or military occupations, or even any popular newspaper of the latter half of the 1940s, the discourse included a large public.⁴ While the attention to destruction and rubble may have created an image of total destruction of European cities rather than partial loss of dwelling spaces, the housing crisis was indeed acute. Problems as they appeared in Berlin were mirrored across Germany. In Germany's larger cities of 100,000 inhabitants or more, on average 40 percent of housing was destroyed. All in all, roughly 7 million persons lost their homes.⁵ The housing and health problems were prominent across Europe. In France, for example, where the housing crisis has been studied by historians Danièle Voldman, Frédérique Boucher and Olivier Ratouis,

2 Akademie der Künste, Archiv für Baukunst [AKAB], Scharoun Nachlaß, Sch-01, Internationales Komitee für Bau- und Wohnungswesen, Oct. 1945.

3 Ibid.

4 For example Fred K. Koehler, "Europe's Homeless Millions," *Headline Series* n. 54 (Nov.-Dec. 1945), and Janet Flanner in *Time Magazine*, Margaret Bourke-White in *Life*, Henry Ries for the *New York Times*. For further literature, see Alice Förster and Birgit Beck, "Posttraumatic Stress Disorder and World War II," in Richard Bessel and Dirk Schumann, eds., *Life After Death: Approaches to a Cultural and Social History of Europe During the 1940s and 1950s* (Cambridge, 2003), 28–30.

5 Steven Brakman, Harry Garretsen, and Mark Schramm, "The strategic bombing of German cities during World War II and its impact on city growth," *Journal of Economic Geography* v. 4 (2004), 201–218; F. Kästner, *Statistisches Jahrbuch Deutscher Gemeinden* 37 (1949), 361–391.

there was severe damage. Estimates point to 20 percent of French housing stock affected, resulting in several million homeless.⁶ Italy had lost roughly one million homes.⁷ In Britain and the Soviet Union, the housing shortages were even higher than in Berlin, as many contemporaries were keenly aware.⁸ And Poland, for example, had lost 45 percent of its urban housing stock, with some cities in Western Poland and the city of Warsaw suffering as much as 80 percent loss of housing.⁹ Despite massive destruction, evacuees, displaced persons, refugees and others were flocking to these cities. In brief, most countries across Eastern, Western and Central Europe emerged from the war with the two-fold reality of population influx and destruction of dwellings.¹⁰ And in every case, the severe housing crisis affected urban centers disproportionately. The scholarly literature to date has noticed the loss of housing, but it has mainly been interested in reconstruction and building debates. As it turns out though, reconstruction was not an option in the late 1940s due to a lack of funds and raw materials, nor was it the most immediate concern.

The loss of housing of course did not only have architectural implications. More importantly, it was central to public safety, public health and welfare debates. And it may have led Europeans, including the European middle class and persons not generally thought of as championing state involvement, to embrace the idea of redi-

6 Danièle Voldman, *La reconstruction des villes françaises de 1940 à 1954. Histoire d'une politique* (Paris, 1997); Frédérique Boucher and Danièle Pauly, *L'architecture de la reconstruction en France 1945 – 1953* (Paris, 1982); *Bulletin des commissions départementales de la reconstruction* v. 4 (1946), 6–8.

7 Paul F. Wendt, "Post World-War II Housing Policies in Italy," *Land Economics*, v. 38, n. 2 (May 1962), 113–133. On Milan, see Achille Rastelli, "I bombardamenti aeri nella seconda guerra mondiale Milano e provincia," *Italia Contemporanea*, v. 195 (June 1994), 309 – 342. On Rome, see e.g. Cesare de Simone, *Venti angeli sopra Roma: I bombardamenti aeri sulla Città Eterna 19 luglio e 13 agosto 1943* (Milan, 1993).

8 Potsdam Conference Protocol of the Proceedings, Art. 17, cited in Senate Committee on Foreign Relations and the Staff of the Committee and the Department of State, eds., *A Decade of American Foreign Policy: Basic Documents, 1941–1949*, (Washington, 1950). See also Sidney Bertheim, "Housing in France," in *Land Economics*, v. 24, n. 1 (Feb. 1948), 49–62; Frédérique Boucher, "Arbiter vaille que vaille, se loger coûte que coûte," in Danièle Voldman, ed., *Images, Discours et Enjeux de la Reconstruction des villes françaises après 1945*, Cahiers de l'Institut d'histoire du temps présent, n. 5 (Paris, 1987), 157; Nicole Rudolph, *At Home in Postwar France: The Design and Construction of Domestic Space, 1945–1975* (New York: 2005)

9 Główny Urząd Statystyczny Polskiej Rzeczypospolitej Ludowej, ed., *Tablice Statystyczne 1953–1954*, (Warsaw, 1956), 381–387; Gregor Thum, *Die Fremde Stadt: Breslau 1945* (Berlin, 2003); Norman Davies, *God's Playground: A History of Poland* (Oxford, 2005); Philip Ther, *Deutsche und polnische Vertriebene: Gesellschaft und Vertriebenenpolitik in der SBZ/DDR und in Polen, 1945–1956* (Göttingen, 1998). On statistics, see especially Katherine Lebow, *Nowa Huta, 1949–1957: Stalinism and the transformation of everyday life in Poland's "first sociality city"* (New York, 2002), 25.

10 Tony Judt, *Postwar: A History of Europe Since 1945* (New York, 2005), ch. 1; Mark Mazower, "Displacement and Social Crisis," in *Dark Continent: Europe's Twentieth Century* (New York, 1998), 214 ff.

tribution of resources and housing. Moreover, the Berlin case shows that in not only health officials and medical experts from the district, municipal and national levels were concerned with health and housing. Allied political officers, police, military, and architectural experts were just as much concerned. They agreed that not just the general health was at stake. Finally, as will be shown, they would concur that a concerted effort was necessary to address a number of pressing concerns.

But what were the primary motivations for Allied actors to be involved with health and housing questions? One British Military observer in Germany put it into words typical of the military records describing the Berlin setting and the health and housing concerns of the Allies. He observed in October 1946: “The loss of housing accommodation as a result of war and the influx of refugees has created a housing situation – which is grave and probably unprecedented in history. Everything that can be done must be done and done quickly.”¹¹ And he continued, warning that lest there be rapid improvement of the situation, “the living conditions ... coupled with ... a harsh winter may bring in their train not just death, [and] disease, but also serious discontent, and even ... popular unrest.”¹² The letter, sent to the British High Command and fellow Allies, is marked “urgent.”

These were the main concerns then: First, the fear of disease and the outbreak of epidemics. Second, the fear of subsequent discontent and unrest and thus, ultimately, the question of governability.

Allied concerns about the spread of illness and the outbreak of epidemics had gained in urgency over time. Not all were initially alarmist, yet in the most moderate health reports of the summer of 1945, housing and fears about health already featured prominently. Compared to many other European cities, Berlin and its residents at first seemed fairly healthy to members of the Allied Housing and Public Health department. This would not necessarily remain so, medical observers noted early on. Thus, upon surveying the city in June-July 1945, one public health report of the US Military Government in Germany instructed the US Surgeon General that “destruction ... ha[d] led to inadequate housing and overcrowding which [,] if coupled with inadequate heating facilities and soap [,] [might] result in lousiness and other unhygienic conditions during the winter.”¹³ Still, in some of the early reports, dangers were described as potential dangers, and seasonal ones at that. The earliest American reports were particularly positive, noting, for example, that under

11 Public Records Office [PRO], Foreign Office Files [FO] 1012/516, Letter on “The German Housing Situation in the British Zone,” 15 Oct. 1946, p. 1.

12 Ibid.

13 12 July, 1945, National Archives and Record Administration [NARA], OMGUS RG 260, AG 720, “U.S. Army Plans for German Public Health under the Allied Control Council: A Report to the Surgeon General, US Army, of Observations Made from 6 June to 12 July, 1945” by Brig. Gen. James S. Simmons, USA Chief, Preventive Medicine, SGO, and Col. Thomas B. Turner, M. C., Director, Civil Public Health Division, SGO, page 6.

the given conditions “the general health of German civilians” was “surprisingly good.”¹⁴ This would change quickly.

Health concerns grew with increasing *in situ* knowledge of the availability of medical services, of the general public health and the increased infection rates of contagious diseases, and of the city's altered topography and infrastructure. Moreover, from late July on, the Allies and Berlin municipal offices collected detailed health statistics and infection rate reports every week from every Berlin administrative district and hospital which allowed them to identify areas of primary concern.¹⁵ Allied and municipal epidemic investigations in Berlin, as in Potsdam, may have also relied on neighborhood-based volunteer sanitary helpers and so-called *Seuchenwarte*. They had deployed the latter systematically to inspect all streets. The sanitary wardens also had to “visit all apartments on a daily basis” in a given neighborhood and report on any seemingly ill persons.¹⁶ Their reports only drove home the point to housing officials that something had to be done quickly in light of the “threatening ... situation.”¹⁷ In addition, the Allies could rely on their own extensive health, hospital and housing surveys, conducted street by street, block by block, in the autumn of 1945. In these surveys they noted the availability of services, the health of the residents, as well as the crowd index, i.e. the number of persons living in one room.¹⁸ Finally, also the increased exchange of information across occupation zones helped show the extent of the health crisis.

Based on the evidence gathered in 1945 and early 1946, the Allies considered Berlin to be headed into a health catastrophe. Like most European cities affected by the war, the spread of disease threatened to take on epidemic, if not pandemic, dimensions. By the end of 1945, Berliners were ailed by typhoid fever, typhus, dysentery, diphtheria, influenza, cholera and tuberculosis, and some of these illnesses were spreading very rapidly.¹⁹ While it may not be unusual to see these in a population of nearly three million, the rates at which they were spreading appeared disconcerting. For example, within just one month, between June and July 1945, the number of persons registered as infected with dysentery in the Russian Zone of

14 Ibid., page 5.

15 Archiv der Akademie der Künste, Abteilung Baukunst, Scharoun Nachlaß, Records Mag 3/2 to 3/5.

16 Landesarchiv Berlin [LAB] C Rep 309, A 5018, Seuchen, Re: Fleckfieberbekämpfung, 6 Feb. 1946.

17 Ibid.

18 PRO FO 1051/803. Major Nuttall Report, “Notes on Visits to Various Premises in Berlin on 10. Sep. 1945,” pp. 1–2.

19 National Archives and Records Administration [NARA] OMGUS RG 260, AG 720, Department of Public Health Berlin, 12 July 1945. Andreas Dinter, *Berlin in Trümmern. Ernährungslage und medizinische Versorgung der Bevölkerung Berlins nach dem II. Weltkrieg* and *Seuchenalarm in Berlin. Seuchengeschehen und Seuchenbekämpfung in Berlin nach dem II. Weltkrieg*, Geschichte(n) der Medizin Series, v. 1–2 (Berlin, 1999).

Berlin doubled from 1,100 cases to 2,380.²⁰ By September 1945, even American officials noted that the local population was not that healthy after all. Furthermore, medical observers worried that Allied and Berlin medical provisions, even if combined, would still be marked by pronounced shortages in vaccines, penicillin, equipment and personnel, and would not suffice to quell an outbreak of epidemics.²¹ The overall health of Berlin residents, like that of other European city dwellers, seemed to be taking a downward turn.²²

Why become engaged, though? Allied officials in Berlin seldomly invoked humanitarian reasons for improving the health of local populations. Germans, they reminded themselves, had brought this calamity upon themselves.²³ Debates in a variety of committees concerned with funding showed the prominent reasoning that since the Nazi Regime had so aggressively pursued war in the name of the well-being of the Aryan *volk* while bringing about immense suffering on the side of its victims, it was now only fair for Germans to suffer, even physically. Certainly, German standards of living were not to exceed those of other European countries.²⁴ According to this vein of debate, if Allied resources were to be dispersed in Germany at all, they were to be administered only to those in most dire need, i.e. the ill and homeless.²⁵ And even here, if humanitarian reasons were invoked, they concerned mostly children.²⁶

A more prominent motivation for engaging in public health planning was the fear of contagion that would transgress class, political and geographical boundaries. Such concerns mirrored those expressed by governments and public health specialists of earlier centuries through to their contemporaries.²⁷ Furthermore, “modern transportation” itself, as U.S. President Harry Truman had reminded the future World Health Organization, had made it “impossible for a nation to protect itself

20 NARA OMGUS RG 260, AG 720, Department of Public Health Berlin, 12 July 1945,

21 *Ibid.*, Dec. 1945, Jan. 1946.

22 In Poland, infant mortality rates by war's end were twenty times, tuberculosis infection rates in 1947 ten times that of US Americans. See Katherine Lebow, *Nowa Huta*, 25.

23 Archives de l'Occupation Française en Allemagne et en Autriche (Colmar) [CArch], Série: Groupe Français du Conseil de Contrôle [1945–1948] GFCC, Caisse No: 3272, Carton No: P30, Allied Control Council, Housing and Building Committee, 53 Séance, tenue le 21 Octobre 1947.

24 Potsdam Conference Protocol of the Proceedings, Art. 17 (1945).

25 CArch GFCC, Caisse No: 3272, Carton No: P30, Allied Control Council, Housing and Building Committee, 53 Séance, tenue le 21 Octobre 1947.

26 Universities Committee on Post-War International Problems, ed. Ralf Barton Perry, *Final Report of the Work of the Committee 1942–1945*, Section V, (Boston, 1945), 3.

27 See the rationale for boards of health established in 16th century Italian cities, the reforms advocated by Johann Peter Frank, Jeremy Bentham, Edwin Chadwick, or records of 19th century international conferences such as the International Sanitary Conference in Istanbul, 1866.

against the introduction of disease by quarantine.”²⁸ Ill and healthy would mix. Though quarantining was still a prominent approach—at borders or points of transit such as train stations—governments and military occupations had realized the degree to which boundaries between countries, between their residents, between occupiers and occupied would be permeable. In the Berlin case, this meant the health of Berliners was directly linked to that of their occupiers. In consequence, it was in the interest of the health of the Allied own troops and employees themselves to push for policies that benefited the health of the general public. A cordon sanitaire between local populations and military occupiers is never possible. Allied units, in moves similar to that of Berlin upper classes in the course of industrialization, relocated from the inner city neighborhoods to the outer districts, for example to Dahlem, Karlshorst, Reinickendorf, and Spandau, in order to get away from the unhealthy and unsanitary inner city.²⁹ However, there was no way to create the “sanitary border” which Allied health professionals had at first called for.³⁰ The contacts were simply too many.

Where and how could illnesses spread from occupier to occupied? The stories of rapes and acts of intimate fraternization—often taking place in Berlin homes and basements—have been well documented.³¹ Not only the Red Army command but also western Allied officials acknowledged the fact that physical interactions between German civilians and occupation personnel would inevitably take place, despite fraternization bans.³² Noting that in German cities “the social chaos among civilians” had made “unusually difficult ... the adjustment of the relationships between soldiers and civilians,” one secret American health report from late May 1945, addressed to the US Surgeon General, advised that it was “not practicable to take action which [would] materially reduce contact between soldiers and prosti-

28 Harry Truman, "Letter of Welcome to the Inaugural Meeting on June 22, 1946," cited in United Nations, *Chronicle of the World Health Organization*, v. 1, n. 1 (1947), 8.

29 William Durie, Friedrich Jeschonnek, Dieter Riedel, et. al., *Alliierte in Berlin: 1945–1994: Ein Handbuch zur Geschichte der militärischen Präsenz der Westmächte* (Berlin, 2002); Norman Naimark, *Russians in Germany: A History of the Soviet Zone of Occupation, 1945–1949* (Cambridge, 1995); PRO FO 1051/150 Requisitioning, Dec. 1946 Report; PRO FO 1012/80 “Housing Allocation in Charlottenburg for Military Persons” [n.d.]; PRO FO 1051/150 Requisitioning 1945–1948, Lt. Col. E.D. Bevan to Military HQ, Berlin 28 Aug. 1946; NARA, RG 260 OMGUS Still Pictures, MGG 260-274-4.

30 NARA RG 260 OMGUS 1945–46 AG 72, 21 Feb 46, signed McNarney.

31 For an overview of this historiography, see Karen Hagemann and Stefanie Schuller-Springorum, *Homefront: the military, war, and gender in twentieth-century Germany* (Oxford/New York, 2002). See also contributions to the War and Rape issue of *October*, entitled “Liberators take Liberties,” i.a. Atina Grossmann, “A Question of Silence: The Rape of German Women by Occupation Soldiers,” and Andreas Huyssen et. al, “Further Thoughts on Helke Sander’s Project” *October*, v. 72, (Spring 1995).

32 For an excellent study of US-German fraternization, see especially Petra Goedde, *GIs and Germans: Culture, Gender and Foreign Relations* (New Haven, 2003).

tutes.”³³ In addition to the spread of venereal diseases like syphilis and gonorrhea, such intimate contact could lead to a spread of typhoid fever, influenza, dysentery, diphtheria and other contagious illnesses which occurred with increasing frequency among military personnel stationed in Berlin.³⁴

The Allies had to fear contagion not merely as a result of intimate physical interactions. There were many other areas of contact. Allied housing officers could, for example, catch infections on their inspection tours, as happened to Major Nuttall who contracted dysentery.³⁵ Berliners and Allies shared the same water, sometimes the same food. They frequented the same train stations and the same streets. And sometimes they even lived under the same roof and shared the same sanitary equipment.³⁶ Furthermore, German employees worked for military administrations of all four Allies. In particular the German food handlers, cooks, and kitchen help for the occupiers, both in the garrisons and the villas of the Highest Command, could and did spread disease. Thus, the “outbreak of disease ... among civilians” could “sufficiently endanger troops or seriously impede military operations.”³⁷ Another member of the military government in Berlin had to remind his superior abroad that the call for funding to improve Berlin’s hygienic infrastructure did not primarily stem from empathy with Berliners. Rather, he noted: “The problem of sanitation in Berlin is of paramount importance for all of us who live here.”³⁸ The records point to a Berlin-based conclusion that reducing the “reservoir [of] infection... among German civilians” would best ensure the health of the occupying forces.³⁹

Reducing this reservoir of infection took many forms and involved individual efforts as well as those of various branches of Allied and municipal government. Over time, a consensus emerged which held that uncoordinated action would not suffice in light of the serious health crisis. Instead, unified planning and the apparatus of the state would be necessary to address the problem.

Initially, though, measures for reducing the threat of the spread of epidemics were taken sector by sector. Reducing the reservoir of disease at first literally related to reservoirs and water supplies. Sanitizing the cityscape physically, removing rubble, shells, corpses of men and animals alike, repairing sewage pipes, and draining

33 NARA RG 260 OMGUS 1945–46 AG 720, 16 May 45 Health Report.

34 NARA RG 260 OMGUS 1945–46 AG 720, n.d. summer 1945, n.d. Jan. 1945, 26 Feb. 1946, n.d. Feb. 1946.

35 PRO FO 1051/803 Letter from A.E. Joll to H.H. Nuttall, [n.d.].

36 PRO FO 1051/150 Requisitioning, Report of 15 Feb. 1947; PRO FO 1012/80 “Housing Allocation in Charlottenburg for Military Persons” [n.d.], and FO 1051/150 Requisitioning 1945–1948, Lt. Col. E.D. Bevan to Military HQ, Berlin 28 Aug. 1946.

37 NARA RG 260 OMGUS 1945–46 AG 720, OMGUS Report to Surgeon General, 6 Jun to 12 July 1945.

38 NARA RG 260 OMGUS AG 720, 19 Apr. 1946, Subject: Sanitation.

39 NARA RG 260 OMGUS 1945–46 AG 720, Jan. 1946 Report.

cess-pools was one way in which Allies and Berliners went about addressing questions of hygiene and infrastructure.⁴⁰ These efforts, often initiated at district levels, were uncoordinated.

Only upon the arrival of large groups of returning evacuees, refugees, and so-called displaced persons (DPs) did the Allied Control Commission create joint policies for Berlin. Despite common interests, these too only emerged with experience on the ground. As Berlin municipal police noted in July 1945, every day between 5000 and 6000 refugees and DPs arrived in Berlin's over-extended train stations, where homeless Berliners were already residing.⁴¹ By the winter months 1945–1946, the records speak of 500,000 refugees a month traversing Berlin.⁴² Allied and railroad personnel were not the only ones who regarded DPs and refugees as a menace. Berliners shared the view of Allied and municipal administrators which regarded such people as a “hearth of disease,” a “flood,” “wave,” or “stream” of menacing proportions threatening the health of the community.⁴³ A police order of the Berlin district of Friedrichshain simply read: “Travelers passing through Berlin who touch [sic] our district ... must leave ... immediately.”⁴⁴ Contagion, again, was to be prevented. Very likely, these refugees, DPs, and former camp inmates were indeed of poor health. Once in proximity to others, Allies and Berliners feared, they might spread their illness or the host of their illness quickly. However, at first policies were at the level of each occupation zone. Soviet decrees from October 19, 1945 demanded that 36,000 German railroaders be immunized against typhoid fever, 11,500 in the Soviet Zone of Occupation alone. But medicine and disinfectants were constantly in short supply in Berlin, and not all could be immunized.⁴⁵ Meanwhile, delousing stations, which refugees and returnees were required to visit, or soap and boiling water provided at

40 LAB C Rep 309 A 5021, “Betr: Der Grundwasserstand as Spiegelbild der Entwicklung und Wirtschaftslage Berlins” letter by Reichsbahn Direktor Kreikemeyer to engineer Dr. I. Denner regarding water and broken pipes, 11 Nov. 1947; LAB, C Rep 303–09, no. 11, “Betr: Bekämpfung von Stechmücken” and “Betr: Entmückungstrupps,” 13 May 1946.

41 Jan Foitzik, ed., *Inventar der Befehle des Obersten Chefs der Sowjetischen Militäradministration in Deutschland (SMAD) 1945–1949*, Series of Institut für Zeitgeschichte (Munich, 1995), p. 16 of “Befehl No. 15,” Berlin, 27 Jul. 1945.

42 Reinhard Rürup, ed., *Berlin 1945: Eine Dokumentation* (Berlin, 1995), 124.

43 Befehle des Obersten Chefs der Sowjetischen Militärverwaltung in Deutschland und amtliche Bekanntmachungen des Stabes der Sowjetischen Militärverwaltung in Deutschland, Sammelheft 1, 1945 (Berlin, 1946), 16, 39–40 and Norbert Podewin, ed., *Ausgangspunkt Chaos: Berlin im Mai und Juni 1945: 100 Dokumente vom Leben rund um den Schlesischen Bahnhof* (Berlin, 1995), 16.

44 Ibid.

45 LAB C Rep 309 A 1910, letter Reichsbahn Direktion Berlin to Reichsbahnsozialamt, 31 Oct. 1945.

the Bahnhofsmission shack, only provided limited protection.⁴⁶ In July 1945, the first unsettled persons to arrive were therefore kindly advised to leave Berlin unless they were already in the care of Berlin relatives.⁴⁷ This strategy proved ineffective with the arrival of ever more refugees. Soon, the tone changed. Those in positions of power concluded that the simplest way to protect the health of the community was to quarantine and ban refugees altogether, and thus limit the spread of disease. By 1946, the Allies agreed on a common policy: any refugee traveling “wildly” [*wildreisend*] and not as part of a group under Allied supervision, was to be captured, taken to the station master, quarantined, delivered to Allied authorities, and forced to leave the city within 24 hours.⁴⁸ Organized mass transports of refugees and DPs which entered the city were also to be held in quarantine, watched night and day by military police and local auxiliary forces. Eventually, in every sector, they were to leave the city within less than a day, refugees and DPs being carried to camps set up outside the city which would provide medical care.⁴⁹

What, however, was to be done with residents within the city and the continuous fear and reality of spreading disease? Military officials and their health officers throughout 1945 to 1948 lamented a shortage of immunizations for German civilians and their own populations; in this area, the means were limited.⁵⁰

The best possible protection, Allies and Berliners came to agree, was to remove the ill, homeless Berliners from the streets and send them to hospitals. Yet the responses here showed different strategies and signs of conflict amongst the Allies. Upon their arrival, hospitals already had been filled beyond capacity, so often infected patients were turned away to stay in already crowded apartments where the tenants or owners would be made to share their dwelling space. Patients known to be contagious lay in mixed-use buildings which served as general hospital, school and housing facilities all at once – or they had simply been sent home.⁵¹ At home though, in crowded living conditions, the sick sharing rooms with healthy could spread their illnesses further.

46 LAB C Rep 309 A 5018, Re: Flüchtlingsangelegenheiten und Seuchen, letter entitled “Fleckfieberbekämpfung,” Provinzialverwaltung Brandenburg, 6 Feb. 1946.

47 LAB C Rep 309 A 5018, Re: Flüchtlingsangelegenheiten und Seuchen, 9 Jul. 1945.

48 LAB C Rep 309 A 5018, Re: Flüchtlingsangelegenheiten und Seuchen, “Betr: Betreuung der aus dem Osten kommenden Umsiedler,” signed RB Direktor Bäuerle, 26 Mar. 1946. These instructions were sent to all border and transit railway stations, including to Berlin.

49 LAB C Rep 309 A 5018, Re: Flüchtlingsangelegenheiten und Seuchen, 25 Jan. 1946, 29 Jan. 1946. On health care policies in DP camps, see Atina Grossmann, *Jews, Germans, and Allies: Close Encounters in Occupied Germany* (Princeton, 2007).

50 NARA OMGUS RG 260, AG 720, OMG Berlin to SGO, Re: Medical Requirements, Dec. 1945, 13 Jan. 1946.

51 AKAB, Scharoun-Nachlass, Mag 3/5, I Reports to Allied Kommandatura by Prof. Hasenpflug and Pfluger, Berlin Municipal Office of Health [*Gesundheitswesen*] to Allied Kommandatura, Re: Leichenhallen.

Allied observers and local public health experts deemed the proximity of Allies, city employees, infectious patients, school children, and residents “not advantageous in the long run.”⁵² Indeed, Berlin health officials frequently compared different responses and health conditions. They thus provide examples of concrete conflicts arising from the various Allied strategies and of tensions between municipal health planners and their Allied counterparts. For example, the close proximity of ill and healthy in Zehlendorf (US Zone) and Lichtenberg (Soviet Zone) left Berlin municipal health personnel outright appalled.⁵³ In one case, observers noted more than 500 tuberculosis patients were made to share space with students and nurses residing in a school building.⁵⁴ As municipal health evaluator Hassenpflug noted, hospital beds for the sick and elderly, as well as overall medical provisions for Berliners were particularly poor in the northeast and east, i.e. the Soviet Sector. The Soviet-occupied districts of Kaulsdorf, Marzahn, Wuhlgarten, and Lichtenberg were singled out.⁵⁵ Here, former military barracks which had been turned into hospitals during National Socialist governance were now being used to house healthy Soviet troops rather than the ill and contagious Berliners. Indeed, compared to other Allies, the Soviets required more potential housing or hospital space as they sought to isolate their personnel more than the Western Allies did. Not only in the realm of health, but possibly also in political ideology, contagion concerns may have been at the forefront of Soviet policy. Noting the overall lack of joint Allied initiative, the lack of resources in the Soviet areas, and the inconsistent measures even among each Allied group, Berlin observers called increasingly for a concerted effort and long-term planning in light of the numerous “inappropriate improvisations.” Having likened many of the Allied health policies to “Nonsense” [sic], they pushed for greater Berlin municipal participation in health policy and for grand planning.⁵⁶

The approach of favoring state and municipal involvement in providing sufficient housing and hospital space and the propagation of the isolation of patients already had a long tradition in Berlin. In his March 1882 lectures at the Hygiene-Institut of Berlin’s Friedrich-Wilhelms Universität, Robert Koch had demanded measures to prevent the spread of infections. They required not only the isolation of patients with open tuberculosis, but most notably, state- and municipality-organized initiatives to improve unfavorable housing conditions. Enough ventilation

52 AKAB, Scharoun-Nachlass, Mag 3/5, I, Reports to Allied Kommandatura on hospital capacity and overcrowding by Prof. Hassenpflug and Pfluger, Berlin Municipal Office of Health to Allied Commandatura, Re: Krankenhaus Kaulsdorf, dated 12 Jul. 1946 and 27 Sep. 1946.

53 AKAB, Scharoun-Nachlass, Mag 3/5, I, Reports to Allied Kommandatura by Prof. Hassenpflug and Pfluger, Berlin Municipal Office of Health to Allied Commandatura, Re: Zinnowaldschule in Zehlendorf, 14 Nov. 1946.

54 Ibid., Gutachten, 14 Nov. 1946.

55 Ibid.

56 Ibid.

and space would be key.⁵⁷ Ultimately, patients and healthy would be separated, once enough hospital space became available.

Yet at which level was health policy to operate? Should there be centralized plans for all of Germany? Should policy operate at the municipal level in a centralized way? At the district level in a decentralized way? The suggestions were many, and the debate about the level at which health care was to be administered continued, not least in response to Nazi policies which had centralized municipal health and welfare while creating competing Reich and NS party agencies to execute them.⁵⁸ Suffice it to note that district and municipal health and housing administrators alike advocated the centralized, comprehensive “hygienische Durchplanung Berlins,” with plans coming from the municipality.⁵⁹

Meanwhile, according to these same municipal observers, the funding for comprehensive measures should come from both Berlin municipality as well as from the state, in this case the Allied Kommandatura.⁶⁰ Initiatives by private insurance companies for repairing hospitals and privately operated hospitals were apparently accepted, though not favored, by Allies or Berlin municipal supervisors. They regarded the private businesses as operating out of business interest, not public health interest. Indeed, more than once, private villas had received building materials and been reconstructed under the guise of operating as a private clinic, never to actually provide the promised services.⁶¹ The same municipal observers meanwhile lauded the Allied Kommandants' joint provision of 4 million Reichsmark in emergency funds to the Magistrate of Berlin for 10,000 extra hospital beds, as the right approach.⁶²

Such calls were indeed eventually met with concerted Allied action by late 1946. Consequently, the Allies jointly agreed to additional funding for the construction of hospitals, for hospital salaries, as well as the provision of building materials, all in response to the urgently perceived danger of epidemics.⁶³

57 Herbert Landmann, “In Berlin begann der Kampf gegen die Tuberkulose,” *Berlinische Monatsschrift*, v. 12 (1998), 12–13, 17.

58 See especially Christoph Sachße and Florian Tennstedt, *Der Wohlfahrtsstaat im Nationalsozialismus* (Stuttgart/Berlin, 1992); Alfons Labisch and Florian Tennstedt, “Gesundheitsamt oder Amt für Volksgesundheit? Zur Entwicklung des öffentlichen Gesundheitsdienstes seit 1933” in *Medizin und Gesundheitspolitik in der NS-Zeit*, ed. Norbert Frei (Munich, 1991).

59 AKAB, Scharoun-Nachlass, Mag 3/5, I, Reports to Allied Kommandatura by Prof. Hassenpflug and Pfluger, Berlin Municipal Office of Health to Allied Commandatura, Gutachten, 16 Nov. 1946.

60 Ibid.

61 Ibid.

62 Ibid., “Kommandanten stellen 4 Millionen Reichsmark”

63 AKAB, Scharoun-Nachlass, Mag 3/5, I, Reports to Allied Kommandatura by Prof. Hassenpflug and Pfluger, Berlin Municipal Office of Health to Allied Commandatura, 14 Nov. 1946 and Re: Seuchenbettenaktion, Dept. of Housing and Building Report to Allied Commandatura, 19 Feb. 1946, 31 May 1946.

Before a concerted response of the type described above materialized in 1946, the different districts and Kommandaturas had taken individual measures against the spread of epidemics, in particular regarding overcrowding and the mixing of infected and healthy residents. The Soviets were the first to do so, both in terms of health infrastructure and actual projects. Per Soviet Military Administration Decree 17, a central health administration, *Zentralverwaltung für Gesundheitswesen*, had been set up in the Soviet occupation zone.⁶⁴ While it differed significantly from NS racial hygiene goals and propagated an egalitarian approach as well as preventative medicine, it followed the NS path of expanding and centralizing the state-run public health system.⁶⁵ Turning to specific interventions, the Red Army had also set up extra infectious disease hospital care in the district of Prenzlauer Berg in late spring 1945. Correspondence among different Allied health offices show that within days of the US and British arrival in Berlin, competition was prominent. Thus, Soviet health administrators urged American health officials to set up extra infectious disease centers in their central districts, e.g. in the populous district Neukölln which was especially short of infectious disease hospital beds.⁶⁶ In addition, they pointed to poor housing structures and crowded living conditions in the West, which, in their opinion, worsened the health situation.⁶⁷ On the other hand, health and welfare offices in the American-controlled districts of Berlin permitted and encouraged aid from outside agencies. These included not just churches and neighborhood charity organizations, but, for example, support from the Swedish Red Cross, the Swiss Red Cross, the International Red Cross, and eventually US health and humanitarian aid organizations which had been approved by CRALOG, the Council of Relief Agencies licensed to operate in Germany.⁶⁸

The Allied material responses to specific housing problems—to broken windows, exposure to elements, or lack of ventilation—presents another example of the slow emergence of concerted state planning in the interest of public health. Destruction

64 Jan Foitzik, ed., *Inventar der Befehle des Obersten Chefs der Sowjetischen Militäradministration*.

65 Udo Schagen and Sabine Schleiermacher, “Gesundheitswesen und Sicherung bei Krankheit,” in Bundesministerium für Arbeit und Sozialordnung/ Bundesarchiv, ed., *Geschichte der Sozialpolitik in Deutschland, v 2: Die Zeit der Besatzungszonen 1945–1949* (Baden Baden, 2002); Ralf Ahrens, “Planwirtschaft, Prävention und Effizienz: Zur Wirtschaftsgeschichte des Gesundheitswesens in der Sowjetischen Besatzungszone und der frühen DDR,” in Udo Schagen and Sabine Schleiermacher, eds., *Sozialmedizin, Sozialhygiene, Public Health: Konzepte und Visionen zum Verhältnis von Medizin und Gesellschaft in historischer Perspektive*, Series Berichte und Dokumente zur Zeitgeschichte 5, (Berlin, 2002) 42.

66 NARA OMGUS RG 260, AG 720, Department of Public Health Berlin, 12 Jul. 1945.

67 NARA OMGUS RG 260, AG 720 Report to Surgeon General, 6 Jun to 12 Jul. 1945.

68 NARA OMGUS RG 260/390/48/13/2/b209/16a, Report on the Activities of Social Welfare from July 1 - December 31, 1946.

Image 2. Interior of Berlin apartment building, Berlin-Wedding, ca. 1946.



Courtesy of Landesarchiv Berlin.

of windows had led to residents being exposed to elements, with detrimental effects particularly during the winter months. Health officials had noted the rise in pneumonia and other acute respiratory diseases.⁶⁹ As counter-measure, warming halls were set up for thousands of Berliners, initially by individual districts, later in a more coordinated manner. This followed a tradition of emergency relief already established by the district social services during the Third Reich and harkening back to the first Berlin warming hall of 1891. Also, by private residents' initiative, or in the Soviet and British cases, per Allied decree, windows had been covered by wool cloth, cardboard, wooden planks, or bricks, so as to make some rooms heatable. This however had limited the supply of fresh air and presented new health challenges, aggravated further by overcrowding. On their joint tours of Berlin dwellings, the members of the Allied Housing and Health Boards had noted numerous cases of serious overcrowding, with up to 15 persons residing in one room.⁷⁰ Bricked up windows and dense settlement featured prominently in health and housing experts' discourses about the health of Berlin's residents in this early post-

69 NARA OMGUS RG 260 AG 720, 1945–46, Public Health, Berlin Report, Dec. 1945, Jan. 1946, 19 Apr. 1946, 24 Apr. 1946.

70 PRO FO 1051/803. Housing Reports I, Housing Report, 28 Sep. 1945.

war period. They were marked in particular by a concern for proper ventilation and minimum living space requirements per person. This dated back to older public health debates. Interwar Berlin and German architects had already called for space, air, light and sunshine in the interest of public health, as had the earlier Prussian housing legislation of 1907.⁷¹ This legislation had made light and proper ventilation mandatory, and in turn, was based on nineteenth-century works on hygienics and housing such as Max von Pettenkofer's *Über den Luftwechsel in Wohngebäuden*.⁷² In this tradition then, and in light of frustrations over non-comprehensive solutions over different standards set for minimum standards of living, by March 1946 the Allied Control Council members agreed on a housing law for Germany which was to entitle every German to ample and appropriate, i.e. healthy, housing space.⁷³ Therefore, when housing conditions were linked with health, and the call came for state involvement, this was part of a longer tradition. Despite this longer tradition of state involvement, the immediate postwar years were a period of particularly noteworthy convergence in regards to welfare and public health thinking. The postwar material setting and the urgent threat of spreading epidemics had made actors on all sides embrace concerted intervention.

Next to the specific material conditions and health crisis, a key reason for the postwar embrace of state intervention lay in the very weakness of the state. In Germany, as in most European countries, the immediate postwar period saw strong state apparatuses coupled with weak, tenuous governments. The provision of welfare came out of the very weakness of postwar governments. As British Military Governor for Germany Sholto Douglas had noted, "the living conditions ... coupled with ... a harsh winter" were likely to bring "not just death, [and] disease, but also serious discontent, and even ... popular unrest."⁷⁴ State legitimacy and, ultimately, governability were the driving concern. In the case of Berlin, Allied offices of public safety, health, housing, and political affairs were very much involved. But no less important were the citizens of each state who expected their postwar state to take care of them and expressed this expectation. A state's failure to do so would lead to dwindling legitimacy.

In the case of Berlin during the early months of occupation, Allies were particularly sensitive to German public opinion. Contrary to most descriptions in the histories of Allied occupation, the representatives of the so-called "Great Powers" in 1945 felt all but secure. The frequently-referenced experience of World War I had

71 The last prewar international architectural exhibit in Berlin, 1932, had thus been aptly entitled "Sun, Light, and Housing for Everyone." See also Paul Wolff's film on Ernst May, *Neues Wohnen in Frankfurt am Main* (Frankfurt, 1928), and David Frisby on Martin Wagner, "The City Rationalized," in *Cityscapes of Modernity: Critical Explorations* (Cambridge, 2001), 270–302.

72 Max von Pettenkofer, *Über den Luftwechsel in Wohngebäuden* (Munich, 1858).

73 PRO FO1051/720. Housing Law 18.

74 Ibid.

shown that having won a war did not automatically preclude future German aggression. The Allies were keenly aware of the challenge of pacifying Germans for the long term. In the earliest months of their governance in Germany, they spent much effort gauging popular opinion. Surveys conducted in Berlin and elsewhere, as well as popular opinion expressed in German media, showed great discontent on the part of Germans vis-à-vis the Allies.⁷⁵ Berliners lamented their standard of living and saw Hitler's prediction fulfilled, i.e. that "the peace would be terrible," that they would suffer under some Allied yoke, that health and living conditions would be close to unbearable.⁷⁶ Berliners did not greet the Allies as liberators in those early months, but as conquerors and enemies that had spread "terror." They still regarded the Allies' presence as "catastrophe" rather than liberation.⁷⁷ Allied housing procedures, furthermore, were repeatedly appealed and questioned in legal settings.⁷⁸ In a weak governance situation then, in which the Allied Control Council—the *de jure* government of Germany—lacked popular support, welfare policies which addressed health and housing concerns could be used to win over a skeptical and apprehensive population. Alternatively, policies the Germans considered insufficient, "nonsense," or detrimental would hinder such support.

Residents of immediate postwar Berlin, as elsewhere in Europe, approached their state's government with great expectations. The idea that a state was to provide for the wellbeing and, by extension, for the health of its citizens, rested on a longer tradition. At least since the Enlightenment, the strength of the European state had come to be identified with strength, resilience, and the well-being of its citizens.⁷⁹ During the French Revolution, with the establishment of a Health Committee of the National Constituent Assembly, "health" had been proclaimed "a natural right." And thus, as historian Anne La Berge has noted, "if governments were instituted to protect natural rights, then public health was the duty of the state."⁸⁰ By this logic, governments would lose legitimacy if they failed to protect those natural rights. These ideas had spread beyond France. Already a century prior to the

75 PRO FO 1051/803. Housing I, "Poor Rebuilding Prospects" [n.d.], Runge quoted by Head of Municipal Building authority and *ibid.*, Ministry of Economic Warfare, confidential report, Press and Broadcast Unit, "Berlin's Housing Problem," 7 Jul. 1945.

76 See Deutsches Historisches Museum Exhibit, *Alltagsleben 1945*, "Geniesst den Krieg, denn der Friede wird schrecklich," attributed to Hitler and Goebbels. For Nazi predictions of the postwar order, see e.g. NSDAP, ed., "Ohne Sieg kein Wiederaufbau," in *Redner-Schnellinformation*, v. 63, (September 1943).

77 Eike Wolgast, *Die Wahrnehmung des Dritten Reiches in der unmittelbaren Nachkriegszeit 1945/46* (Heidelberg, 2001).

78 FO 1051/804, Housing Reports Berlin 1946–1949. Dec. 1946 Housing Report Berlin.

79 Thomas Osborne, "Of Health and Statecraft," in Alan Petersen and Robin Bunton, eds., *Foucault, Health and Medicine* (London, 1997), 173–188.

80 Ann F. La Berge, *Mission and Method: The Early Nineteenth-Century French Public Health Movement* (Cambridge, 1992), 16.

Allied and Berliner debates of the 1940s, at a time of similar political crisis, Rudolf Virchow had emphasized that “any reasonable state constitution” would have to note firmly “the right of the individual to a healthy [*gesundheitsgemäÙe*] existence.”⁸¹ The wellbeing of every citizen would have to be ensured by the state and its government.⁸² And as Jessica Reinisch has shown, this very Rudolf Virchow would become an icon for postwar Berlin medical officials. His calls for state and health reform were particularly hailed in the Soviet Zone.⁸³ Lay persons may have likewise come to equate state legitimacy with health. During the early part of the twentieth century, both the institutions of the German state and the scientific community, including social hygienicists, doctors, and statisticians, had spent considerable effort in presenting national health statistics to general audiences. In popularized form, such as in the *International Hygiene Ausstellung* in Dresden in 1911 and 1930/31, as well as the *Grosse Ausstellung zur Gesundheitspflege, Soziale Fürsorge und Leibesübungen* 1926 in Düsseldorf, the link between state and government legitimacy and collective strength or health of the nation, later *volk*, had been strongly emphasized.⁸⁴

Most importantly, the experiences of the 1930s and 1940s had brought health and state legitimacy to the forefront. “It is a cruel paradox, but war, despite its immediate, catastrophic effects on human well-being, has played a major role in the evolution of the welfare state,” historian Gregory Kasza has noted about the emergence of the Japanese welfare state.⁸⁵ In Berlin, across Germany, and across Europe, the war is likely to have played this role. The Beveridge report and subsequent public health legislation in Britain would be unthinkable without the context of war which had at once empowered the interventionist state and strengthened the idea of the social contract. It encouraged popular demands vis-à-vis the state as caretaker. In France, likewise, the sacrifices made during the war had heightened popular

81 Rudolf Virchow, “Mittheilungen über die in Oberschlesien herrschende Typhus-Epidemie,” *Virchows Archiv für pathologische Anatomie und Physiologie und klinische Medizin* n. 2 (1849), 317. Quoted by Heinz-Peter Schmiedebach, “Gesundheit und Prävention in Abhängigkeit vom Gesellschaftsbegriff im 19. Jahrhundert,” in Sigrid Stöckl et al., *Prävention im 20. Jahrhundert: Historische Grundlagen und aktuelle Entwicklungen in Deutschland* (Weinheim, 2002) 27.

82 Rudolf Virchow, “Die öffentliche Gesundheitspflege,” *Die Medizinische Reform* n. 1 (1848), 22.

83 Jessica Reinisch, “‘Zurück zu unserem Virchow!’ — Medizinische Karrieren, Nationalhelden und Geschichtsschreibung nach 1945,” in Axel C. Hüntelmann, Johannes Vossen and Herwig Czech, eds., *Gesundheit und Staat: Studien zur Geschichte der Gesundheitsämter in Deutschland, 1870–1950* (Husum, 2006) 255–271.

84 Sybilla Nikolow, “Statistische Bilder der Bevölkerung in den großen Hygieneausstellungen als Wissensobjekte,” in Rainer Mackensen and Jürgen Reulecke, ed., *Das Konstrukt “Bevölkerung” vor, im und nach dem “Dritten Reich,”* (Wiesbaden, 2005), 476–477, 481–483.

85 Gregory J. Kasza, “War and Welfare Policy in Japan,” *Journal of Asian Studies*, v. 61, n. 2 (May, 2002), 417.

expectations for health care and welfare in the postwar period.⁸⁶ State capacities to intervene, even after 1945, were not suddenly reduced, nor were expectations lesser. If anything, the apparatus of the state was needed to solve the massive crises of the postwar period: food, water, health, and housing (later on, also work) in half-destroyed cities being among the most urgent problems to be addressed. Scholars working on postwar Eastern and Central European societies have argued that the postwar conditions and crises even led to a crescendo of planning and centralized state control, initially accompanied by popular approval.⁸⁷ In Western Europe, technocrats, conservative and socialist politicians alike, as well as large segments of society found a consensus and also embraced the expanded, mobilized capacities of the state to solve the crises of the postwar period.⁸⁸

Concerning the consensus on state planning and involvement, the Berlin and German case was typical, as were the motivations of those creating health and housing policy on location. Yet the peculiarity of the German setting should not be overlooked either. The role of National Socialism in the rise of the postwar European welfare idea is a paradoxical one. National Socialism's professed "socialism," coupled with its troubling emphasis on racial health and *Volksgesundheit* may have raised great expectations among a considerable portion of the German population.⁸⁹ To be clear: the National Socialist regime was anything but universally egalitarian with its emphasis on racial hierarchies and resulting health and death policies. Yet its rhetoric toward those considered part of the *volk* was egalitarian and, as historian Norbert Frei and others have pointed out, it helped spread "sentiments of equality" across former class divisions.⁹⁰ Equally important, the National Socialist compari-

86 René Girault, "Les Voies de la Reconstruction 1945–1949," in Dominique Barjot, Rémi Baudouï and Danièle Voldman, ed., *Les Reconstructions en Europe (1945–1949)*, 33, 51.

87 For example Bradley Abrams, "The Second World War and the East European Revolution," *East European Politics and Societies* (Fall 2002), 623–664; Jan T. Gross, "Social consequences of war: preliminaries to the study of imposition of communist regimes in east central Europe," *East European Politics and Societies*, v. 3, n. 2, (Spring 1989), 198–214; Tony Judt, *Postwar*, 63–99; Hugh Seton-Watson, *Eastern European Revolution*, (London: Methuen: 1950).

88 See Barjot, et al., *Les Reconstructions en Europe*; Mark Mazower, *Dark Continent*, 298–302; Tony Judt, *Postwar*, 63–99; Rémi Baudouï, *Raoul Dautry (1880–1951). Le technocrate de la République* (Paris, 1992); Philip G. Nord, *France's New Deal: From the Thirties to the Postwar Era* (Princeton, 2010); Herrick Chapman, "French Democracy and the Welfare State," in ed. George Reid Andrews and Herrick Chapman, *The Social Construction of Democracy* (New York and London, 1995).

89 Kurt Nowak, "Widerstand, Zustimmung, Hinnahme: Das Verhalten der Bevölkerung zur Euthanasie," in Norbert Frei, ed., *Medizin- und Gesundheitspolitik in der NS-Zeit* (München, 1991), 235 ff.

90 On the debate regarding the socialism of National Socialism, see Axel Schildt, "NS-Regime, Modernisierung und Moderne: Anmerkungen zur Hochkonjunktur einer andauernden Diskussion," *Tel Aviver Jahrbuch für Deutsche Geschichte*, v. 23 (1994), 3–22, in response to works of Goetz Aly; Norbert Frei, "Wie modern war der Nationalsozialismus?," *Geschichte und Gesell-*

sons of German public health with those of the societies living under other political systems—propagated in film, press, professional and primary education, as well as in grand-scale exhibits such as *Das Sowjetparadies*—would have constructed a framework which linked a society’s health and living standards with the legitimacy of its government.⁹¹ This ideological framework, as the Berlin sources show, had been accepted and did not suddenly disappear in 1945. As the Allies keenly noted, Berliners in the fall of 1945 still invoked volkish health and so-called rights to life in a resentful, expectant tone.⁹² Likewise, German medical officials’ discourses in the immediate postwar period were clearly based on nationalist premises, as historian Jessica Reinisch has convincingly demonstrated.⁹³ Thus, among laypersons and professionals, neither terminology nor expectations had vanished in regards to public health and state responsibility. In the quest for legitimacy in the postwar quadripartite state, the Allies had to outperform the promises that Nazis had made to Germans. At the same time, the brutal, inhumane National Socialist regime and its selection based on pseudo-scientific notions of racial hygiene also served as the anti-model. While the Allies had no distinct name yet for what we now refer to as the “Holocaust,” and while they had not yet grasped the full extent of euthanasia programs, their increasing knowledge of these shaped their visions for the new order. From now on in Germany, there was to be no victimization or discrimination, and, ideally, welfare for all, not just for those at the top of some racist, social-darwinist hierarchy.⁹⁴ Allied policy and their preceding discussion of living standards, even for Germany, seemed determined to teach Germans the centrality of basic and universal human rights.

Finally, the wider European and global context of health and human rights favored an interventionist state. In the Berlin case, neither lingering Nazi volkish welfare ideology and expectations, nor the Allied perceived necessity to outdo NS promises alone explain the prominence of ideas regarding the importance of state involvement in public health and welfare affairs. Equally important was an increasingly publicized international human rights discourse of which Berliners would have been aware and which their claims to Allied responsibility regarding public health reflected. Already in the 1945 documents of the Potsdam Conference, and

schaft, v. 19 (1993), 367–387; Riccardo Bavaj, *Die Ambivalenz der Moderne im Nationalsozialismus: Eine Bilanz der Forschung* (Munich, 2003).

91 Norbert Frei, ed., *Medizin- und Gesundheitspolitik in der NS-Zeit* (Munich, 1991), Introduction; Michael Burleigh and Wolfgang Ippenmann. *The Racial State: Germany 1933–1945* (Cambridge, 2000); Claudia Koonz, *The Nazi Conscience* (Cambridge, 2005). Reichspropagandaleitung der NSDAP, *Das Sowjetparadies: Ausstellung der Reichspropagandaleitung der NSDAP: Ein Bericht in Wort und Bild*, (Berlin, 1943), 19, 34–35, 38–47.

92 LAB C Rep 309 A 1912 RB, Fritzner to Soviet Military Administration, 22 Oct. 1945

93 Jessica Reinisch, “‘Zurück zu unserem Virchow!’ – Medizinische Karrieren, Nationalhelden und Geschichtsschreibung nach 1945,” 258.

94 PRO FO 1051/803 Housing Reports I, 3 Oct. 1945.

certainly by the time of the United Nations Declaration of Human Rights of December 1948, the advocates of universal human rights proclaimed everyone's right to "a standard of living adequate for the health and well-being of his family," and explicitly mandated states to ensure the adequacy of "housing and medical care."⁹⁵ The signatories of the 1946 Constitution of the World Health Organization had furthermore declared "the enjoyment of the highest attainable standard of health" to be "one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition."⁹⁶ This would presumably apply to Germans as well, despite their past. It would have also been known that the Allies in particular had been key in creating this WHO Constitution. Of all the national delegations to this conference, those of the United States, the Union of Soviet Socialist Republics, Britain, and France had been the largest and most vocal.⁹⁷ And unlike the UN Declaration of Human Rights from which the Soviet Union had famously abstained, the WHO Constitution had seen no abstentions and had been unanimously adopted on 22 July 1946.⁹⁸ Health in this constitution had been defined in rather general and broad terms as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."⁹⁹ What was "social well-being"? This was not exactly defined, though the absence of social well-being, according to the constitution, seemed to merit governmental "social measures" such as the provision of housing.¹⁰⁰ Thus "governments," very explicitly, were charged with the "responsibility for the health of their peoples" and the "provision of adequate health and social measures."¹⁰¹ And lest those governments responsible for health provisions and policies should fail to see the wide-reaching impact, this constitution, similar to Potsdam and UN provisions, linked health with security and peace, declaring health to be "basic to the happiness, harmonious relations and security of all peoples."¹⁰² Likewise, it agreed with the United Nations Declaration of Human Rights which had provided that while

95 Art. 25 of the Universal Declaration of Human Rights, Dec. 1948: "Everyone has the right to the standard of living adequate for the health and well-being of his family, including food, clothing, housing and medical care"

96 United Nations World Health Organization, *Official Records of the World Health Organization, No. 2: Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference Held in New York from 19 June to 2 July 1946*, (New York and Geneva, 1948), Preamble, 22 Jul. 1946, "Text of the Constitution of the World Health Organization," 100.

97 *Ibid.*, 7–11.

98 *Ibid.*, 93, "Minutes of the 17th Meeting, 22 Jul. 1946." To abide with national constitutions and procedures, most signatures had been made *ad referendum*, or *subject to ratification* by the respective delegates. The only signature marked *with reservation* came from Yugoslav delegate Dr. A. Stampar. *Ibid.*, 115–118.

99 *Ibid.*, Text of the Constitution, Preamble, 100.

100 *Ibid.*

101 *Ibid.*

102 *Ibid.*

the international community was to monitor abundance and, in the case of the WHO coordinate the work of individual governments and NGOs, as well as provide assistance and “promote ... the improvement of nutrition, housing, sanitation, economic or working conditions and other aspects of environmental hygiene,” it was the duty of the individual nation states and their governments to ensure the right to health.¹⁰³ In short, the onus to provide for health and social welfare—the basis of peace at home and peaceful, healthy relations between nations—lay upon individual states and their governments. And again, failure to ensure these most basic rights would indicate a lack of legitimacy.

The increasing Cold War divide played another important role in the connection between health care, living standards and regime legitimacy. As has been shown in the case of hospital beds, or as could be shown in the case of general living and housing conditions, the Allies continuously challenged the legitimacy of one another by pointing to their competitors’ deficiencies. Initially, this was done across the board. Eventually, an East-West divide became prominent. Comparisons between living and health standards became comparisons between different regimes and types of government. Yet while pronounced inter-Allied conflict prevailed among the divisions of manpower, economics, politics or transportation from July 1945 on, within the divisions of housing and health cooperation was the norm until 1947. Though milder than in other areas, competition and smear campaigns were not entirely absent. Both in direct correspondence and via the Berlin municipal offices and even the Berlin press, sometimes in the form of friendly reminders, more often blaming the other side for being ill-guided in their policies and practices, the Allies pointed to health and housing standards in various sectors to position themselves strategically vis-à-vis other claimants for power.¹⁰⁴ Thus the question of public health and housing appeared to be one not just concerning the health of Berliners and the Allied military on location, but one concerning the legitimacy of each of the four Allies.

Why then did they arrive at the idea of welfare and redistribution? Again, similar to the conditions after World War I, this can be explained in part by the idea of the social contract: citizens gave to the state during the war, and afterwards, they expected something in recompense. As previous historians have noted, for example Foucault in the case of Britain: “just at the moment when war was causing wholesale destruction, a society [had taken] upon itself the task of explicitly guaranteeing to its members not only the fact of life but of life lived in good health.”¹⁰⁵ The post-war convergence in welfare ideas had indeed relied heavily on mobilization and its

103 Ibid., Constitution, Art. 2a, 2i; Universal Declaration of Human Rights. Art. 22, 29.

104 Ibid., and NARA OMGUS RG 260, AG 720 Department of Public Health Berlin, December 1945 Report.

105 Michel Foucault, “Crise de la médecine ou crise de l’antimédecine,” *Dits et Ecrits*, v. III (Paris, 1994), 40–58.

subsequent policies during World War II. In the course of the war, states across Europe had become increasingly interventionist regarding basic welfare and health services. And, as historians and political scientists have shown in the past four decades, already during the war economic planning, nationalized services for the mobilized masses, and a rhetoric of national solidarity and common sacrifice had led to some acceptance of the re-distributionist model.¹⁰⁶ The resistance movements across Europe had likewise embraced redistributionist policies for mere survival.¹⁰⁷

And finally, not just for mere governability issues but also from the point of view of the general population, the idea of redistribution had gained support, given not just a history of Nazi appropriation and redistribution but also the uneven destruction and loss of resources. Moreover, now the middle class was affected as well. Welfare models are more likely to be accepted in “homogeneous countries” where “issues of mutual distrust and misuse do not arise so acutely.”¹⁰⁸ Across Europe, the war with its general mobilization, the effects of bombings, and the systematic evacuation of millions, as Mark Mazower and others have noted, had brought together “classes and communities hitherto divided or ignorant of one another.”¹⁰⁹ In the case of Berlin housing this meant that now some members of the middle class lived in overcrowded, unsanitary conditions, sometimes in settings that mixed classes. It was perhaps less in a spirit of class solidarity or even mutual trust than in self-interest that the middle class now also embraced redistribution. For it had turned out that not all housing in the German capital was destroyed. The city was only partially destroyed. And while in some cases Berliners lived in overly crowded conditions, with sometimes more than 10 persons to a room, there was still plenty of undestroyed dwelling space. Once the gaze had moved beyond the immediate destruction which had at first seemed total, it was evident that a good number of Berliners lived well and with ample space. It was not uncommon that only one apartment of a building was rendered inhabitable while the rest remained intact. According to a 1946 Berlin municipal statistic, 19.1 percent of all Berlin housing

106 Jytte Klausen, *War and Welfare: Europe and the United States, 1945 to the Present* (New York, 1998), 2–13; Gordon Wright, *The Ordeal of Total War 1939–1945* (Prospect Heights, 1997), 234–267.

107 Ibid.; Bradley Abrams, “The Second World War and the East European Revolution,” *East European Politics and Societies*, (Fall 2002), 623–664

108 Tony Judt, “What Is Living and What Is Dead In Social Democracy?,” *New York Review of Books*, v. 56, n. 20, (Dec. 17, 2009).

109 Mark Mazower, *Dark Continent*, 185.

Image 3. Partial rather than total destruction favored a redistributionist approach.



Courtesy of Landesarchiv Berlin/Otto Hagemann, 1947.

was destroyed beyond repair.¹¹⁰ This meant that there was a critical mass of Berliners affected and calling for redistribution. But it also meant that there were still enough resources to be distributed.

Not only Berliners, but also Soviet, American, British and French housing and health officials realized that, given the lack of monetary resources, redistribution would be the route to take.¹¹¹ Reconstruction was not an option in 1945 or 1946. Allied policy-writers, furthermore, had to take into account that their native countries also suffered a scarcity of funds and resources and that any resources going to Germany rather than to their own country would be met with scrutiny.¹¹² At the same time, charged with governing Berlin, the Allies were interested in governabil-

110 “Gebäudezustand nach Beendigung der Kampfhandlungen” in *Mitteilungen des Hauptvermessungsamtes der Stadt Berlin*, 1946.

111 PRO FO 1051/803, Housing Reports I, “Housing in Berlin,” letter Brigadier Ryan to A. E. Joll, 30 Aug. 1945, pp. 1–2; PRO FO 1051/803, Housing Reports I, letter Major H. Nuttall to Lt. Col. J. D. Watt, 6 Sep. 1945.

112 CArch, Groupe Française de Conseil de Contrôle [1945–1948], Caisse No. 3272, Carton No. P32. Correspondence GFCC Division Travail – Commandement en Chef Français en Allemagne – Com[m]ité de Logement, Letter C. Dechamp to Colonel Blachere, Berlin-Frohnau, 15 Sep. 1945; NARA RG 260 OMGUS 1945–46 AG 720, Jan. 1946 Report.

ity and wanted Berliners content. Already in the fall of 1945, they had contemplated state-directed reallocation of resources, noting “there should be a complete survey made by sector and redistribution of population before [the] end [of] October for a) overcrowding, pure and simple, b) damaged conditions, c) unhealthy conditions.”¹¹³ While such redistribution proved a complicated affair, the ideas soon took hold in laws as well. As a result, for example, taxes for hospitals and building reconstruction were levied, and the joint Allied housing legislation of 1946 already included the idea of redistribution. The law justified this policy by noting that rights for living standards should be universal and available to all.¹¹⁴ This basic premise of redistribution, not mere reconstruction, lay at the foundation of postwar Germany and would be continued after 1949 in both German states.¹¹⁵

Conclusion

As the European health and welfare models are being re-evaluated in our own time, it may be good to remind ourselves of the circumstances under which they evolved. The physical context, the debris coupled with a massive population flux, as well as an acute housing and health crisis, played an important role. The evidence of the Berlin case furthermore points to a physical setting in which Allies and local populations were aware of the commonality of the context beyond the confines of Berlin. In Berlin, they worked with each other, exchanging ideas and letters, visiting each other, founding think tanks on health and housing problems as they considered a problem shared by all. They likewise were part of an engaged global human rights discourse which came as a response to the racist, exclusivist policies of the National Socialists and which set out to make health rights universal. This is the positive view.

However, housing and health considerations and policies were not primarily motivated by a common concern about the well-being of the populations. Allies and local population alike heavily relied on a war-time tradition of state involvement and planning in regard to public health and housing. In other words, they continued along interventionist structures which had roots in earlier welfare policies, not least those established during World War II. Despite their bleak outlook on the shambles around them, Europeans had expectations vis-à-vis their governments. Finally, as this paper has argued, the postwar interventionist consensus was

113 PRO FO 1051/803. Major Nuttall Report, “Notes on Visits to Various Premises in Berlin on 10. Sep. 1945,” pp. 1–2.

114 PRO FO1051/720, Housing Law 18, Allied Kommandatura Decree, March 1946.

115 See for example Paul Betts, “Building Socialism at Home: The Case of East German Interiors,” in *Socialist Modern: East German Everyday Culture and Politics*, eds. Katherine Pence and Paul Betts (Michigan, 2008), 96–132.

driven by Allied and German administrators' search for political order, security and legitimacy at a time in which these were deemed painfully absent.

The late Historian Tony Judt has reminded us to pay attention to the significance of the early postwar period across Europe as one in which the groundwork for the latter half of the twentieth century was laid.¹¹⁶ And he has reminded us of the conditions at the time: in these first postwar years, most Europeans did not expect a bright future.¹¹⁷ The world to them was threatening, unclear and disordered. All across Europe, cities and entire societies were in shambles.¹¹⁸ Almost all European countries shared a severe housing crisis. And in all settings, not least in the case of Berlin, war and catastrophe as well as the immanent danger of epidemics and unrest gave rise to discussions about the ideal redistribution of space and power, about a new order, and about the prevention of future calamities, not least of all aggressive nationalist politics and the rise of yet another Hitler.

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116 Tony Judt, *Postwar: A History of Europe Since 1945*.

117 *Ibid.*, 3, 13.

118 *Ibid.*, 13-40.

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Juvenile Delinquency in Romania: The Indirect Result of the Transition Process

Andrea Fabian

When we try to discover the problems associated with juvenile delinquency should be very attentive towards the social, demographic, economical, and political situation of a certain society. Without these issues we would not be able to draw a real picture about the considered phenomenon, neither related to its qualitative, nor related to its quantitative evolution. In the same time represents an absolute necessity to consider the psychological factors of juvenile delinquency, as far as there are both social and psychological aspects involved into the phenomenon.¹ Meanwhile is not less interesting how a society perceives the phenomenon and what thinks about the causes of juvenile delinquency. The paper follows these directions.

The Geography and Socio-Demography and the Economical and Political Context of Romania

Romania is situated in the South-Eastern part of Central Europe, with the Carpathian Mountains at the North and the Danube at its Southern border exiting to the Black Sea. Population estimates from 2006 revealed 21.58 million inhabitants, representing a 5.4% reduction from 1992.

This population decline corresponded with a decline in fertility and birth rates and an increase in the death rate. In 2006, the female population constituted 51.3% of the total population and the proportion of the population aged 0–14 years was 15.4%, while those aged 65 years and older represented 14.7% of the total population. Annual population growth has been negative: -2.8/1000 inhabitants in 2002, the lowest since 1989. The value remained negative but there was a trend to decrease the size of this negative value. In 2006, the population growth recorded was -1.8/1000 inhabitants.² The urban population was 55.1% in 2006.

1 Carey, 1992; Miroiu, 2002; Mitrofan, N., Zdreghea, V., Butoi, T. 1994; Morash, M., Rucker, L. 1989; Brantingham, P.J., Brantingham, P.L., 1991, Adler, 2000.

2 Ministry of Public Health, 2007a.

Table 1. Population/demographic indicators, 1948–2006.

| | 1948 | 1956 | 1966 | 1977 | 1992 | 2002 | 2006 |
|---|-------|-------|-------|-------|-------|-------|-------|
| Total population (millions) | 15.87 | 17.49 | 19.10 | 21.55 | 22.81 | 21.69 | 22.81 |
| Women (% of population) | 51.7 | 51.4 | 51.0 | 50.7 | 50.9 | 51.2 | 51.3 |
| Population aged 0–14 (% of total) | – | 27.5 | 26.0 | 25.4 | 22.4 | 17.4 | 15.44 |
| Population aged 65 and above (% of total) | – | 6.3* | 7.9* | 9.7 | 11.1 | 14.0 | 14.68 |
| Population density | 66.6 | 73.4 | 80.1 | 90.4 | 95.7 | 90.9 | 90.52 |
| Fertility rate (births per woman) | – | – | – | – | 1.5 | 1.3 | 1.3 |
| Birth rate (per 1000) | 23.9 | 24.2 | 14.3 | 19.6 | 11.4 | 9.7 | 10.2 |
| Death rate (per 1000) | 15.6 | 9.9 | 8.2 | 9.6 | 11.6 | 12.4 | 12.0 |

Source: National Institute of Statistics, 2006; a Central Directory of Statistics, 1969; Vlădescu, C., et al., 2008.

Table 2. Urban and rural distribution of the population, 1992, 2002, 2004, 2006.

| | 1992 | 2002 | 2004 | 2006 |
|--------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | No. (%) | No. (%) | No. (%) | No. (%) |
| Total | 22 810 035 (100.0) | 21 698 181 (100.0) | 21 673 328 (100.0) | 21 584 365 (100.0) |
| Urban | 12 391 819 (54.3) | 11 436 736 (52.7) | 11 895 598 (54.9) | 11 913 938 (55.1) |
| Rural | 10 418 216 (45.7) | 10 261 445 (47.3) | 9 777 730 (45.1) | 9 670 427 (44.8) |

Source: National Institute of Statistics, 2007; Vlădescu, C., et al., 2008

Since the revolution of 1989, Romania has gone through a period of rapid and major change in every sector, though the process of economic reform has been gradual rather than radical. Transition has generated an acceleration of poverty, social stratification and exclusion. Most incomes decreased in purchasing power, which has especially injured young families and those with more than one child to raise.³ Non-contributory social benefits deteriorated sharply with child allowance reaching its lowest level in 1996 at 28.6% of its 1989 value.⁴ Various measurements, using different methodologies, indicated the proportion of Romanians living in poverty between 22%⁵ and 39% in 1994,⁶ compared with about 6% in 1989.⁷ After the failed stabilization plan of 1997, Romania went through a second deep transitional recession (the first transformation recession was between 1990–1992), but in 2000, a modest economic recovery was seen and after 2004 we could see an economy recovery. Unemployment is concentrated in urban areas: 8.9% (rural

3 Ehrke, M., 2004.

4 Giles, 2002, 204.

5 World Bank.

6 C. Zamfir, 1995, Milanovic, 1995.

7 Giles, 2002.

Table 3. Unemployment rate 1996–2005.

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|--------------------|------|------|------|------|------|------|------|------|------|------|
| Total (%) | 6.6 | 8.9 | 10.4 | 11.8 | 10.5 | 8.8 | 8.4 | 7.4 | 6.3 | 7.2 |
| Of which woman (%) | 7.5 | 9.3 | 10.4 | 11.6 | 10.1 | 8.4 | 7.8 | 6.8 | 5.6 | 6.4 |

Source: National Institute of Statistics, 2007; Vlădescu, C., et al., 2008

4.3%). However, it is important to note that the measurement of employment may be inaccurate to some extent.

Following the dramatic collapse of the economy and slow recovery during the transition period, social disparities and wealth inequalities increased rapidly. According to the constitution approved by referendum in December 1991, Romania is a republic in which the rule of law prevails in a social and democratic state with separation of powers. The constitution also guarantees private property rights and a market economy. Romania experienced significant political transformations after 1989, changing from the monopoly of a single party to a diversity of political parties. Romania is a member of the United Nations, the Council of Europe, the World Trade Organization, NATO and, since 1 January 2007, the EU. The Government of Romania has ratified a range of international human rights treaties recognizing the right to health and other health-related rights, including the:

- the Convention on the Rights of the Child (CRC). It has also ratified regional human rights treaties including:
- the Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms and its Protocols,
- the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, etc.⁸

The transition from a centralized system to a democratic one and to the market economy in Romania entailed a lot of social problems. The economic decline, enterprises restructuring, unemployment, widening disparities in different domains, sharpening of external migration, etc., had unfavorable consequences on family lives and, not in the least, on children condition. The sharpest impact was on the families with more children, who faced great difficulties in assuring subsistence means, in children growing up and education. This generated family and school abandon trends, which represent major causes for the proliferation of certain phenomena, such as “institutionalized children” and “children of the streets” and, implicitly, for the amplification of pre-delinquency and juvenile delinquency trends.

8 . Vlădescu, C., et al. 2008.

Table 4. The age of criminal responsibilities in different countries

| The age of criminal responsibility | Country |
|------------------------------------|---|
| 10 | England, France, Wales |
| 12 | Cyprus, Greece, Scotland, the Netherlands, Ireland (until 2006, the age of criminal responsibility was 7 (!)) |
| 14 | Austria, Bulgaria, Estonia, Germany, Hungary, Italy, Latvia, Lithuania, Slovenia and Spain, Czech Republic (from 15 to 14 in 2005), Romania |
| 15 | Denmark, Finland, Italy, Slovakia and Sweden |
| 16 | Belgium, Luxembourg, Poland and Portugal |

Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006

Psychologists object that imposing harsher punishments on young criminals will not solve much unless societal roots of this problem are addressed. In order to the Romanian Law, the underage child who did not turn 14 is not criminally liable; the underage child between 14 and 16 is criminally liable, only if it is proved that he committed the crime with power of judgment, but the underage child who has turned 16 is criminally liable.

For assessing the rate and particularity of juvenile delinquency in Romania after 1989 (the post revolutionary period), we used data from:

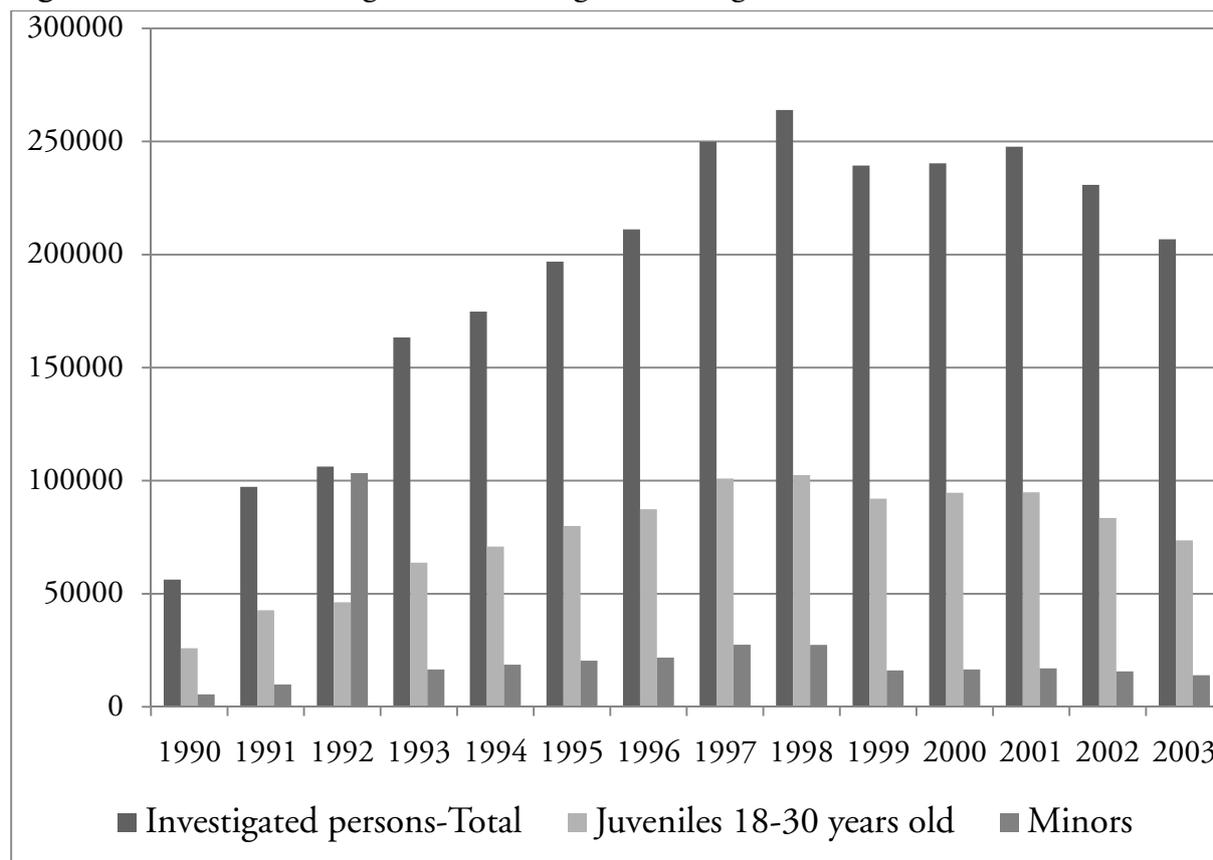
- Police General Inspectorate,
- National Committee for Statistics,
- Ministry of Justice,
- The Direction for Social Reinstatement and Supervision,
- Forensic Medicine from Cluj-Napoca,
- National Reports,
- International Reports.

During 1989–2003, 237.259 minor delinquents have been identified, which means an annual average of 16.947 minor delinquents identified. The biggest number of minor delinquents has been registered in 1998, when 27.382 minor delinquents have been identified. After 1998 the number of minor delinquents has lowered reaching to 15.670 in 2002 and 13.961 in 2003.

The specific crime rate of juveniles between 14 and 17 years (as ratio between the numbers of crimes committed by persons belonging to this age group and the population of the respective group, on July 1st) is very high and significantly higher than the crime rate calculated for total population.

The evolution over time shows that after a decrease between 2000 and 2004, there was an increase in 2005, under the conditions where total crime rate fell from 1.577 cases per 100,000 inhabitants in 2000, to 963 cases in 2005.

Figure 1. Persons investigated according to their ages (1990–2003)



Source: Figure 1–4 were made by the author based on the results of the applied statistical tests on the data from *Anuarul Statistic al României* (Romanian Statistical Yearbook) 1990–2005, Chapter 18, 18.2, 18.3, 18.4, 18.5, 18.9.

Table 5. Number of crimes committed by and with the participation of juvenile offenders 2000–2005.

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|----------------------------------|--------|--------|--------|--------|--------|--------|
| Total | 353745 | 340414 | 312204 | 276841 | 231637 | 208239 |
| In ages 14–17 years | 25470 | 23511 | 21460 | 19167 | 18826 | 18578 |
| Weight in total crimes, % | 7.2 | 6.9 | 6.9 | 6.9 | 8.1 | 8.9 |

Source: Panduru, F., Pisičă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.14.

Table 6. Total and juvenile crime rates 2000–2005.

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|--------|--------|--------|--------|--------|--------|
| Total crime rate¹ | 1.577 | 1.519 | 1.432 | 1.274 | 1.069 | 963 |
| Specific crime rate for children between 14–17 years² | 1985.7 | 1745.9 | 1542.6 | 1380.1 | 1345.6 | 1444.0 |

¹per 100000 inhabitants; ²per 100000 persons aged 14–17 years (on July 1st)

Source: Panduru, F., Pisičă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.15.

Most of the crimes committed by children belong to the category against the patrimony (property): theft, robbery, destroys, etc., which held a weight around 70% of total infringements committed by children. However, during last years, an

Table 7. Number and distribution of crimes committed by or with the children's participation (0–17 years), by main categories, 2000–2005.

| Year | Number | | | | | Distribution (total=100.0) | | |
|------|--------|---------------------|-------------------|--------|--------|----------------------------|-------------------|--------|
| | Total | Of which | | | Others | Against persons | Against patrimony | Others |
| | | Against persons | Against patrimony | Others | | | | |
| | Total | Of which, homicides | | | | | | |
| 2000 | 26.170 | 957 | 29 | 20.052 | 5.161 | 3.7 | 76.6 | 19.7 |
| 2001 | 24.289 | 1.033 | 28 | 18.144 | 5.112 | 4.3 | 74.7 | 21.0 |
| 2002 | 22.135 | 983 | 33 | 13.144 | 5.008 | 4.5 | 72.9 | 22.6 |
| 2003 | 19.801 | 878 | 36 | 14.394 | 4.529 | 4.4 | 72.7 | 22.9 |
| 2004 | 19.732 | 1.157 | 36 | 13.892 | 4.683 | 5.9 | 70.4 | 23.7 |
| 2005 | 19.728 | 1.454 | 32 | 13.24 | 4.850 | 7.4 | 68.0 | 24.6 |

Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.15

increase in the number of crimes against the person was recorded (as well as of their weight in total crimes committed by children), particularly for those related to sexual life. In 2005, as compared to 2003, the number of crimes against persons rose by 65%.

Two categories of special protection measures are stipulated by law for children who have penal responsibility: punishments and educative measures.

The number of irrevocably convicted juveniles oscillated during 1990–2003 between 1983 persons in 1990, to 6738 persons in 2000, to 7005 persons in 2002 (when the highest level was recorded) and to 6820 in 2003.

Most of irrevocably convicted juveniles (81 - 85% during 2000–2005), were convicted for crimes against patrimony, a fact which is linked, among others, to the precarious economic situation of many families with children from Romania.

The types of sentences applied to irrevocably convicted juveniles were changed – in terms of structure – beginning with 1999. The most obvious change refers to the fact that the number of persons convicted to imprisonment significantly fell.

During 2000–2004, the total number of those sanctioned with educative measures (in case of children who not reach 16 years of age) significantly decreased (with 794 children, respectively about 40%), while an increase with 1.495 persons was recorded in 2005.

Figure 2. Irrevocably convicted minors between 1980-2003



The convictions for crimes against persons hold a weight of about 9 – 11% of total, thus drawing the attention on the danger of violent behaviors juveniles.

Table 8. Distribution of irrevocably convicted juveniles, by type of crime (%), 2000–2005.

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|----------------------------|-------|-------|-------|-------|-------|-------|
| Total persons | 6.738 | 67.26 | 7.005 | 6.820 | 6.341 | 6.796 |
| Out of which (in %) | | | | | | |
| - against persons | 8.8 | 8.9 | 9.1 | 11.3 | 10.8 | 9.3 |
| - against patrimony | 84.6 | 83.4 | 83.1 | 81.0 | 81.4 | 83.8 |
| - others | 6.6 | 7.7 | 7.8 | 7.7 | 7.8 | 6.9 |

Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.15.

The rate of irrevocably convictions for juveniles – all punishment types, per 100,000 persons aged 0–17 years, had an oscillatory evolution, from 133.4 in 2000, to 154.3 in 2005, recording much lower values as compared to irrevocably convictions rate for the population as a whole. On the contrary, the rate of irrevocably convictions specific to underage persons of 14–17 years recorded higher values as compared to the one for total population.

During 2000 – 2005, the weight of juveniles convicted to freedom deprivation punishments in the total number of underage persons irrevocably convicted decreased. The decrease of this weight was significant for those aged between 16 and 17 years, from 68.1% in 2000 to 35.1% in 2004 and 2005. As for those aged

Figure 3. Irrevocably convicted juveniles, by punishment type, 1990–2003.

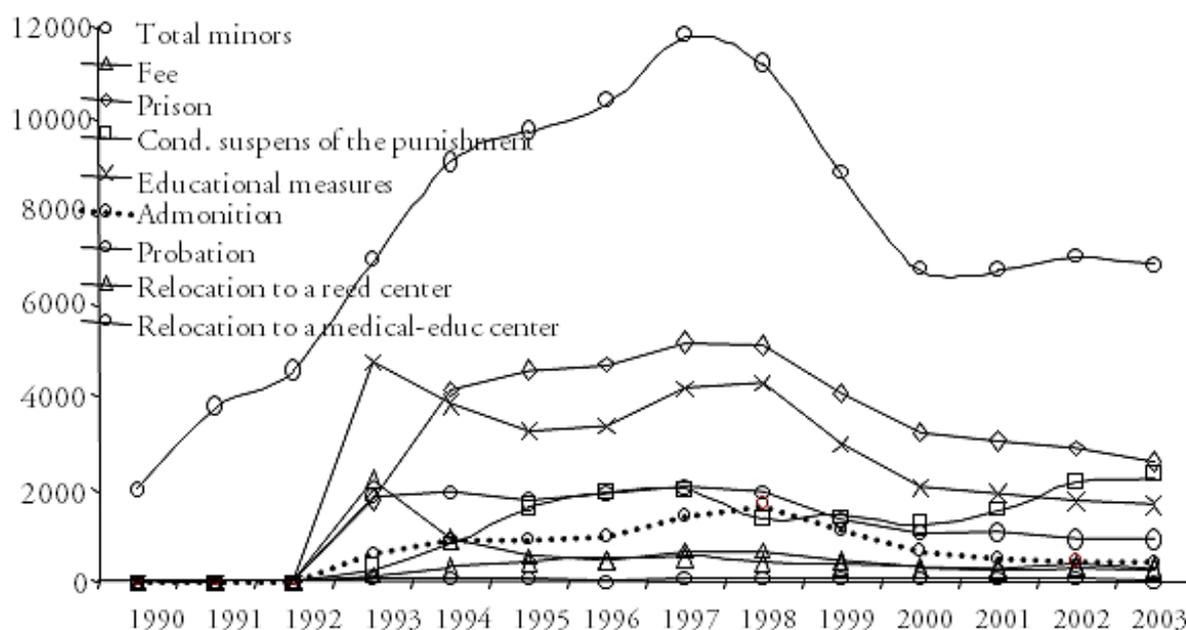


Table 9. Rate of irrevocably convictions, by main types of punishments, 2000–2005.

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|-------|-------|-------|-------|-------|-------|
| Romania | | | | | | |
| Total | 336.0 | 370.0 | 375.0 | 353.0 | 320.0 | 304.0 |
| - punitive punishments ¹ | 224.0 | 275.9 | 287.9 | 280.0 | 262.2 | 248.8 |
| - imprisonment | 167.9 | 150.6 | 149.2 | 142.3 | 117.3 | 104.8 |
| Rates for juveniles² | | | | | | |
| Total | 133.4 | 135.5 | 145.4 | 145.7 | 139.1 | 154.3 |
| - punitive punishments ¹ | 87.7 | 92.1 | 103.6 | 104.0 | 94.6 | 101.5 |
| - imprisonment | 63.6 | 61.4 | 59.6 | 55.0 | 39.4 | 42.2 |
| Specific rates for juveniles³ | | | | | | |
| Total | 525.3 | 499.5 | 503.5 | 491.1 | 453.2 | 528.2 |
| - punitive punishments ¹ | 345.1 | 399.7 | 359.0 | 350.4 | 308.1 | 347.7 |
| - imprisonment | 250.3 | 226.5 | 206.6 | 185.6 | 128.2 | 144.6 |

¹ Refer to: imprisonment, conditional reprieve, reprieve of punishment under supervision; ² per 100000 persons of 0–17 years; ³ per 100000 persons of 14–17 years. The population number for indicators computation represents the population on July 1st

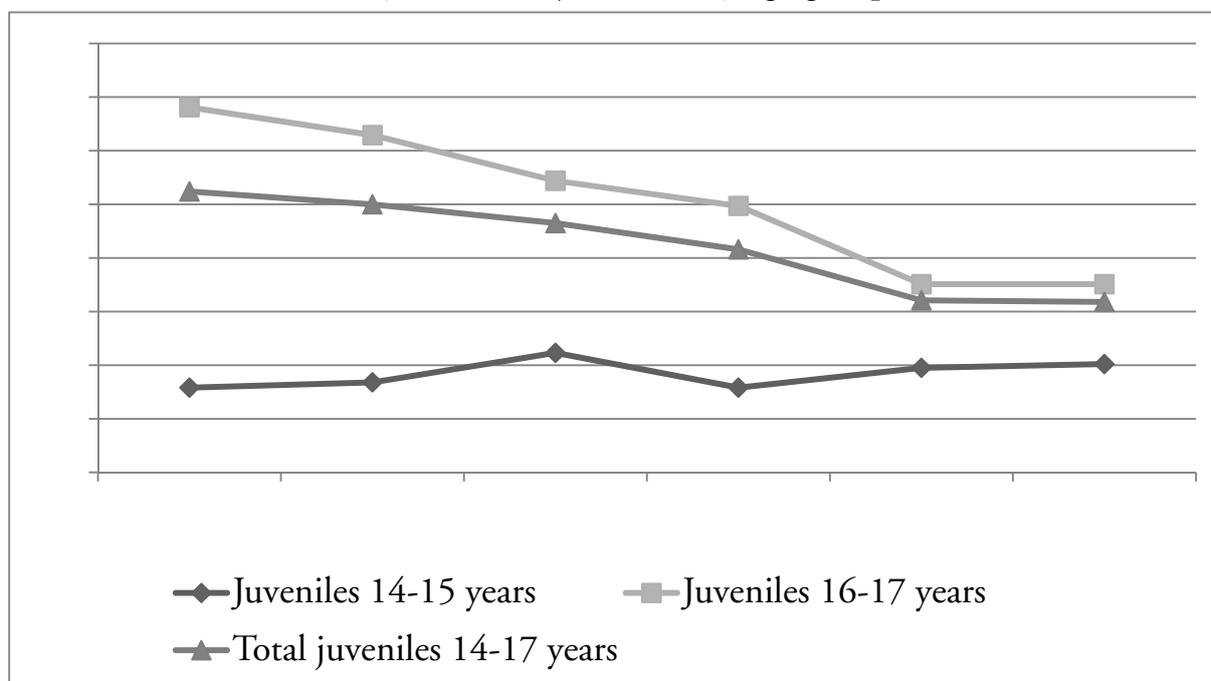
Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.19.

Table 10. Number of children for whom educative measures were applied, by type of punishment , 2000-2005

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|--|-------|-------|-------|-------|-------|-------|
| Total, Of wich: | 2.023 | 1.880 | 1.722 | 1.639 | 1.229 | 1.495 |
| - reproof | 684 | 512 | 452 | 466 | 453 | 491 |
| - freedom under supervision | 1,019 | 1,058 | 886 | 914 | 537 | 702 |
| - internment in a reformatory centre | 291 | 277 | 361 | 247 | 135 | 298 |
| - internment in a medical-educative centre | 29 | 33 | 23 | 12 | 4 | 4 |

Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.19

Figure 4. Weight of juveniles convicted to freedom deprivation punishments in total number of irrevocably convicted juveniles, by age group (%), 2000–2005.



Source: Panduru, F., Pisciă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.19.

between 14 and 15 years, this weight oscillated over time, at present being around 20%.

For children *in conflict with law and having penal liability*, in Romania, exists three types of correctional facilities: reformatory centres for underage persons (RCU); penitentiaries for underage persons and youth (PUY); sections within penitentiaries for adults (within most of the penitentiaries for adults sections for underage persons exist, for most of them the trials being ongoing, who are to be afterwards transferred to a RCU or PUY).⁹

9 Panduru et al. 2006.

Table 11. Juveniles in reformatory institutions, at the end of the year, 2000–2005.

| | | | | | | |
|--|-----|-----|-----|-----|-----|-----|
| | 937 | 735 | 743 | 655 | 570 | 593 |
| - in residential reformatory schools (RCU) | 359 | 279 | 238 | 185 | 170 | 261 |
| - in penitentiaries | 578 | 456 | 508 | 470 | 353 | 332 |

Panduru, F., Pisičă, S., Molnar, M., Poenaru, M., *Children in conflict with the law in Romania*, MONEE Country Analytical Report, November 2006, p.23

The total number of juveniles placed in reformatory institutions (at the end of the year) decreased from 2000 to 2004, from 937 persons to 570 persons, slightly increasing in 2005 as compared to previous year, to 593 persons.

During 2000 – 2005, the sharpest decrease was recorded for those from penitentiaries (246 persons, respectively over 40%). A significant decrease was also noticed for those from residential reformatory schools, from 359 to 170 in 2004, afterwards increasing to 261 in the next year (by 53% as compared to previous year).

Psychological particularities of juvenile delinquents

It is very important to underline the importance of psychological processes for youth ending up in delinquent behavior. In the transition period the society was characterized by less inner control and less outer control. In such conditions it was obvious that we will find some psychological particularities on delinquent's behavior.

The presentation is based on an extensive study of 420 prisoners from Gherla Extreme Safety Prison and External Section from Cluj-Napoca (210 of them are between 14-18 years old and 210 are between 19-21) chosen at random and other 420 persons from the control group (half of them between 14-18 and half between 19-21) chosen by the methods of pattern stratification, who were tested with the following psychological tests:

1. Nowicki & Strickland's Internal-External Control Scale for Children
2. McGuire & Priestley's Testing Your Reaction,
3. Zuckerman-Kuhlman's Personality Questionnaire ¹⁰

The results were compared with previous research data on Romanian population. In case of the psychological factors we used t test to check if there is any differences between the two groups (see table 12).

¹⁰ Kurko-Fabian, 2006, Fabian, 2007.

Table 12. Differences between the delinquent and control group regarding the psychological factors.

| Psychological factor | Delinquent | Average | t-value | Df | Significance |
|----------------------|------------|---------|---------|-----|--------------|
| Self control | Yes | 17.28 | 19.03 | 838 | 0.000 |
| | No | 12.33 | | | |
| Impulsivity | Yes | 19.17 | 7.22 | 838 | 0.000 |
| | No | 15.93 | | | |
| Sensation seeking | Yes | 9.62 | 19.00 | 838 | 0.000 |
| | No | 5.87 | | | |
| Sociability | Yes | 7.67 | -2.53 | 838 | 0.011 |
| | No | 8.08 | | | |
| Activity | Yes | 11.33 | 6.40 | 838 | 0.000 |

Source: This and the following table were made by the author using statistical methods on data from the following source: Police General Inspectorate and Forensic Medicine from Cluj-Napoca

Table 13. Psychological factors, a measure of delinquency related to the number of committed crimes (standardized regression coefficients, significance). Dependent variable: the number of committed crimes.

| Independent variable | Beta coefficients | Significance |
|----------------------|-------------------|--------------|
| Type of self control | 0.164 | 0.001 |
| Sensation seeking | 0.151 | 0.003 |
| Sociability | 0.108 | 0.022 |
| R square (%) | | 7.7 |

From the above table turns out that: The value of self control is much higher in case of delinquents than in case of the other group (value t: 19.03 at 0.000 significance). Juvenile delinquents are more impulsive than non-delinquents (value t: 7.22, significance: 0.000). There is a difference at the delinquents' advantage concerning the sensation seeking (value t: 19.00, at 0.000 significance). We can say that juvenile delinquents have more pronounced desire for sensation seeking. Delinquents are more active than their non-delinquents mates (value t: 6.40, significance: 0.000); they are less sociable (value t: -2.53, significance: 0.011) than non-delinquent mates, but the more sociable a delinquent is, the more he commits crimes (value Beta: 0.108, significance: 0.022) (see table 13).

As we already said, the transition period was characterized by less inner control and less outer control. We can see its effects on delinquent's behavior: in lack of other possibilities, they live their desire for sensation seeking in criminal acts; of course their high score of impulsivity and activity consolidate this antisocial behavior.

These results confirm the fact that there are significant differences from the psychological point of view between juvenile delinquents and non-delinquents.

Romanian Public Views on Juvenile Crime and Punishment

According to the results of a pilot study made in 2003 in Bucharest, the capital of Romania (on 295 respondents aged 18 and over) there is a mismatch between the “real” juvenile crime trend and the public’s perception of that “reality”:¹¹

1. the majority of respondents (75.9%) believed that juvenile crime was on the increase (as official crime statistics show that juvenile crime declined over the period in question),
2. the overwhelming majority of respondents (91.5%) also substantially overestimated the extent to which juvenile crime involves violence, while underestimating the proportion of crimes involving theft (67.2%) (statistics available at the time of conducting the research¹² show that the vast majority (83%) of juveniles convicted in 2001 were involved in acquisitive crimes (mainly theft) and only 8.8% were convicted for violent crimes).

There are a number of possible reasons why people’s estimations of crime and sentencing figures are so wide of the mark.¹²

1. official crime statistics are inaccessible to the public and often out of date, lack of knowledge is therefore hardly surprising,
2. secondly, as the media are the main source of information, public attitudes are subject to influence by unrepresentative reporting,
3. discrepancies between national and local crime rates could induce differences of opinions.

Interestingly, Chi-square tests indicate that respondents’ level of knowledge about some aspects of juvenile crime differed according to socio-demographic variables:¹³

- Poorer (low income or no income) respondents were more likely to overestimate the proportion of juvenile offenders engaged in violent crimes;
- Younger respondents tended to overestimate imprisonment rates for juvenile offenders;
- The elderly underestimated the imprisonment rates for juvenile offenders who had committed theft and burglary.
- About the role that sentencing has in preventing crime, almost two thirds of the sample (63.6%) believed that sentencing was one of the major factors in preventing crime.

11 Haines, 2007.

12 Ibid., 2007.

13 Ibid., 2007

- Prison was not ranked highly as a first option for reducing juvenile crime (2.4%), nor were more police on the beat (0.6%). By far the most common response to this question was better parenting (48.1%), followed by better discipline in schools (33.8%) and more positive leisure opportunities for young people (20.5%). There was also support for greater use of non custodial sentences, such as community service and probation (see table 14).

Table 14. Best Strategies for Juvenile Crime Prevention

| The first most effective juvenile crime prevention measure | % |
|--|------|
| Improve discipline in the family | 48.1 |
| Increase severity of sentencing | 14.7 |
| Increase the offer for jobs/opportunities for work | 14.7 |
| Improve discipline in schools | 8.9 |
| Increase positive leisure opportunities for young people | 5.1 |
| Increase use of community sentences like probation | 3.8 |
| Increase use of imprisonment | 2.4 |
| Increase use of community sentences like community service | 1.7 |
| Increase numbers of police officers | 0.6 |
| Other measures | - |

Source: Haines, A. (2007): Juvenile crime and punishment in Bucharest, Romania: A Public Opinion Survey In. *Internet Journal of Criminology*

General Conclusions About the Juvenile Delinquency as the Indirect Result of the Transition Process

The communist period was characterized by poverty, meanwhile, mostly after 1990 new possibilities have appeared. Thus, a Mertonian situation occurred, which meant that albeit there were clear goals and targets, the legitimate instruments for their achievements were missing. Given this missing link, a category of the population made use of illegitimate instruments for goal-achievements. Such people enriched the lines of the delinquents.

Another important factor is represented by social mobility. Due to the modernization process, many rural inhabitants have migrated to cities. This horizontal mobility meant in many of the cases, the impossibility of social integration, the sentiment of rootless, and the missing link between the goals and instruments for their achievement. These facts resulted also in delinquency. Many youngsters with rural origin became urban delinquents. The results of our research show the fact that the preferred area of minor delinquents is the city (the number of crimes committed by minors in 1990 was 43.426 in urban area, and 20.571 in rural area and in 2000 was 224.236 in urban area, and 129.135 in rural area) from the total crime, because represents a space that besides opportunities offers them anonymity.

The city is a favorable place for the formation of delinquent gangs. Young people who are not supervised neither by their family, nor by the community in which they live, those who abandon the school and spend the most of their time on the streets, and lack any other form of occupation are attracted by the opportunities of this way of life.

Our research results confirm the fact that there are significant differences from the psychological point of view between juvenile delinquents and non-delinquents (they have much higher value of self control (value t: 19.03 at 0.000 significance), they are more impulsive (value t: 7.22, significance: 0.000), they are more characterized by sensation seeking (value t: 19.00, at 0.000 significance), they are more active (value t: 6.40, significance: 0.000) and they are less sociable (value t: -2.53, significance: 0.011) than their non-delinquents mates.

About the public opinion regarding the juvenile crime and punishment it would be wrong to characterize the Romanian public as being highly punitive in respect to juvenile crime and sentencing. In contrast to judicial practice in Romania, there is public support for community based sentencing alternatives for juvenile offenders, especially those committing minor offences. The public do not have a great deal of confidence in the ability of the courts to prevent crime. They believe that preventing juvenile crime is more a question of changing the family and school environment and increasing the chances of gaining employment and providing opportunities for young people to spend their spare time positively, rather than stressing more imprisonment or police on the beat. However, this does not mean the public see no role for sentencing in preventing crime.¹⁴

In conclusion we can say that the communist regime as a totalitarian and repressive system has inhibited criminality. During the transitional period laws were ignored, the population was not afraid from the police which loose its dignity due to the illegitimate acts of the former, communist 'militia'.

Democracy is vulnerable because is permissive regarding individual freedom. The direct consequence of this wrongly interpreted freedom was the rising tendency in criminality.

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14 Ibid., 2007.

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The Social and Economic Effects of Deterioration in Health: 'Naked-eye' Evidence from a European Panel Survey

Antigone Lyberaki and Platon Tinios

A Naked-Eye Approach to the Mobilization of Societal Reserves

Social solidarity and cohesion are often extolled and frequently theorized. Especially in times of hardship the mechanisms of social solidarity by providing help where that is needed comprise the social safety net. Much of the literature comparing and contrasting the European and US experiences of growth models lay stress on the key importance of European Social safety nets as a factor differentiating Europe and explaining some of the salient differences.¹ Similarly, within Europe, important streams of literature concern themselves with providing typologies of Welfare states and systems.²

To complement this theoretical difference it is important to see the mobilization of social reserves in action as applied to individuals. To examine, in other words, concrete cases where social support systems are called to serve an apparent and indisputable need. This paper examines one particular class of such events, where a clear instance of need arises, in order to discern what responses are called forth. The same event is examined in a random sample of cases across Europe in order to try to discern patterns of similarity and difference of response in different institutional (and national settings). The case of 'need' examined is that of the onset of sudden and serious illness in older individuals (between 50 and 80) across Europe. Such cases would certainly fulfil any definitions of 'deserving need', while the fact that information is available on specific individuals identified to have suffered serious deterioration in their health status between the two waves of panel survey allows us to correlate responses and consequences in a systematic manner. In doing so, it is

1 Alber, 2006; Boeri, 2002; CEC, 2002; Sapir, 2005.

2 Esping-Andersen, 1990, 1996; Ferrera, 1996.

possible to see how responses in different social protection systems would differ in practice.

The social protection systems identified in the literature³ are the Anglo-Saxon, the Nordic and the Continental. Ferrera (1996) further distinguishes the Mediterranean as a distinct category within the conservative typology.

To approach this rather complex issue is certainly an ambitious undertaking, and exploits the availability of individual data from the European panel survey of persons aged 50+. The Survey of Health and Retirement in Europe (SHARE)⁴ allows us to begin an approach towards this undertaking. The SHARE data combines *four* qualities that, uniquely, allow an explicit consideration of many questions.

1. It contains data referring to individuals. Working at the level of the individual, we are able to pick out social support responses of an informal nature which are seldom captured in macro, system-wide data. SHARE has data for 30 thousand individuals spread out over 12 countries (in the first wave⁵).
2. There is an explicit time dimension. The data set is a panel, i.e. the same individuals were interviewed in 2004 and again in 2007/8). This allows the identification of cases where an illness or health condition first appeared in 2007 –i.e. to spot cases of the onset of health problems. In such cases it is possible to disentangle the before and after of the illness, to separate cause from effect.
3. The questionnaire is multidisciplinary in construction. Given that responses to illness will call forth reserves and have consequences on the family, society and economy, data must be open to insights from the disciplines of medicine, economics, sociology, psychology. Indeed the SHARE questionnaire was fashioned as multidisciplinary exercise with this necessity in mind.

3 Such as in the work of Esping-Andersen, 1990, 1996.

4 SHARE offers a valuable source of information on economic, health and social issues while allowing international comparisons on the basis of a common interview material covering 30,000 individuals aged over 50 in 11 European countries (Börsch-Supan et al., 2005, www.share-project.org). The SHARE data collection has been primarily funded by the European Commission through the [5th framework programme](#) (project QLK6-CT-2001- 00360 in the thematic programme Quality of Life) and through the [6th framework programme](#) (projects SHARE-I3, RII-CT- 2006-062193, and COMPARE, CIT5-CT-2005-028857). Additional funding came from the [U.S. National Institute on Aging](#) (U01 AG09740-13S2, P01 AG005842, P01 AG08291, P30 AG12815, Y1-AG-4553-01 and OGHA 04-064, IAG BSR06-11, OGHA04-064).

5 In the second wave further data have been collected in Czech Republic, Poland as well as Ireland. The third wave will collect data in sixteen countries in 2008-2009 (Börsch-Supan et al., 2008).

4. There must be comparability across countries. This comparability goes beyond a consistent translation of the language of the questionnaire and proceeds to comparability of concepts. Indeed international comparability was one of the key concerns of SHARE from the outset. The wide international dispersion allows consideration of Mediterranean countries (Spain, Italy and Greece), Continental European countries relying on social insurance (Austria, Germany, Belgium, France and Switzerland) and Nordic (Sweden and Denmark). Given the similarity in social protection system the Netherlands is included (for the purposes of this paper) in the Nordic group.⁶

This paper first identifies the cases of direct health deterioration between the two waves of SHARE in all 11 countries that have data for both waves. In doing so a tradeoff must be struck between similarity (and seriousness) of condition and sample size. A group of 2 thousand individuals spread equally across the three welfare state regimes between 50 and 80 who have seen deterioration in their health is thus identified; this identification of this group allows the analysis to proceed.

Having identified a group the analysis of this paper, proceeds by an impressionistic approach, relying on descriptive statistics and simple comparisons to identify general areas of similarity and/ or difference. The object of this 'enterprise' is to give an overview and brief characterization of the problems faced by different individuals in different parts of Europe when confronted by similar problems. Such a 'naked eye' approach should pick up major effects and, by spreading the net widely and impressionistically, could identify large cross-cutting effects. It is thus left for subsequent more focused analyses to probe further by isolating specific areas and examining particular hypotheses in depth.

The analysis then proceeds by examining direct health consequences – physical deterioration most obviously but also mental health. The contacts with the health system are then examined both in terms of frequency and of out-of-pocket expenses. Implications outside the health area are the subject of the last two sections: labour force participation is a very live issue for the group 50-64 who are on the threshold of retirement anyway.

The area of social consequences is touched upon by seeing whether health deterioration can call forth a response in informal care received from outside the household. The tentative conclusions bring to a close the naked-eye analysis by suggesting avenues of further study.

⁶ SHARE was consciously designed to be comparable with the Health Retirement Survey (HRS) of the US and the English Longitudinal Study on Ageing (ELSA) (Börsch-Supan and Jürges, 2005; Meijer et al., 2008)

This kind of evidence documents the contact of a random sample of the population with the health system in a wide selection of health care (and social policy environments), faced with similar challenges. This contemporary evidence may be thought to encapsulate the integral of key policy and social changes taken over long periods as they impinge on individuals over 50 years of age. It thus, by providing illustrations of actual operation of health systems on a controlled sample of the population, it may aid understanding of health systems themselves.

Identifying Health Deterioration

The object of the analysis is to identify a group in the SHARE longitudinal sample who, between the first and second wave of the study, have obviously suffered a sudden and serious health deterioration that disturbs programs and forces changes in the rhythms of daily life. It was thus decided to limit our attention to individuals younger than 80 years of age; over 80 years health deterioration is much more common and hence, one would presume, anticipated. The lifestyles of respondents of individuals 80+ are already geared to the anticipation of health deterioration and thus the onset of illness can be expected to lead to different effects. Moreover, the possibility of returning to the pre-deterioration physical, social and economic situation is presumably very different for the over- and under-80s. Similarly, the event of a death between the first and second wave has important effects on those left behind, which however can be expected to be different than an illness⁷. For some analysis though the effect of illness on the life and decisions of the (healthy) spouse is examined separately.

The definition of health deterioration has to walk a tightrope: on the one hand the health conditions should be, as far as possible, similar in their wider economic and social implication, which implies a threshold of 'seriousness' and possibly a grouping of similar conditions. Moreover, they would have to satisfy the criterion of 'suddenness' – i.e. it should be something that did not exist in the first wave. On the other hand, and crucially, one must be mindful of securing sample sizes that allow statistical inference to proceed. Given that the group of 50-80 year-olds contains two separate subgroups: (a) People aged 50-65 for whom participation in employment or gainful activity if not a reality is at least a live option. (b) Those aged 65+ who have mostly severed their links with the labour market.

⁷ In the case of death in the SHARE sample, the deceased's family or other informed persons are asked to complete an 'Exit interview'.

The definition finally settled on relies on a combination of observed major illness and deterioration in self-perceived health. Thus the selecting algorithm selects an individual as having suffered health deterioration if:

- Either he/she declares in the second wave that he/she suffered any of 4 illnesses between 2004 and 2006/7: Heart attack, Stroke, Cancer, Hip fracture.
- Or, he/she experienced deterioration in rating of Self-Perceived Health (SPH): All those whose estimation of their status changed to “Poor” or whose SPH was reduced by more than two scales.

Thus in the question that asked interviewees about their current health status, the possible answers range from: “excellent”, “very good”, “good”, “fair” and “poor” according to the self-perceived health based on US version (SPHUS). Using this information for wave 1 and wave 2, we define deterioration in health status if:

- a person was in **excellent** health in wave 1 and now is in **fair** health status (-3 scales)
- a person was in **excellent** health in w1 and now is in **poor** health status (-4 scales)
- a person was in **very good** health in 1 and now is in **fair** health status (-2 scales)
- a person was in **very good** health in w1 and now is in **poor** health status (-3 scales)
- a person was in **fair** health in w1 and now is in **poor** health status (-1 scales for those already in less than good health).

Finally, in order to maximize sample sizes it was decided to segment the sample not by country but instead to group countries according to typology of welfare states. Thus all results are reported in terms of “Nordic countries” (Sweden, Denmark, Netherlands), “Continental countries” (Germany, Belgium, France, Austria, Switzerland) and “Southern countries” (Spain, Italy, Greece). This typology apart from geographical criteria and characteristics of the social protection systems⁸ can be further justified with two arguments: First, significant differences are known to exist across European countries regarding institutional care and home help services targeted to elderly persons. For instance, Bettio and Plantenga (2004: 98-99) document that the Mediterranean countries exhibit the lowest rates of residential and community services for the elderly people, while, on the other hand, the Nordic countries (Denmark, Netherlands and Sweden) are represented among the

8 Esping-Andersen, 1990, 1996; Ferrera, 1996; Sapir, 2005.

Table 1. Application of the Health deterioration algorithm to the SHARE longitudinal 50-80 years of age sample (number of cases).

| SHARE 50-80 | Self- perceived deterio- ration | Identified health events | | | | Any of the four chronic diseases | Total Health deterio- ration |
|----------------|--|--------------------------|--------|--------|-----------------|---|---------------------------------------|
| | | Heart attack | Stroke | Cancer | Hip Fracture | | |
| Nordics | 337 | 178 | 60 | 107 | 41 | 364 | 624 |
| Continental | 493 | 292 | 98 | 109 | 57 | 556 | 899 |
| Southern | 396 | 150 | 54 | 43 | 32 | 269 | 593 |
| All countries | 1226 | 620 | 212 | 259 | 130 | 1189 | 2116 |

Source: SHARE (Survey on Health, Ageing and Retirement in Europe), wave 1 (2004) and wave 2 (2008)

top four providers regarding these services. Second, observed differences across European countries regarding family ties,⁹ family support,¹⁰ as well as labour force participation of the elderly.¹¹ Hence, disaggregating by country groups (Nordics; Continental and Southern) allows for depicting potentially differential effects of the dynamic changes of these parameters on health outcomes across country groups.

Table 1 gives the sample sizes and an impression of how the selection algorithm operates.

Given that the analysis is based on re-interviews, it is likely to be sensitive to different average lengths of time intervening between the two waves. In particular, if the gap between waves is longer in some cases rather than in others, that is likely to be reflected in a greater (apparent) probability of health deterioration. Table A1 in the appendix provides information on the distribution of gaps by country, country grouping and health category. Gaps are notably short in France and Belgium; however little systematic difference is apparent by health status. The distributions may back the argument that the probable gain in explicitly correcting for differential time gaps does not outweigh the loss in simplicity of exposition. As a result, though this caveat must be borne in mind, no correction for this feature was attempted.

The total longitudinal sample in SHARE is 18741 individuals in 11 countries. Those aged between 50 and 80 years are 16807 individuals. The total number picked out by the algorithm is 2116 individuals, or 12.6% of the sample. This sample is split more or less evenly in each of the three country groupings. Slightly more than half of the sample is selected for having suffered one of the four identified health events: The largest group is heart attack (620) followed by Cancer (259), Stroke (212) and Hip fracture (130). The balance of slightly under one thousand

9 Reher, 1998; Kohli et al., 2005.

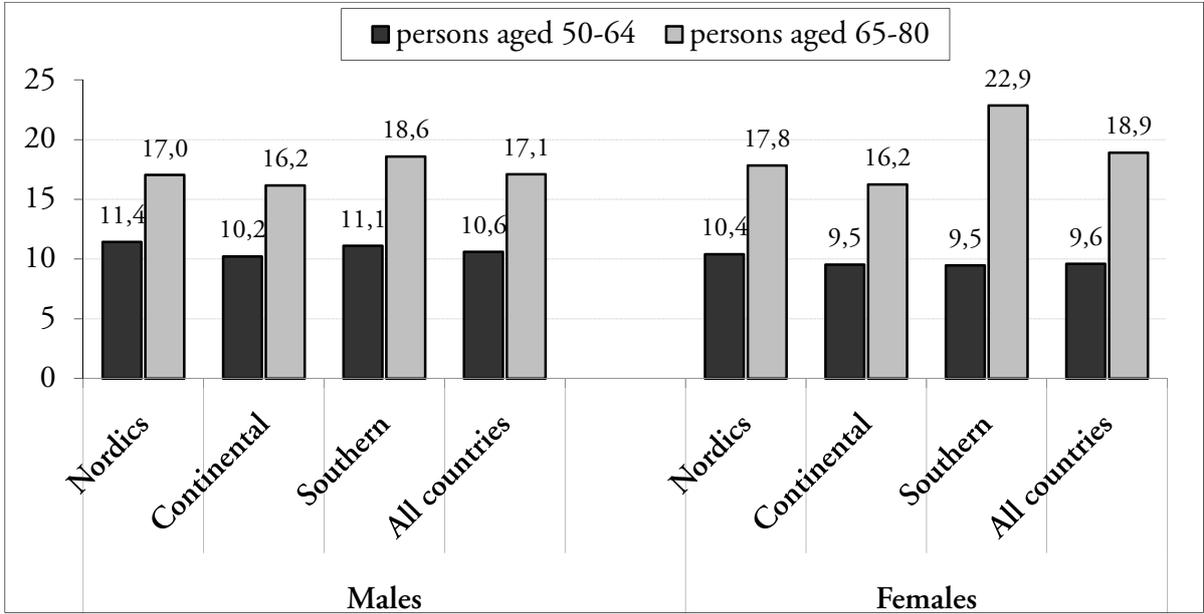
10 Attias-Donfut et al., 2005.

11 Brugiavini et al., 2005.

individuals are picked out because of a declared deterioration in self-perceived health. This could be due to the onset of a condition not specified explicitly, or because of a general sense of not being well. Finally for some analyses, the group whose spouse suffered a health deterioration but are themselves healthy were also identified (7.5% of the sample of 50-80 who live with a spouse or 972 individuals).

Figure 1 examines the prevalence of serious health deterioration by gender, age and country group. The headline that could be attached to the figures could be ‘Disease does not discriminate’: As one would expect the prevalence of deterioration is larger for the older group 65-80 by 6-7 percentage points. Prevalence hardly differs by gender or by country group. There is a 1-point greater prevalence for younger men, which disappears for the older group. It is worth mentioning that the difference in the prevalence of health deterioration between males and females appears to be statistically significant at a conventional level (P-value 0.0535) only for persons aged 65-80 years in Southern Europe. The one anomaly concerns the older age group for women in Southern countries: The prevalence of deterioration is more than twice as high (11 points) than those of younger women in the same countries and some 4.3 points higher than men of the same category. It is interesting to note, further that this anomaly is caused by self-perceived health deterioration rather than the identified illnesses (where prevalence is similar to that pertaining for the same group in other countries).

Figure 1. Prevalence of health deterioration by gender, age and country group.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

Immediate Effects of Deterioration in Daily Life

The immediate and most proximate effects of health deterioration can be expected to be seen in physical measures of the ability to function. We utilize three of the direct measurements of physical condition that SHARE contains:

- The extent to which the ability to perform simple ‘Activities of Daily Living’ (ADL) are impaired. The question on ADLs is a well-known and well-understood question in health condition survey (Avendano and Mackenbach, 2008; Mackenbach et al., 2005). It asks respondents if they had difficulty performing a number of simple everyday activities on their own (e.g. a) Dressing; b) Walking across a room; c) Bathing or showering; d) Eating; e) Getting in and out of bed; f) Using the toilet). This measure can be scored from 0 to 6, depending on the number of ADL activities the respondent is unable to perform.
- Similar in nature is the Instrumental Activities of Daily Living (IADL), which asks respondents whether they are able to perform tasks needed to function in society on their own (e.g. a) Using a map to figure out how to get around in a strange place; b) Preparing a hot meal; c) Shopping for groceries; d) Making telephone calls; e) Taking medications; f) Doing work around the house or garden; g) Managing money). This measure varies from 0 to 7 depending on the number of IADL activities the respondent is unable to perform.
- Finally limitations in functioning are measured by self-reports on mobility (Nicholas et al., 2003). A question is asked on mobility due to a health or physical problem covering activities as (a) walking 100 meters; b) sitting for about 2 hours; c) getting up from a chair after sitting for long periods; d) climbing several flights of stairs without resting; e) climbing one flight of stairs without resting; f) stooping kneeling or crouching; g) extending your arms above shoulder; h) pulling or pushing large objects; j) carrying weights over 5 kilos; k) picking up a small coin from a table). This measure varies from 0 to 10.

Table 2 tries to track physical deterioration on ability to function. The percentage of respondents reporting a deterioration of at least 1 ADL, 1 IADL or 1 on the mobility score is reported. Given that our sample is composed of older individuals and that the passage of 2-3 can be expected to worsen these scores in any case, the corresponding percentages for those not reporting health deterioration are also included. Finally, odds ratios are calculated (the number of times the probability of the deterioration group exceeds those *not* reporting deterioration).

As expected, Table 2 is unequivocal that health deterioration leads to major physical handicaps that impair the ability to live normally, at least as that is

Table 2. Effects of health deterioration on ability to function, (% reporting deterioration in measure and odds ratios by health deterioration status).

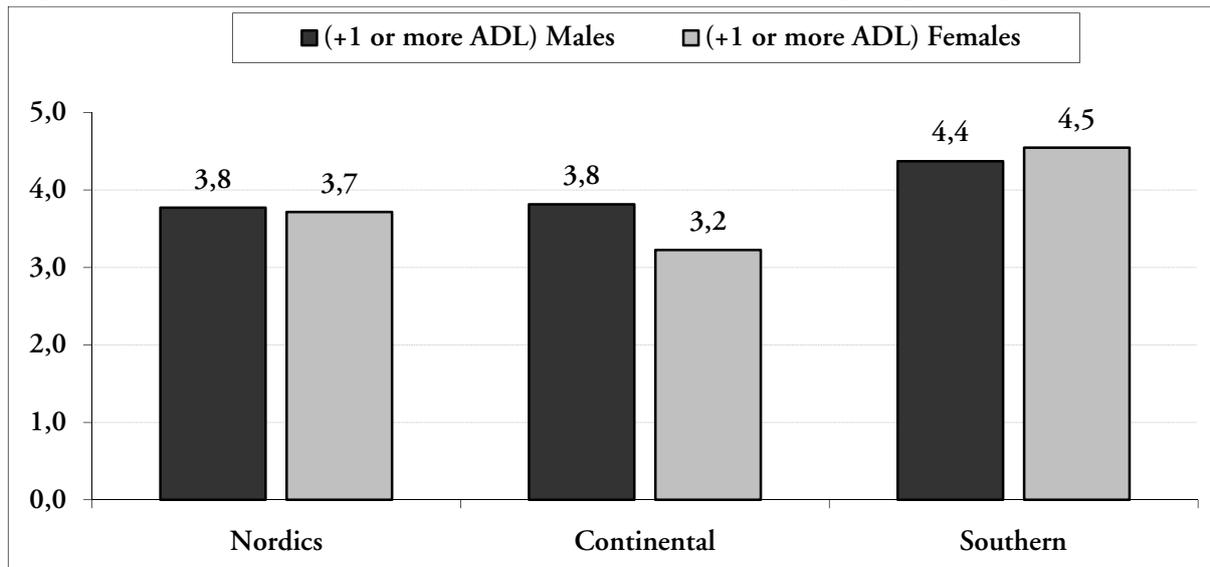
| Age | Change in health | +1 OR MORE ADL | | +1 OR MORE IADL | | +1 OR MORE MOBILITY | |
|-------|------------------|----------------|---------|-----------------|---------|---------------------|---------|
| | | Males | Females | Males | Females | Males | Females |
| 50-64 | No deterioration | 2.5 | 3 | 4.3 | 5.8 | 3.5 | 3.4 |
| | Deterioration | 7.6 | 9.7 | 10.1 | 16.8 | 7.9 | 9.2 |
| | Odds ratio | 3.04 | 3.23 | 2.35 | 2.90 | 2.26 | 2.71 |
| 65-80 | No deterioration | 4.9 | 6.9 | 7 | 11.9 | 5.7 | 4.9 |
| | Deterioration | 19 | 23.1 | 25.3 | 36 | 18.3 | 20.2 |
| | Odds ratio | 3.88 | 3.35 | 3.61 | 3.03 | 3.21 | 4.12 |
| 50-80 | No deterioration | 3.60 | 4.8 | 5.5 | 8.7 | 4.5 | 4.1 |
| | Deterioration | 14.2 | 18.5 | 18.9 | 29.4 | 14 | 16.5 |
| | Odds ratio | 3.94 | 3.85 | 3.44 | 3.38 | 3.11 | 4.02 |

Source: SHARE, wave 1 (2004) and wave 2 (2008).

measured by being able to perform simple tasks. In all cases the probability of ability to deterioration is some 3 or more times greater than of individuals with the same age and sex. It appears that the deterioration is felt sharper by men rather than by women: All odds ratios when comparing the younger with the older age group rise faster for men than for women. In the case of men the odds ratio rises from 3.04 (50–65) to 3.88 (65–80); for women the increase is more moderate (3.23 to 3.35), a pattern which is repeated in IADLs, though not for mobility where (presumably due to obesity problems), the effect on mobility is much larger. A further point to note, which is somewhat obscured by the odds ratios, is that the extent of problems in daily functioning and their link with age is large even in the group not suffering for health deterioration.

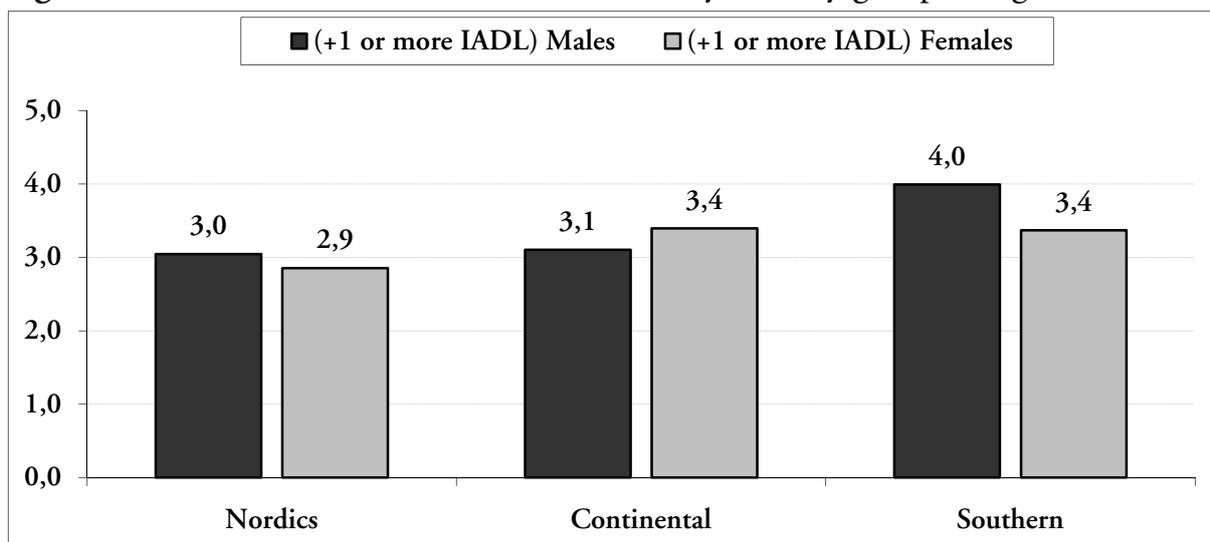
Looking at this issue in greater detail, Figures 2a, 2b and 2c examine odds ratios by age, gender and country group. It appears that the South feels the effects more keenly, in the sense that odds ratios of reporting functioning impairment as a result of illness are consistently higher there as compared to other areas by gender. Odds ratios are larger by over 0.7, and more so for women. The special feature affecting mobility and older women is confirmed, and is shown to affect especially women from the north and centre of Europe, rather than the south.

Figure 2a. Odds ratios for ADL deterioration by country group and gender.



Source: SHARE, wave 1 (2004) and wave 2 (2008)

Figure 2b. Odds ratios for IADL deterioration by country group and gender.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

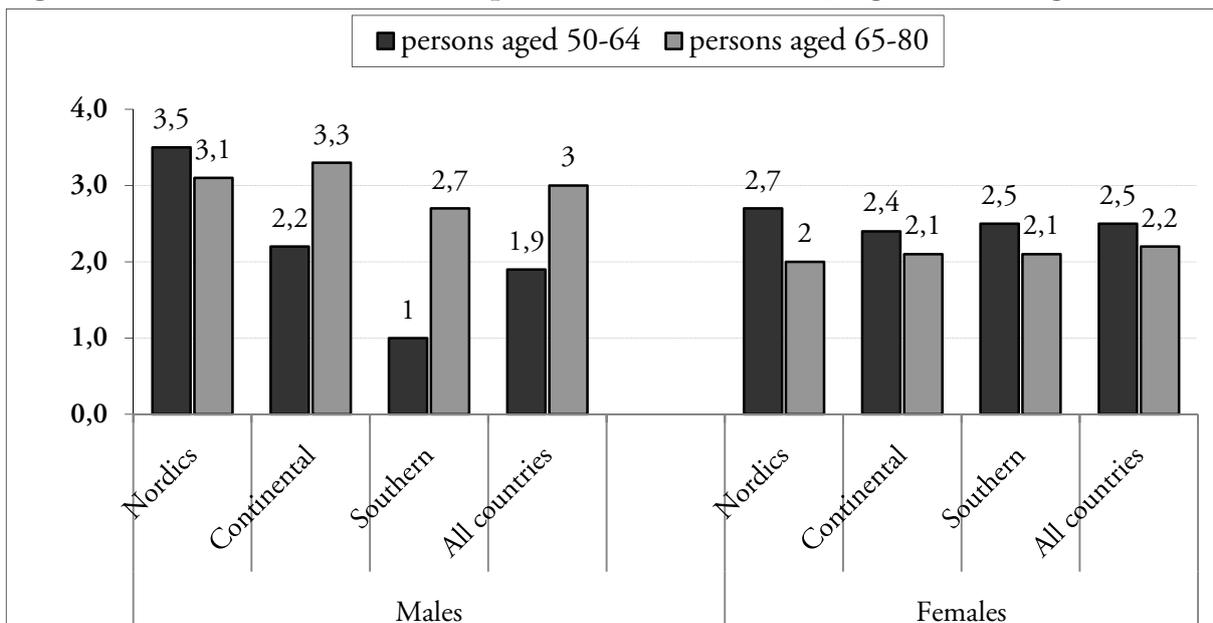
Illness and deterioration in health in addition to physical must be expected to have psychological and mental effects. Depression prevalence is measured in SHARE by the EURO-D scale a 12 point scale designed to spot the cases where replies indicate the presence of (possibly untreated) clinical depression (Prince et al., 1999a; 1999b). Figure 3 reports odds ratios of reporting a EURO-D score of greater than 3, a level which is conventionally taken to indicate the prevalence of possibly clinical depression (Dewey and Prince, 2005) by age, country grouping and separately by gender.

Figure 2c. Odds ratios for mobility deterioration by country group and gender.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

Figure 3. Prevalence of clinical depression (odds ratios) by age, area and gender.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

Figure 3 shows an interesting, if complex, picture. Women are anyway more prone to depression than men: the % of EURO-D >3 in the 'healthy' (non-deteriorating) group is 6.7% for men and 10.2 for women. However, the onset of illness appears to be felt more dramatically by men, especially as age progresses. Thus while men exhibit a steep age gradient (with the possible exception of the North), in all cases age gradients for women appear to be falling with age. An interpretation that could be offered is that men see illness as a very important indicator of advancing age and hence of mortality; women all across the sample appear to be taking a much more philosophical view and are not reacting as violently as men when illness strikes.

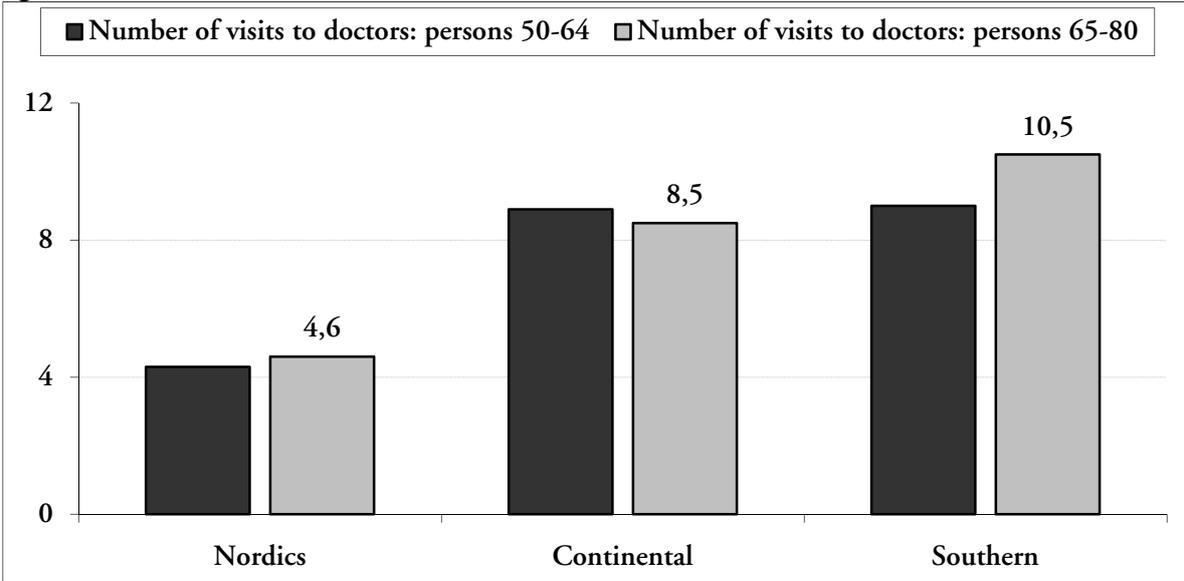
Indeed, the picture of Figure 3 shows rather that women are increasingly coming to terms with impending mortality.

Contacts with the Health Care System

The first call, when illness strikes, is made to the health care system. Figures 4a and 4b examine the number of visits to the doctor and the percentage who stayed in hospital over the last 12 months, respectively. For some this period would cover the period of their illness itself, while for others it might represent the aftermath of the disease. What is most readily apparent in the data of the two parts of the figure is the variety of the treatment styles of the different countries covered in the survey. In particular visits to the doctor appear to be much more frequent in the South (almost twice those of the north), while frequency of hospital stays seems larger in the Continental countries. Whereas the age effect is not very clear in doctor visits, it is present very clearly in the data on hospitals.

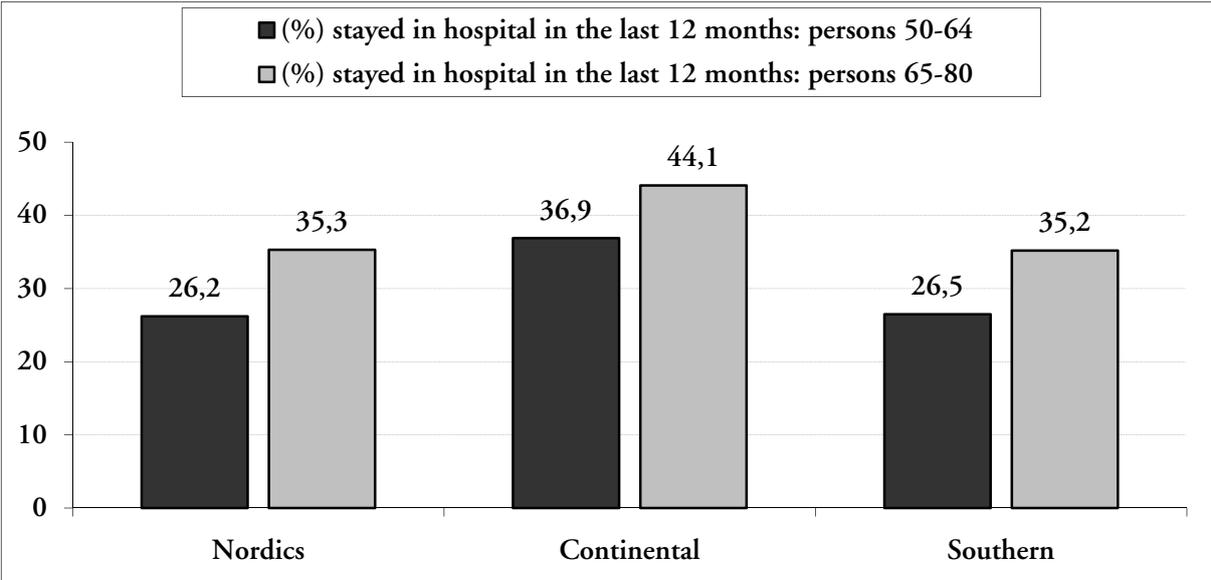
A consideration of key importance is the immediate economic effect of illness in the sense of the direct costs of treatment to the individual and of the indirect costs his/her treatment would impose. Given that the group is selected to have greater need for medical and health care intervention, one would expect health care expenditure to loom large in the story. Figure 5 examines out of pocket expenses on inpatient care, prescribed drugs and outpatient care for the group who have suffered health deterioration. To facilitate comparison the expenses of the same individuals in the first wave (i.e. before the onset of illness) and the second wave (i.e. after illness struck) are plotted together. The picture emerging is intriguing and complex: In the **Nordic** countries out of pocket health care expenses were actually larger before the illness, especially for inpatient care, and less so for outpatient care. Only drugs-related expenses are larger after than before the illness. This picture could be consistent with an activation of Welfare State mechanisms designed to protect the ill. If that is so, what we are seeing before the illness is discretionary payments not covered by the social protection system. In **Continental** states, there is some increase following the illness, which is more marked for the older group. In the **South**, there is a definite increase for both groups for inpatient care and prescription drugs. Outpatient visits are moving in the opposite directions for the two age groups. In terms of an age gradient there appears to be little relationship in Nordic States, a strong positive link in the Continental states and a weak *negative* relationship in the south.

Figure 4a. Number of visits to doctors of those who suffered health deterioration.



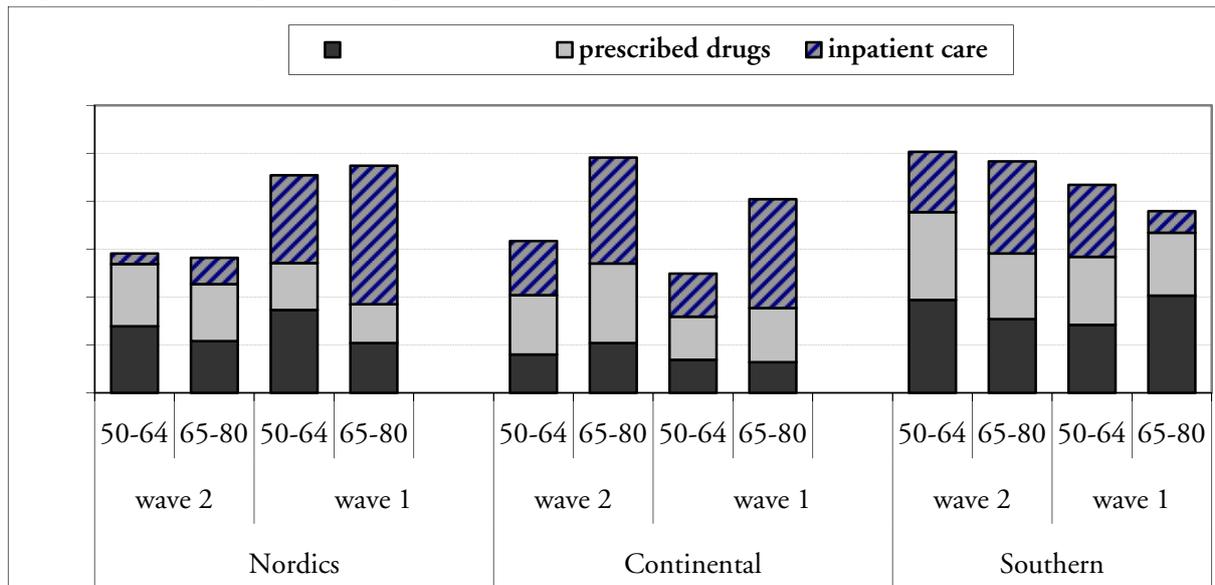
Source: SHARE, wave 1 (2004) and wave 2 (2008)

Figure 4b. (%) stayed in hospital in the last 12 months of those who suffered health deterioration.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

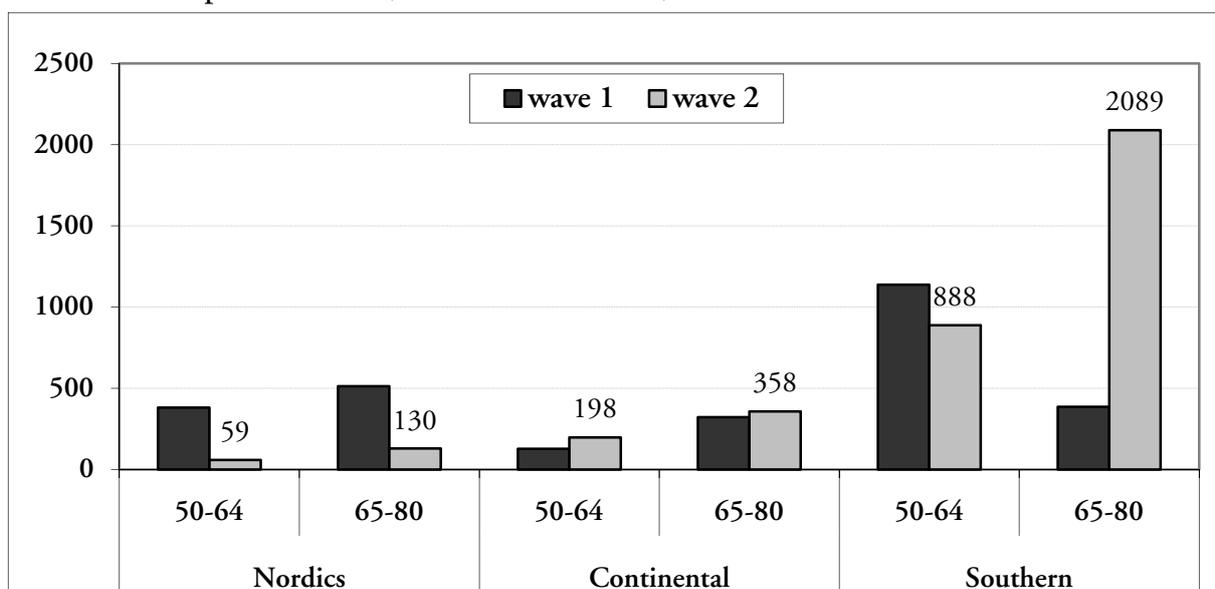
Figure 5. Out of pocket expenses (in euros) for the last 12 months.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

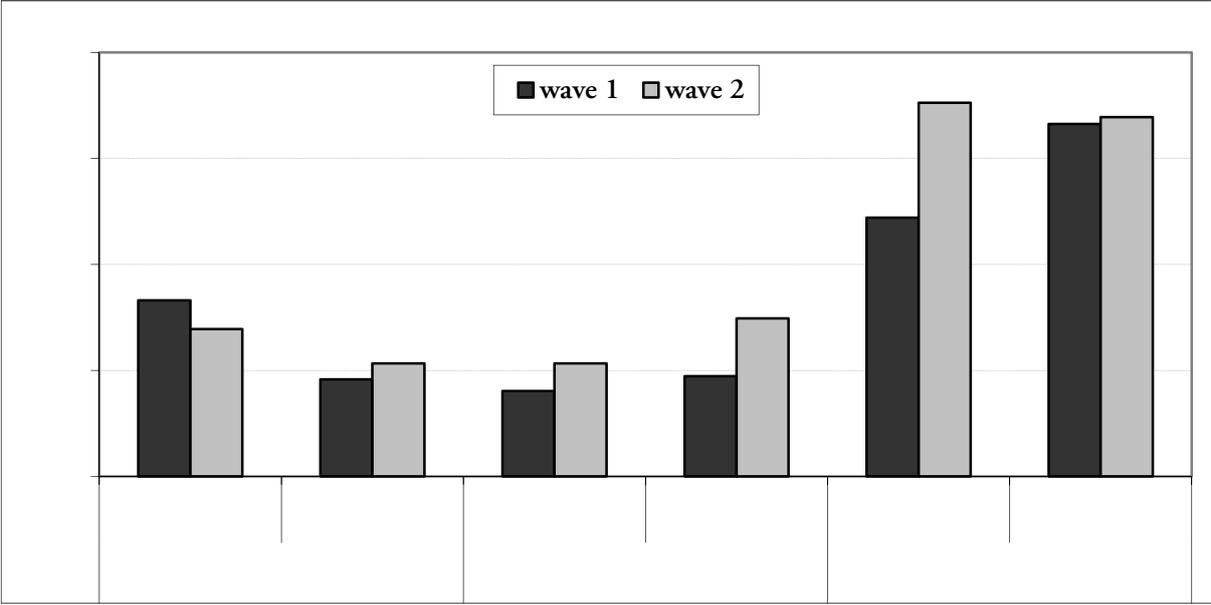
One surprising fact about the data in Figure 5, given that this is a sample of older individuals selected for having serious health deterioration, is the relative modesty of the average amounts. The maximum average expenditure over a year is EUR 503 (for the younger group in the South). This, of course, disguises considerable variability. Figures 6a, 6b and 6c examine the average for non-zero values of expenditure only. We thus see that positive expenses can be much larger, especially in the south. The variability, however, is such that, pre-illness expenses (wave 1) are sometimes higher than those postdating the illness.

Figure 6a. Average non-zero out of pocket expenses (in euros) over the last 12 months for inpatient care (wave 1 and wave 2).



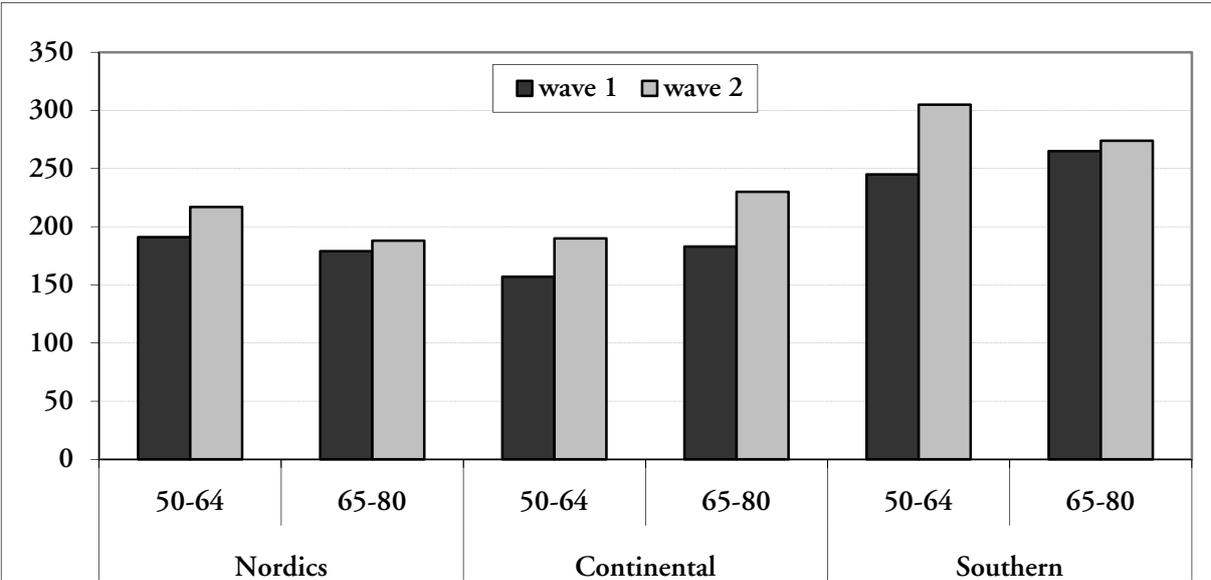
Source: SHARE, wave 1 (2004) and wave 2 (2008).

Figure 6b. Average non-zero out of pocket expenses (in euros) over the last 12 months for outpatient care (wave 1 and wave 2).



Source: SHARE, wave 1 (2004) and wave 2 (2008).

Figure 6c. Average non-zero out of pocket expenses (in euros) over the last 12 months for prescribed drugs (wave 1 and wave 2).



Source: SHARE, wave 1 (2004) and wave 2 (2008).

An important observation (not reported here) is that if one splits the sample further into three income classes, there appears no discernible pattern for extra out-of-pocket expenses for the three country groups.

To approach the question of variability, Table 5 examines above-median expenditure at specific points in the distribution for each category of out-of-pocket expenses. Thus, once we isolate positive expenses, the expenditure in the Nordics is

Table 5. Distribution of positive total expenditure in Wave 2 (€/year).

| | Top 50% | Top 75% | Top 90% |
|-------------|---------|---------|---------|
| Nordics | 267 | 402 | 805 |
| Continental | 250 | 610 | 1300 |
| Southern | 250 | 600 | 1250 |

Source: SHARE, wave 1 (2004) and wave 2 (2008)

€267, in the South €250 and in the Continent the same. Rather surprisingly, the distributions for the Continent and the South coincide at the points of 75% (EUR 600) and 90% (EUR 1250-1300), possibly reflecting open market prices. In the north, amounts at the top end are considerably lower.

The overall impression derived from Figures 5, 6a, 6b, 6c and Table 5 can be summarized as follows:

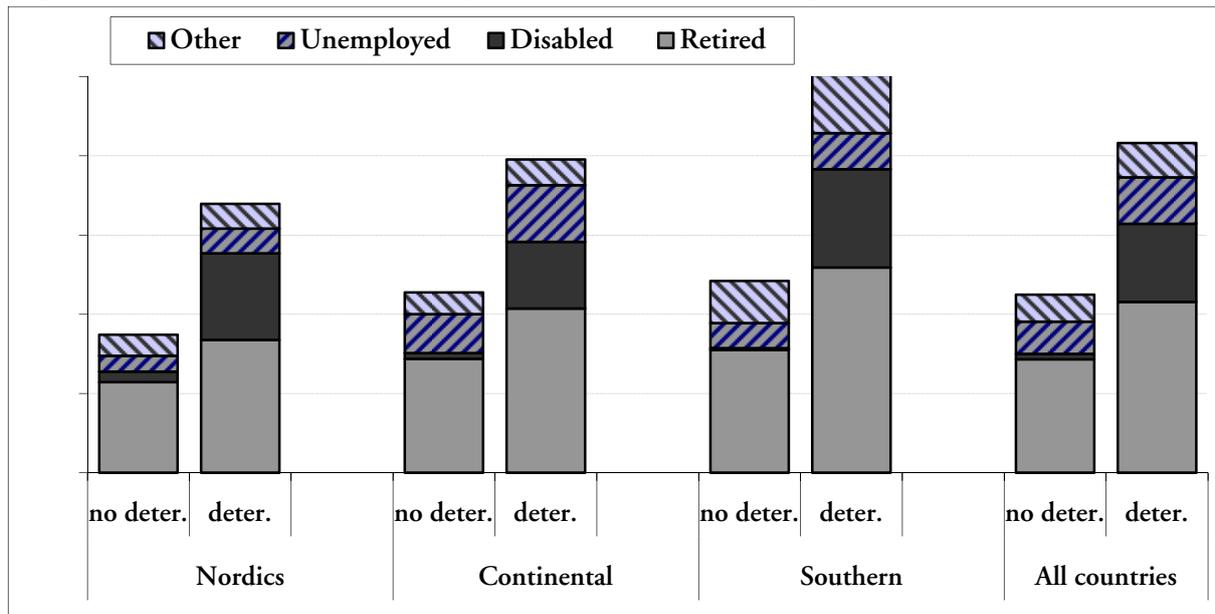
- In the Nordic states, there is a fall in expenditure when one is ill. Could this be evidence of the operation of the welfare state?
- In the Continental States there is a small but consistent increase, possibly related to copayments.
- In the Southern States: Expenses are both larger and more variable. Could this be evidence of gaps or inequalities in coverage?

Consequences Beyond Health: Employment and Care

The decision to focus on individuals aged 50+ in the SHARE sample (and in its precursors HRS and ELSA) is justified as allowing us to focus on three groups whose fortunes together comprise the ageing puzzle: A first, younger group, between 50 and 65 who are still actively engaged in the labour market, participation in which is at the very least a live option. At the other extreme are the very old, aged 80+, for whom health considerations can be expected to be paramount. In between, we find the group who are healthy but have broken links with the labour market and for whom quality of life is most important.

The group who is most likely to be affected by sudden illness is the first group – that still involved in the labour market. Illness, in particular is likely to play a part in their decisions to retire or, in general, revise their planning about the timing of retirement. The analysis thus focuses on those who were working in wave 1 of SHARE and have changed their labour market affiliation between the two waves. Figure 7 contrasts transitions out of the labour market of those who have suffered deterioration in health with those who have not.

Figure 7. Transitions out of employment, those working in Wave 1.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

For people of the ages of the SHARE sample, exit from the labour market is a live option. Figure 7 shows that over 20% of those working in Wave 1 had exited the labour market. This figure is higher in the South and the Continent, reflecting institutional features of their pension systems. The importance of different pathways to retirement is also evident, with the importance of unemployment in Continental states and of disability pensions in the North (especially in Holland). What figure 7 shows is that health deterioration hastens decisions to exit dramatically. In particular, 42% of those who suffered deterioration had left the labour market by the second wave; that figure is 50.2% for the South, 39.6% in the Continent and 34% in the North. Also noteworthy is the large percentage (much larger in the South) of those who qualify for an old age pension, which means that people had been working when they had completed the requirements of being awarded an old age pension. (Hence the reason for the larger group in the South is related to low retirement ages). Unemployment as an exit strategy does not play a larger role for health deterioration, a distinction sought (predictably) by disability pensions. Disability pensions are especially important in the North and in the South. Finally, the relatively large 'other' category is composed primarily of women who drop out of the labour market mostly in anticipation of being awarded a pension later on (one would think that a large group may have submitted applications for pensions which must still be pending – a common bureaucratic hurdle in the South).

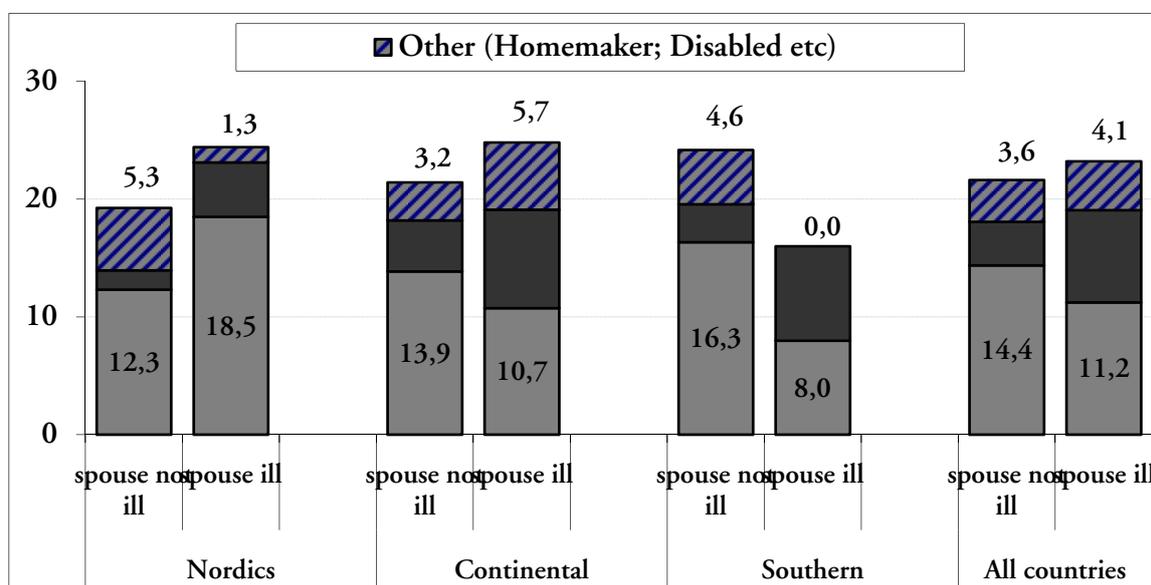
An important effect (and one that in the US plays a significant role) is the effect of the illness of one spouse on the decision of his/her spouse to retire.¹² Figure 8

12 See e.g. Munnell and Sass, 2008.

attempts to look at transitions out of the labour market for working spouses of individuals who suffered health deterioration. As a control, the transitions of working spouses whose partners did not suffer deterioration are also included.

Figure 8 tells an interesting story. The caring-for-an-ill spouse effect appears to exist and to be relatively sizeable in the Nordic (5.1 percentage points difference) and in the continental regions (4.3 percentage points). In the South the difference is large (9.5 percentage points), but is in the ‘wrong’ direction – spouses of ill individuals are less likely to exit the labour force. Though sample sizes are small, the juxtaposition of North and South gives rise tantalizingly to drawing a conclusion connecting the lack of generosity of the welfare state with the necessity to supplement income to cover the extra expenses of illness.

Figure 8. Transition out of work for working spouses of those who suffered health deterioration.



Source: SHARE, wave 1 (2004) and wave 2 (2008).

Of interest in this context of examining exits from the labour market are the reasons for retirement given by the respondents themselves. Table 6 examines the results of a question for which multiple replies were possible. To become eligible for a pension (public or private) is most frequently cited as a self-evident reason – confirming that many retirees interpret and act as if minimum retirement ages were maximum ages. Nevertheless, it is the *combination* of eligibility and health (16% overall, 22.4% in continental countries, whereas in the South it is actually less than in the healthy group). As an interesting aside, illness causes opposing effects in the North and in the South: in the North fewer exits ‘to enjoy life’ (22% healthy vs 10% deteriorated), whereas in the South it causes more (2.9% healthy, while 15% deteriorated). This may reflect differences in philosophical stances on reminders of mortality.

The last area to be dealt with is that of informal social networks. The onset of sudden and serious illness may be expected to elicit responses in the form of personal care offered to the respondents. SHARE divides help to three types: Personal care –help in bathing, eating dressing etc, Practical care (cooking, shopping, and cleaning) and help with bureaucracy (filling in forms, tax returns, going to the bank, etc). In a sample of ill people of this kind we would expect personal care to loom large and possibly secondarily, practical care. Given this expectations, the results of Table 7 are quite surprising. Personal care is received by only 3% of under 65s and 6.5% of over 65s; only in the South does the help given to over-65s come close to 10%. Practical care is more important, though it never rises above a quarter of the sample. This picture of small importance of care offered is consistent with most care being provided within the household – most commonly by the spouse. In such situations, the mobilization of care within the household would obviate the need for outside help.

Table 6. Reasons given for retirement for those who retired between the two waves.

| Reason for retirement | All countries | | Nordics | | Continental | | Southern | |
|---|---------------|--------|-----------|--------|-------------|--------|-----------|--------|
| | no deter. | deter. | no deter. | deter. | no deter. | deter. | no deter. | deter. |
| Became eligible for public pension | 48.7 | 63.5 | 33.3 | 44.7 | 45.5 | 63.0 | 61.1 | 71.1 |
| Became eligible for other kind of pension | 21.0 | 18.2 | 20.8 | 50.7 | 21.6 | 7.7 | 19.7 | 26.0 |
| Was offered an early retirement option | 19.6 | 8.0 | 31.0 | 21.8 | 23.3 | 6.5 | 7.7 | 5.7 |
| Made redundant | 3.8 | 3.1 | 8.7 | 10.5 | 2.8 | 3.3 | 4.2 | 0.0 |
| Ill health | 7.5 | 16.0 | 5.2 | 10.1 | 8.3 | 22.4 | 6.6 | 6.1 |
| Family reasons | 8.9 | 4.9 | 14.9 | 7.9 | 10.9 | 6.9 | 2.6 | 0.0 |
| To enjoy life | 8.6 | 9.5 | 22.1 | 9.6 | 8.9 | 6.5 | 2.9 | 15.1 |

Source: SHARE, wave 1 (2004) and wave 2 (2008).

Given the indicative findings of Table 7 the disturbing possibility emerges of a, possibly serious, gap in care. Care may be provided by informal help from outside the household, or by professional carers. Equally, though care may be provided by a member of the family – the spouse or, in the case of cohabitation with other generations a child. In the last type of care, physical proximity (residence in the same household or the same building) acquires greater importance. Table 8 attempts to approach this complex question.

Table 7. Types of help provided to those whose health deterioration.

| Country groups | Personal care | | Practical care | | Help with bureaucracy | | Any type of help received | |
|----------------|---------------|-------|----------------|-------|-----------------------|-------|---------------------------|------|
| | 50-64 | 65-80 | 50-64 | 65-80 | 50-64 | 65-80 | 50-64 | 65+ |
| Nordics | 2.6 | 2.0 | 27.8 | 21.7 | 6.0 | 6.4 | 33.2 | 26.1 |
| Continental | 2.4 | 4.7 | 22.9 | 27.1 | 2.0 | 9.0 | 24.3 | 31.4 |
| Southern | 3.9 | 9.5 | 6.4 | 19.1 | 7.0 | 17.3 | 13.5 | 26.5 |
| All | 2.9 | 6.5 | 18.0 | 23.3 | 4.1 | 12.3 | 21.8 | 28.9 |

Source: SHARE, wave 1 (2004) and wave 2 (2008).

Table 8 disaggregates the sample by age and looks at all kinds of help that can be identified by the questionnaire: daily help, coresidence of a family member and a combination of both. Co-residence bears the brunt of care offered, as one could expect, even in the Northern Countries. Even so, there remains a large percentage, which is growing with age, of people who receive *neither* type of care (16% in the younger group, 24% in the older). The percentage is especially large among the older group in the North (39%), and is below one in ten only for the younger group in the South.

Table 8. Gaps in care? Help daily (A), Coresidence (B) and their absence.

| Country Groups | Persons aged 50-64 | | | | Persons aged 65-80 | | | |
|----------------|--------------------|--------|--------|-----------------|--------------------|--------|--------|-----------------|
| | A and B | Only A | Only B | Neither A nor B | A and B | Only A | Only B | Neither A nor B |
| Nordics | 1,0 | 1,8 | 69,4 | 27,9 | 1,2 | 2,2 | 58,0 | 38,6 |
| Continental | 3,0 | 0,1 | 79,2 | 17,7 | 3,0 | 2,9 | 72,1 | 22,0 |
| Southern | 2,0 | 1,1 | 88,2 | 8,7 | 6,2 | 4,3 | 67,2 | 22,3 |
| All countries | 2,4 | 0,6 | 81,1 | 15,9 | 4,2 | 3,4 | 68,8 | 23,5 |

Source: SHARE, wave 1 (2004) and wave 2 (2008).

This incomplete, yet sobering, finding of the possibility of major gaps or at the very least serious lags in social response, is possibly a fitting place to stop this impressionistic analysis of the social responses to the onset of illness. Despite the spread of the Welfare State there appear to be large numbers of older citizens who apparently cope with a serious illness on their own.

Conclusions –the Way Forward

This paper identified cases of immediate and serious need that affected a random sample of older European citizens between 2004 and 2006/7. Using only simple tabulations and descriptive statistics we attempted a ‘naked eye’ overview of how

the social and economic effects of illness played out in 11 European countries categorized (for reasons of sample economy) into three broad regions with comparable social protection systems. The analysis tried to uncover relationships by disaggregating according to gender and age. In doing so we have reached a number of conclusions:

- The prevalence of health deterioration was roughly uniform across countries. Women in the South could be said to be more prone, but due to 'generalised malaise', rather than to an identified illness
- Health deterioration produced major effects on the ability to function in everyday living. This effect increases with age, while women appear to feel effects more keenly.
- The effect on mental health and the tendency to depression is important. Men's health impact rises sharply with age, while women are more stoic and appear to accept deterioration as a natural part of ageing.
- Treatment styles are very different across Europe. More hospitals in Continental States, whereas Doctor visits are more common in the South.
- Out of pocket Expenses on average are not particularly high. But there exist instances of considerable expenses in all areas. In the North there is evidence supporting the efficacy of the Welfare state in reducing expenses for the sick. In the Continent the picture is consistent with copayments, whereas in the South gaps in coverage must be part of the story.
- Health deterioration is instrumental in all cases in driving individuals out of employment, especially in the South.
- Health deterioration appears to have an effect of the decision of the spouse to retire. In the South, the spouse remains in the labour market, possibly to compensate for loss of earnings. In the North, on the contrary, spouses leave the labour market, presumably to look after their sick partners.
- Finally, there appears to be some evidence of large gaps in Care offered to sick.
- This explorative naked- eye examination of the data has already yielded a good deal of food for thought, Even in the relatively short time span between the two waves of SHARE, some tantalizing effects, as well as disparities between behaviour in the North, the centre and the South of Europe are beginning to emerge.
- This picture can be complemented, as a second step by looking at effects on income and, most importantly, in running down assets as a response to illness. However, this kind of complex effect is unlikely to be discernible in the simple analysis of this paper. A diagrammatic analysis is essentially an analysis of limited dimensionality employing reduced forms. Complex effects are much more likely to be reflected in partial coefficients of fully specified

multivariate models. Though in those kind of models there is greater chance of discerning effects, the immediacy of direct observation is lost. Nevertheless, and regardless of the merits of a 'naked eye' approach, the next steps must be to exploit in a more thorough manner the panel nature of the data and thus to extract more and better defined information from the same data.

- Returning to the original theme of the paper, the mobilization of social resources following illness, the direct evidence from SHARE lends some early support to a hypothesis that social systems play a significant role in guiding responses to a social and family emergency. The differences that were almost a constant accompaniment of the naked eye analysis, are consistent with being – at least partly – the reflections of social policy choices. How much, and to what extent must await a fuller investigation employing sophisticated econometric tools, and/or later waves of SHARE where the passage of time would have had the effect of increasing the sample size.

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Appendix

Table A1. Distribution of time gaps between w1 and w2 interview.

| Country | Difference between w1 and w2 in months | | | |
|---------|--|--------|-----|------|
| | 25% | Median | 75% | Mean |
| SE | 26 | 28 | 30 | 28.2 |
| DK | 29 | 30 | 32 | 30.6 |
| NL | 31 | 32 | 33 | 31.9 |
| DE | 29 | 30 | 32 | 30.5 |
| BE | 19 | 21 | 24 | 21.3 |
| FR | 17 | 25 | 26 | 22.4 |
| AT | 29 | 30 | 32 | 30.5 |
| CH | 29 | 30 | 31 | 30.1 |
| ES | 29 | 30 | 32 | 30.4 |
| IT | 29 | 31 | 32 | 30.5 |
| GR | 27 | 33 | 34 | 30.1 |

| Longitudinal sample | | | | |
|---------------------|-----|--------|-----|------|
| Country group | 25% | Median | 75% | Mean |
| Nordics | 28 | 30 | 32 | 30.0 |
| Continental | 21 | 26 | 30 | 25.4 |
| Southern | 29 | 31 | 33 | 30.7 |

| Persons with no health deterioration (as defined in the analysis) | | | | |
|---|-----|--------|-----|------|
| Country group | 25% | Median | 75% | Mean |
| Nordics | 28 | 30 | 32 | 30.1 |
| Continental | 21 | 26 | 30 | 25.4 |
| Southern | 29 | 31 | 33 | 30.8 |

| Persons with health deterioration (as defined in the analysis) | | | | |
|--|-----|--------|-----|------|
| Country group | 25% | Median | 75% | Mean |
| Nordics | 28 | 30 | 32 | 29.8 |
| Continental | 21 | 26 | 30 | 25.6 |
| Southern | 29 | 31 | 32 | 30.6 |

Source: SHARE, wave 1 (2004) and wave 2 (2008).

Wellbeing and Work: Social Inclusion of Vulnerable Groups in Northern Spain

Oscar Fernández

Introduction

The European Union considers employment to be the best protection against social exclusion. All the policies and actions that are on offer from the various bodies and organizations in this area are directed towards achieving this objective and concentrate on the people involved obtaining employment. Nonetheless, the great heterogeneity noticeable in these processes shows the necessity of providing responses, actions and programmes that are differentiated and specific. With this requirement, interventions must address in an integrated and open way the needs arising in given contexts. The work being described here was carried out in the urban district of Ponferrada in the Province of Leon in Spain through a case study on the employability of certain groups at risk of exclusion. This is the first stage towards a comparative study we are carrying out in southern European countries including Portugal and Italy.

The study had the participation of groups that are users of the services of the Social Action department of the municipal authority. This means that it was used the database of the municipal social services, offered by them, because they were the main interested in solve the problem of their unemployment users. The groups we work with were similar to those countries described before. Among them are women at risk, who were the majority of people, the disabled, immigrants, the population of drug addicts and former addicts, and other groups such as the homeless or ethnic minorities.

A special case in these ethnic minorities is the Romany community. The marginalization of the Romany community in Spain, as elsewhere in the world, has its roots in a centuries-old history of ethnic segregation. In response, the Romany community has come to feel intimidated and rejected. This has led to the establishment of communities on the outskirts of cities, generally with very poor living standards. The historical past still has a significant impact on the manner in which mainstream society tends to relate to the Romany community. All statistical indi-

cators show this community to be the most widely rejected group in European society.

As it will be showed, the majority of participants were women aged between 30 and 50. This offers the first clues as to the sort of difficulties for work insertion faced by this age range among the different groups.

A qualitative methodological design was used. One feature investigated was the various factors that make people belonging to these groups liable to exclusion. These factors relate primarily to the personal, family, educational, training, social, cultural, and life experience circumstances of the different individuals involved. Another feature was the position adopted by employers with regard to such groups. On the basis of an analysis of the data, a range of tools, strategies and competencies was outlined for consideration so as to achieve their social inclusion.

Awareness of the real situation of the people in certain groups at risk of exclusion from society and the world of work was the fundamental criterion guiding this research. On the basis of this primary criterion, the objectives proposed for the investigation were the following:

1. To identify and analyse the factors restricting the employability of vulnerable groups.
2. To discover and define the competencies for employability of such groups, at various levels of professional qualification.
3. To construct tools for inclusion and for evaluating employability, taking into consideration competencies and risk factors.

Theoretical Framework

When vulnerable groups are mentioned, two fairly closely related concepts come into play: poverty and social exclusion. Generally research into social exclusion contributes to studies on poverty, since these have been increasingly taking into account social, rather than purely monetary considerations.

In social research, as noted by Hilary Silver¹, work at present generally concentrates on the indicators that allow social exclusion to be measured. For example, the indicators proposed by Barnes² covered seven dimensions of social exclusion: financial situation, ownership of consumer durables, quality and habitability of housing, perception of the neighbourhood, personal social relationships, physical

1 Silver, Hil "The process of social exclusion: the dynamics of an evolving concept", *Chronic Poverty Research Centre, Working Paper, 95*. (London, 2007).

2 Barnes, M. *Social Exclusion in Great Britain. An Empirical Investigation and Comparison with the EU*. (Aldershot, 2005).

health and psychological well-being. In earlier work, Barnes et al.³ measured exclusion as a multidimensional disadvantage in the areas of housing, health, education, social relationships and participation.

Using the British Household Panel Survey, Burchardt, Le Grand and Piachaud⁴ worked with four inter-related systems of indicators of participation in normal social activities: (i) consumption (less than half the average household income or revenues) and savings; (ii) production (those who are economically active but not linked to any valued social activity); (iii) political linkages or commitments (those who do not vote or belong to any political organization); and, of most importance for the present purpose, (iv) social interaction (absence of anyone to offer support, such as listening, comforting, or helping in a crisis, or of somebody with whom to relax and have a good time, or someone who really appreciates them).

The Rowntree Foundation sponsored a team of researchers in Bristol⁵ to conduct a new survey of poverty and social exclusion. They utilized secondary data and information to study four themes relating to social exclusion: (i) poverty in terms of income and lack of material goods; (ii) exclusion from the labour market; (iii) exclusion from public services; and (iv) exclusion from social relationships. Four aspects of this latter topic, social relationships, received particular attention. Firstly, there were indicators of participation in common social activities. Respondents indicated if they considered an activity essential, that is if they were really involved in it, and if not, why they avoided it. In respect of certain essential social activities, sizable minorities were found not to have even one free afternoon a fortnight, not to eat out even once a month, or not to have even one week's holiday away from home, or had no hobby or pastime, or no group of friends with whom to go out for a meal or a drink. Secondly, indicators of social isolation and solitary life included marital status and family composition. Thirdly, isolation and non-participation implied the lack of social aid, both emotional and material. Fourthly, decoupling from any civic or electoral matters was the norm, rather than any formal linkage or even any actual participation in public affairs. One major innovation of this work is that it examined specifically social aspects of exclusion.

German studies have used other dimensions of exclusion. For example, Kronauer listed the roots of exclusion from the world of work: financial, cultural, spatial, social and institutional as quoted by Littlewood and Herkommer⁶. On other hand,

3 Barnes, M., Heady, C., Middleton, S., Millar, J., Papadopoulos, F., Room, G., and Tsakoglou, P. *Poverty and Social Exclusion in Europe*. (Cheltenham, 2002).

4 Burchardt, T., Le Grand, J. and Piachaud, D. "Degrees of exclusion: developing a dynamic, multidimensional measure", in Hills, J. Le Grand, J. and Piachaud, D. (eds), *Understanding Social Exclusion*. (Oxford, 2002).

5 Gordon, D., et al., *Poverty and Social Exclusion in Britain*. (York, 2000).

6 Littlewood, P. and Herkommer, S. "Identifying social exclusion: some problems of meaning", in Littlewood, P. (ed.), *Social Exclusion in Europe: Problems and Paradigms*. (Aldershot, 1999), pp. 1–22.

Petra Böhnke⁷ used Eurobarometer surveys to measure social exclusion in subjective terms, creating an index of belonging that was related to social support and family ties, as also to confidence in institutions. She also utilized the German Welfare Survey of 1998, to find a relationship between distributional or material exclusion and relational or participatory exclusion. To sum up, researchers have drawn up a varied panorama of the dimensions of social exclusion, in order then to attempt to correlate them. However, these studies have largely been based on transversally sectioned micro-data.

In December 2000, at Nice, the Council of the E.U. decided that the struggle against social exclusion was to be given a legal basis, and set about co-ordinating the social dimension of E.U. strategy. Every two years, starting in June 2001, member states were to draw up plans for national actions aimed at social inclusion, progressing towards agreed goals for a range of social indicators, which were to take into account national variability. Between 2001 and 2003, A. B. Atkinson and others⁸ worked out strategies based on the distribution of income, access to the labour market (measured in terms of levels of employment and unemployment, and of unemployment as a characteristic of a family), the functioning of the education system (measured in terms of school drop-out rates) and of access to health care (measured by life expectancy). The Commission's attempt to consolidate the "social dimension" of the Lisbon Strategy for growth and employment, and its efforts to reform social inclusion affected first pensions, then health and medical care. The Commission's moves to stimulate this process also involved a reduction in the number of strategy reports to a frequency of one every three years from 2006 onwards. The indicators for inclusion drawn up by the E.U. must be viewed critically, since in general they refer to the world of work rather than to citizenship or political participation or to many other aspects that may affect immigrants. For example, they have no word to say about re-uniting families, ensuring that people feel safe or similar matters.

Recognizing the challenges of social cohesion and the peaceful incorporation of newcomers through a process of mutual acceptance and tolerance, the British Council of Brussels Foreign Policy Centre and Migration Policy Group began developing the "European Civic Citizenship and Inclusion Index". This was intended to indicate the degree to which immigrants have rights and obligations comparable to those of E.U. citizens. The index was based on nearly one hundred indicators from five political areas, grouped progressively as a progression towards complete citizenship, and thus incorporated a dynamic logic. The index accepted that the process of inclusion of immigrants requires: (i) inclusion in the labour

7 Böhnke, P. *Am Rande der Gesellschaft: Risiken sozialer Ausgrenzung*. (Opladen, 2006).

8 Atkinson, A. B., Cantillon, B., Marlier, E. and Nolan, B. *Taking forward the EU social inclusion process*. (Luxembourg, 2005),

[Hhttp://www.ceps.lu/eu2005_lu/inclusion/report/final_report.pdf](http://www.ceps.lu/eu2005_lu/inclusion/report/final_report.pdf)

market, (ii) re-uniting of families, (iii) long-term residence rights, (iv) naturalization, and (vi) anti-discriminatory measures. The first annual report provided data from 2003 for each country, and revealed that, as might be expected in a context of dependency and exclusion, countries were implementing their own commitments to inclusion in very different ways, although tending to align themselves on the five areas.

In Spain, the Observatory of Processes of Exclusion and Social Incorporation created by the SARTU Federation in 2001 is the leader in the creation of information tools putting scientific research at the service of individuals and of social intervention. Among the novel features it incorporates is an attempt to reconcile social bodies, institutions and economic agents in order to handle these questions. For this purpose its work has concentrated on the construction of social indicators of exclusion and incorporation into society, and on the factors affecting these, by means of carrying out studies and creating specific working parties. To achieve this, the Observatory is organized around three axes or areas of action:

1. Study of the processes of incorporation of people who are excluded or at risk of exclusion, viewed longitudinally.
2. Study of professional practices aimed at the social incorporation of groups that are in a situation of exclusion or at risk of being excluded.
3. Exchange of information good practice norms between the various social bodies and agents involved in the processes of social incorporation of groups suffering from or at risk of exclusion.

On the basis of the work undertaken by the teams participating in this observatory, it can be deduced that, unlike poverty and marginalization, the phenomenon of exclusion is not related solely to financial weakness, which could be dealt with by policies for minimum incomes, but rather to the weakness of social linkages. This has also been pointed out by Fitoussi⁹ and Castel¹⁰. Situations of exclusion, in the most extreme case, may involve a complete breaking of relationships and the isolation of people, leading to a deficit in social cohesion. This phenomenon co-exists alongside a context of economic growth, which makes it even harder for those who are in a situation of exclusion or at risk of being excluded to face up to the problem, or to bear it.

From a sociological point of view, it should be emphasized that exclusion is not limited to any single social class. On the contrary, one characteristic of advanced technological societies is the risk of destabilization of the stable, triggered by processes of rapid downward mobility.

9 Fitoussi, J. and P. Rosanvallon, *La nueva era de las desigualdades*, ed. Manantial, (Buenos Aires, 1998).

10 Castel, R., *Las metamorfosis de la cuestión social*. (Buenos Aires, 1997).

From this perspective, the process of social incorporation may be understood in operational terms as the process undertaken by people, whether at their own initiative or at the suggestion of systems for social protection, with the intention of achieving a change in social position such as to allow them to move from a situation or risk of exclusion towards circumstances of integration. Such a process of social incorporation affects one or more areas of life related to employment, housing, income, training, education, legal status; family situation, health, social participation and personal development.

Gil¹¹ notes the particular features arising from speaking of “social and work” insertion, as opposed to “work” or “social” insertion on its own. This leads to a conglomerate of different policies, measures and actions that sometimes are of varying types with differing approaches, and involve different players (public and/or private). Nonetheless, all these actors should be brought together by the purpose of ensuring that unemployed individuals can get a job and be able to live a life as similar as possible to those of their fellow citizens. Among the factors relating to the individual, mention can be made of determinants such as sex, age, the social surroundings in which individuals find themselves, training, experience, capacity to learn, attitudes towards insertion, vocational maturity or preparedness for seeking employment, amongst others.

In the views expressed in the work cited, what defines insertion actions is the profile of users or subjects of them, and more specifically the needs that characterize the latter. These, according to Gil, shape a given life scenario, in which the presence of deficiencies or unfulfilled potentials relating to work, training, education, finances and so forth builds up a complex web of threatened or actual social exclusion. This is affected or acted upon by social and work insertion actions, and implies a lack of integration into community and society.

One note with respect to the migrant population in particular, as the largest group requiring insertion, is that the IOE Group¹² investigated the characteristics of foreign immigration and its consequences for the shape of Spanish society. It is an interesting approach that provides a cross-section of the world field in which migrations take place. This is because it leaves to one side the circumstances of their societies of origin and their inclusion into the world scene, as also the increasing links that migrants are establishing between various countries, acting as they sometimes do as authentic transnational communities.

11 Gil, M.A., “Empresas de inserción: contexto, orígenes y situación”. *Herramientas*, (2003) 69, pp. 34–41.

12 Colectivo IOÉ, “Inmigrantes extranjeros en España ¿Reconfigurando la sociedad?”, *Panorama Social*, (2005), 1, pp. 32–47. See also: Colectivo IOÉ, “Barómetro Social de España: nuevos indicadores sobre la evolución del país” en *Papeles de relaciones ecosociales y cambio global*, CIP-FUHEM, 101 (2008), pp. 165–185.

Content of the Study

The study concentrated principally upon the identification of the factors making employability hard to achieve, that is to say, the social and work inclusion of the following groups:

- Women at risk,
- The disabled,
- Immigrants,
- Ethnic minorities,
- Population of drug addicts and former drug addicts, and
- Other excluded groups or those at risk of exclusion.

In the case of women, a distinction may be made in accordance with whether they were single mothers; separated women, sometimes with family responsibilities, who were coming into the world of formal work for the first time; abused women, victims of domestic violence; and women aged over 45. In some instances, more than one of these profiles fitted a single person. These were the groups directly involved in the work.

We would like to say something about the position of Romany women. Young Romany women are especially isolated, since they both belong to marginal ethnic group and they are women. Young girls between the ages of 9 and 16 are expected to give up the childhood to take on mature family responsibilities. Boys, just because they are boys, enjoy a series of privileges that start at an early age. With the responsibility girls have in the family it is more likely they will miss school or end their school careers completely. Because they are women they have to do the household chores and take care of younger children. Girls are the pillar of family organization, yet this leads to truancy and the perpetuation of illiteracy. Moreover, Romany culture does not consider a girl's education necessary. Even mothers do not regard mainstream non-Romany education as something important for their daughters' future.

On the basis of reflections obtained from the previous section, an attempt was made to look closely at specifically social aspects. For this reason, attention was paid to features governing the theme under consideration, but from the perspective of the family and of the household. Hence, fieldwork took into account a study of the position of women within the family; division of labour between the sexes for family chores; power relations within the household: access to resources, decision taking; transmission of the values typical of the social environment of the family; family, school and training; the creation and articulation of networks for co-operation and help within and outside the family; access to information and the different ways it is used; the situation of the young; personal, social and identity conflicts; and the like.

Development of Methodology

The core methodological approach for the undertaking of this study has its roots in Socio-cultural Anthropology. In this way, the field work technique was an ethnographical method, so that it concentrated on a qualitative investigation. The research began with the drawing up of a survey script intended to cover the stated objectives, as well as to permit identification of the profile of users of the social services provided by the local authorities in Ponferrada.

Initially, 290 users of social services took part, being identified from a database provided by the services themselves. Later an attempt was made to get broader and more intensive participation on a voluntary basis, so that the size of the sample shrank¹³. Little by little, joint sessions were held, attendance these also being voluntary, which allowed common points in the same problem area for differing groups to be highlighted.

In parallel a questionnaire was drawn up, intended for entrepreneurs, institutions, trade unions, non-government organizations and other bodies, with an eye to learning the requirements of the labour market in respect of sectors, training, skills, abilities and other work competences in relation to the groups at risk of exclusion. After this information had been gathered, it was interpreted in such a way as to permit analysis of the causes of the social and work exclusion of these groups, and also to offer solutions for including them. The data obtained from the first part of the semi-structured questionnaire were subjected to a statistical treatment, so as to evaluate the representativeness of the sample. They are displayed in graphs that indicate the real data. Co-ordination with the Social Action department of the Municipality of Ponferrada was continuous and fluid. This was because in principle it was a question of resolving doubts that had arisen within this department, the work being carried out at times when one or the other of the two sides requested.

Through the field work, it was intended to analyse and assess an employability or “placeability” index. It was desirable to learn about the following:

- a. Value and worth set on employment.
- b. Attribution of unemployment.
- c. Availability for employment.
- d. Self-image, personal and occupational.
- e. Style of seeking employment.
- f. Occupational maturity.
- g. Demonstrated job-seeking skills.
- h. Social and family support
- i. Need for insertion.

13 The author would like to express thanks at this point to all those participating in the study, as also to the people and institutions that encouraged and facilitated it.

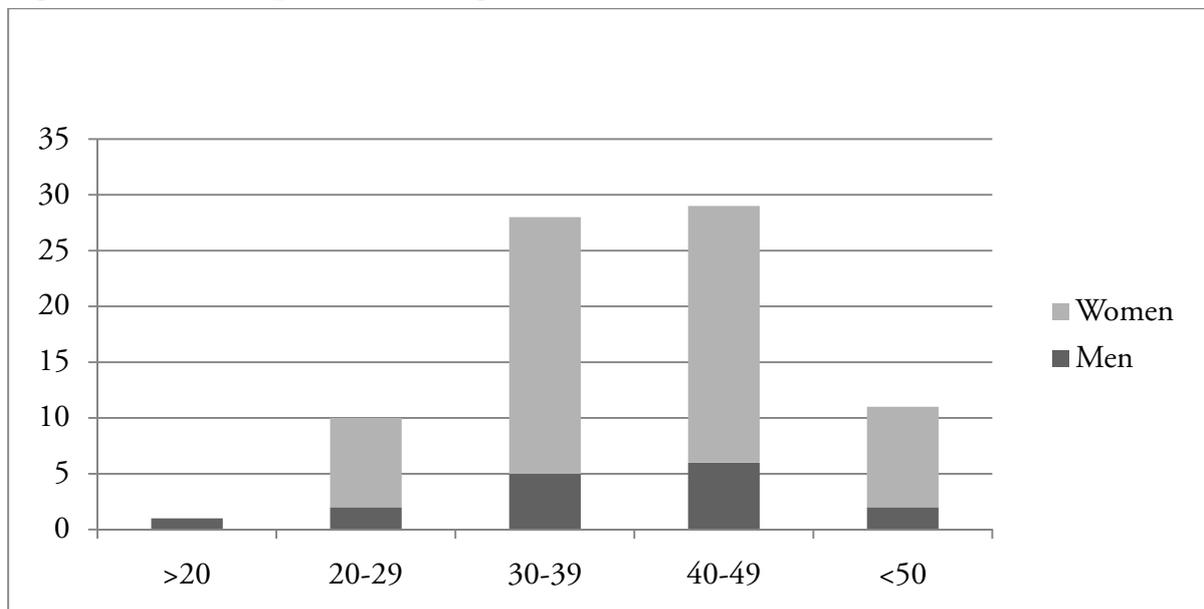
Field Work with Various Groups

Sample and Profile of the Population under Study

In undertaking the work, a database provided by the Social Action department of the Municipality of Ponferrada was used, this listing users suitable as participants in the study. This database contained 290 users, as noted above. With the data gathered during field work, various graphs have been produced here to show user profiles. All these graphs show actual totals for the population under study, not percentages.

With respect to the profiles of the users of social services who were involved in the work, as shown by Graph 1, they were mostly women. The majority were women aged between 30 and 50, with the numbers of women aged between 20 and 30 and of women over 50 being roughly the same. The proportion of men in the various age groups was similar, but they were fewer in number. As may be observed, the majority of participants were aged between 30 and 50. This offers the first clues as to the sort of difficulties for work insertion faced by this age range among the different groups.

Figure 1. Study Population by Age and Sex.



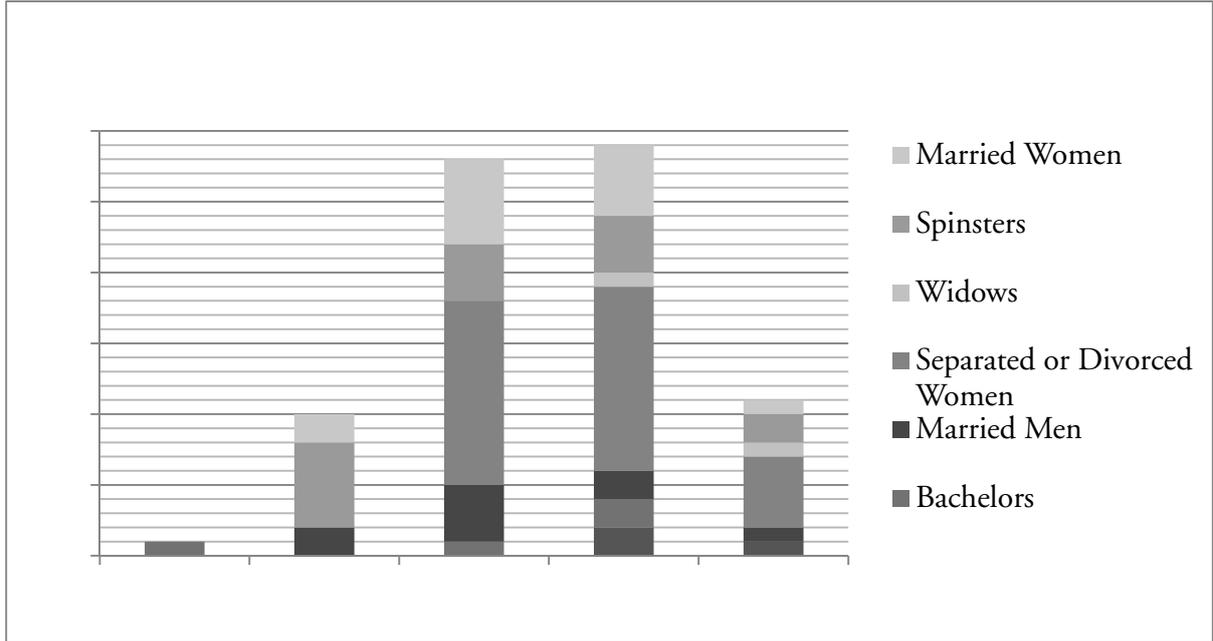
Source: Own elaboration.

With respect to the marital status of those participating in the study, there is a difference by age group. As can be seen from Graph 2, the women taking part in the study were mostly separated or divorced individuals aged between 30 and 50, these constituting virtually half of all the women involved. A further two sectors of

some importance were single women aged between 20 and 29 and married women between 30 and 39 years old.

With regard to men, married men aged between 30 and 39 were prominent, after whom came separated, single and married men from the age range 40 to 49 years old. The graph in question shows the total of those actually participating in the study divided according to sex, marital status and age group. As may be observed, there was a preponderance of separated or divorced individuals who were in the age range 30 to 50 years old.

Figure 2. Marital Status by Age and Sex.

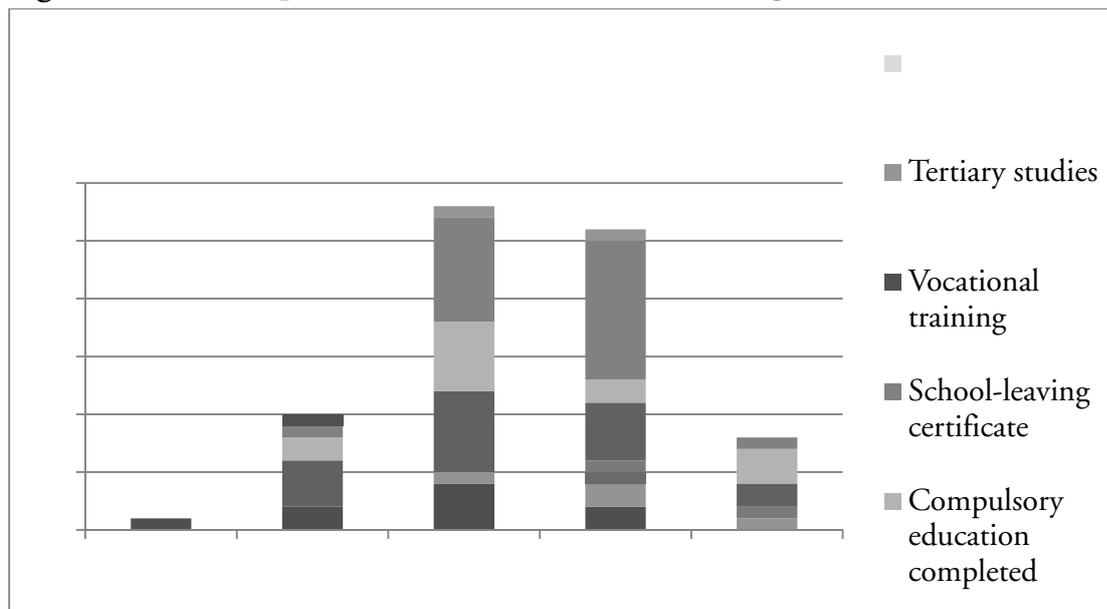


Source: Own elaboration.

With regard to education, the largest group among women was those with a basic level: primary and the compulsory part of secondary studies only. There was also a large group of women aged between 40 and 50 who had studied at secondary level up to an academic or vocational school-leaving certificate standard. The situation in respect of men was similar, in the sense that the group having completed only basic or primary studies was the largest. In the case of both sexes there were two people who had undergone university-level studies or training.

Graph 3 shows totals by level of education, age group and sex. It can be observed that the overall level of education and training was low.

Figure 3. Study Population: Educational Levels by Age and Sex.



Source: Own elaboration.

In respect of place of birth or of origin of the individuals taking the greatest part in the study (79), this was very varied. However, somewhat more than half (46) were from Ponferrada. After these came a range of smaller groups made up of:

- Immigrants from outside the European Union, principally from Latin America, (9), coming from Bolivia, Ecuador, Argentina and the Dominican Republic.
- There were other immigrants from Portugal (2) and Morocco (2).
- Another group were people from other districts elsewhere in the Province of Leon (8).
- People from provinces in other parts of Spain (12).

With regard to the risk groups into which the various individuals fell, these were also varied in size. Thus, for example, there were disabled people (13), ethnic minorities, principally Gypsies (5), immigrants (11), former drug addicts (1). The remainder, a large number, came under the heading “Others”. Analysis of the data showed that this grouping was composed for the most part of women. These, regardless of their age and marital status, had some further added feature. Thus, they were mostly separated or divorced women, victims of domestic violence; separated or divorced women entering the labour market; or single women with family responsibilities (involving parents or children).

To sum up, the profile of the population of participants was fundamentally one of middle-aged individuals, between 30 and 50 years old, having only a basic education or a low level of training, among whom the proportion of women was high, these primarily being separated or divorced.

Analysis of the information gathered showed that, despite a good predisposition towards working among those surveyed, there was a whole series of factors that made it impossible for them to find employment. Among these was one affecting nearly half of those questioned, who stated that they did not have the work experience required for a job. A similar proportion declared that they did not have the educational level or training demanded. In both cases those affected were generally people who were seeking their first regular job with a contract and contributions to the Social Security system. They were for the most part women, regardless of their age. Moreover, it should be kept in mind that the set of people involved were usually looking for employment that required few qualifications and little training. Yet, however little was being asked for, they were not able to provide it, unless they had been undergoing training for some very specific type of work.

Another argument put forward in relation to the previous claim was that they had never worked or were not accustomed to working. This is to be understood, of course, as a working day subject to a strict timetable, lasting for a considerable time, and the like. This also is an obstacle to finding work, or rather, more specifically, to coming to terms with the world of work. A similar sized group felt that what prevented them from finding employment were their personal problems. In the majority of cases this referred to their family situation. Fundamentally, it was a question of having children to look after or caring for elderly people.

A smaller group among those surveyed, around a quarter, felt that what prevented them from finding work was a lack of the information and guidance needed to seek out a job. This group was generally made up of the disabled, principally those who had a disability of recent origin who needed to change their activity if they wanted to continue working. They were required to confront a new social and work situation, both in respect of the way of seeking employment and with regard to the type of work they could do.

Other factors constituting an obstacle to finding work that were also mentioned included the existence of social and workplace discrimination, this being cited generally by immigrants or women. It should be stressed that this view was not widely put forward by ethnic minorities, as might have been expected. There were also comments on the lines that business owners only want to exploit workers or that it is not worth working for the amount of pay that is on offer. To a lesser degree, there were arguments of the kind that if somebody gets a job, it is because of pulling strings.

Psychological and Social Characteristics and Attitudes towards Work

As it has been pointed out in other place¹⁴, the people in the at-risk groups studied generally gave a positive image of themselves when asked about their qualities and attitudes towards work, even though they recognized that they were faced by a series of obstacles, lacks or other factors that made it impossible for them to get work. Thus, they considered themselves to be reliable and responsible in carrying out their commitments; they were ready and willing to work, and in general felt that they fulfilled the conditions for being a “good worker”. Some stressed they were punctual, or good with their hands.

The following list of comments gathered during field work gives a sample of the values, attitudes and social and work priorities of some of the individuals who participated in the study. They can be seen to have similar characteristics to those typical of the working population that does not fall within any at-risk grouping:

➤ SELF-ESTEEM:

- In my job I was recognized as a professional (HCP).
- In the places where I've been, people have been delighted with me (AVL).

➤ SACRIFICE:

- I've worked a lot of hours for very little money (TSM).

➤ IMPORTANCE OF THE FAMILY:

- My parents support me in everything (PFG).
- For me, my children are the most important thing (APF).
- You have to maintain your family (IPG).

➤ SPIRIT OF SACRIFICE (Abnegation)

- I've never complained about hard work (AGM).
- Need makes you take whatever is on offer (NLM).

➤ CRITICISMS OF THE WORLD OF WORK:

- They normally hire young girls (PLL).
- They just want a beautiful girl measuring 36-24-36 (CCC).
- However many qualifications I have, they are no use unless I find work (PPM).
- Less pay than I was hoping for (FGB).
- There's no such thing as continuity of employment (APB).
- Just where do they really give men and women equal pay? (AGM).
- I've worked a lot of hours for very little money (TSM).
- If a man puts in his C.V. that he's got a six-year-old child, it won't be a problem for him (MJLC).
- I've got experience, but I have no way of proving it (NLM).

14 Fernández, O. “La inserción sociolaboral de colectivos de riesgo”. *Actas VII Congreso Internacional de la Sociedad Española de Antropología Aplicada*. (Santander, 2006).

- FLEXIBILITY (Availability):
 - I'm an open person; I like to improvise; I'm as happy with the elderly as with small children (CVP).

- SOLIDARITY AND ASSISTANCE:
 - They've helped me a lot since I got separated (FGB).
 - I very much like helping the elderly (AAA).

- ABUSE:
 - I've been an abused woman since I was sixteen (AFM).
 - They've helped me a lot since I got separated (FGB).

- PHILOSOPHY OF LIFE (Way of looking at things):
 - I've looked for the meaning of life, but I haven't found it yet (AC).
 - The world doesn't belong to any one person, it belongs to everyone (CPL).
 - I'm being me; I like the person I'm turning out to be (CVP).
 - Working is a way of being useful to society and it helps me to build relationships and realize my potential (PPM).
 - I'm well aware of what the word Gypsy means and implies (CB-AJ).
 - Work is only one part of my life (APB).

- WISHES:
 - I'd like to do what I'm best at doing (JRJR).
 - Education is something I like; being able to pass on knowledge, that's an idea I find interesting (CAF).

- OPINIONS:
 - As for me, if someone does me harm I forget them (AVT).
 - Nowadays some things are not what they used to be; people change (CB-AJ).
 - My friends are in the same situation (EM).
 - Gypsy culture is never lost (JRJR).
 - I hate unfairness; if somebody isn't right, I won't say they are (AVT).

- REJECTION:
 - People just don't accept you (PFG-I-).
 - Since I'm a foreigner, I can't get work (LE).
 - Business owners expect more out of us foreigners (DL).
 - There are lots of handouts for foreigners, lots for the handicapped, but us single mothers need help too (RSG).
 - I follow the rules, just like any Spaniard would (CPL).

- MISTRUST:
 - There's still a disliking for Gypsies (CB-AJ).
 - If the first thing they look at is your race, that's wrong (CB-AJ).

- DESIRE FOR IMPROVEMENT:
 - I've tried to learn everything I could (ROF).
 - You have to be the best at what you do (AFM).

- INSECURITY:
 - I was afraid I'd look silly in a job I wasn't familiar with (JAB).
 - I had giddy spells because of ear trouble and they wouldn't let me in, but what could I do? (IC).

- PREOCCUPATIONS:
 - Health is the number one thing (POG).

- DYNAMISM:
 - I don't like staying at home; I'd prefer to be out and about (CTD).

Analysis and Assessment of the Data Obtained

Generally, positive attitudes to work may be observed in the information gathered. That is to say, there is a relatively good motivation for seeking employment, even if it is in given sectors that normally require limited qualifications. In this way, the average “index of placeability”, understood as the relationship between the personal and occupational profile and the posts to which people aspire, and what businesses usually demand for such posts, lies in general terms in bands which can be seen as normal if compared with those of groups that are not at risk of social or work exclusion, noted in some of the references listed at the end. This normal index arises from an overall analysis of the data, since if they are considered in closer detail, it would have to be adjusted downwards, as will be seen below.

This placeability index covered aspects mentioned above. These included the value attributed to employment and unemployment; availability for work; the personal and professional self-image; the style of search for employment; occupational maturity; skills demonstrated in the search for employment; social and family support; and the need for insertion. Although this evaluation was performed for each of the individuals who participated, here the results of an overview for each of the items will be given.

a) In respect of the value and worth set on work, although work was not considered the most important thing in life, since others such as health and the family were soon mentioned, it was felt that work is a means to self-fulfilment. In this sense, there would be other reasons making it important and necessary to work, besides making one's living. The majority also believed that it is better to live by one's own work than to be dependent on one's family or on society, whether through handouts or benefits. However, on this point not all informants were unanimous.

b) With regard to the values attributed to unemployment, the majority felt that in varying personal situations, its causes are fundamentally to be sought in the peculiarities of each person. That is, it was recognized that among the reasons for not finding work would be lack of experience, lack of training, personal character, or even not knowing where or how to seek it. Thus, it was understood that the situation of unemployment in which individuals find themselves does not depend exclusively on the shortage of offers of work, but upon other factors, among which personal capacities are one of the most crucial. Likewise, although it was also accepted that the fact of having influential friends or being able to pull strings might make it easier to get employment, this was not a factor considered to be of any great weight, and it was seen as being in the area of intangibles, of luck, and hence uncontrollable.

c) With respect to availability for work, individuals generally indicated they were ready and willing to do any sort of work, within the framework of preferences relating always to limited qualifications. People were even prepared to lower their aspirations as long as there was some sort of a job, or even to work in marginal or illegal situations, or in the black economy. However, there was no such availability for employment if it required a change of place of residence, away from Ponferrada and its surroundings, or implied working to a strange or difficult timetable.

d) With regard to personal and professional self-image, individuals consider themselves sufficiently prepared to carry out the jobs to which they wish to gain access. It has already been mentioned that these are generally low-grade employment. People even think they would be good at these jobs and that their image and personal appearance is ideal for such employment. Hence, they think they would have no trouble at all in doing the work. Moreover, there is always an underlying belief in all individuals that they are good workers in their speciality.

e) As for the style of search for employment, it is mostly recognized that efforts put into seeking work are not very assiduous. There is no continuous dedication to this, as something for which time is set aside every day. In most cases, it is even true that very few hours a week are spent on looking for work. Whether it is through their being tired with the process, or because some people have been searching for work for a long time, search activity is mostly sporadic or occasional, and when it does take place it is because of a suggestion, imposition, or recommendation from somebody else than those concerned. This is frequently because they are carrying out a series of activities or doing informal work by the hour and it is only when they are free and have time that they set out to look for work.

f) In accord with this viewpoint, the occupational maturity demonstrated is not great. This means that they do not think it necessary to train or to be recycled in the employment to which they aspire, or even to continue training in the job that they might be doing. Whether this is because the work they would like to have is low grade, or because what they are seeking is just a job of any sort, training is

viewed as something that may help in finding employment, but that is not always such. This is the explanation for the different and contradictory opinions expressed about training courses.

g) With respect to the skills shown in seeking employment, those individuals who have attended training courses, or who receive counselling from the Social Action service, do have some idea, at least in theory, of what constitutes an employment interview, of how to behave in such situations or of how to draw up their curriculum vitae. However, the limited work experience of some, or the fact that they have never attended training courses, leads them not to have any clear idea of how to present themselves when seeking work, what to do or say in an interview, how to get through a situation of that kind, or how to conduct a planned and orderly search for employment. This is despite the fact that they generally mention that they have received assistance in these matters from social services.

h) With reference to social and family support, most individuals recognize that they receive aid and encouragement from family members and friends in respect of undergoing training and of seeking work, and even that it is these people who inform them about job offers. However, in the same way, many people state that it is their own family situation that prevents them from seeking employment or indeed from taking on work offered.

i) As for the need for social and work insertion of the individuals surveyed, they are generally considerable, as apart from having to work to maintain themselves, most have family responsibilities. Paradoxically, as mentioned above, these are sometimes what prevents them from working. However, they do not describe their situation as desperate, since in most cases social welfare allowances or casual work by the hour provide some solution to the problem.

What Employers Say¹⁵

In general terms, to sum up the information provided by business people, employers and institutions, these all said that they set no different value on workers because of their belonging to one or another social group. What they stated they valued is a hard worker, who carries out the work assigned in an acceptable way. What they also said they take into account is that there are numbers of individuals who may have a range of personal, family or social difficulties that may affect the way they do their work. However, according to the views expressed by the majority

¹⁵ Collaboration and responses were received from small- and medium-sized businesses, in sectors such as electrical installations, the automotive trade, bakeries, food production, the meat trade, cleaning, trade unions and the social action service. The degree of representativeness cannot be seen as very high, since the level of co-operation was low.

of employers, this can equally well happen to people not belonging to any of the groups being considered.

Even so, they did mention groups that may face rejection, top of the list being drug addicts and former drug addicts. These were followed by ethnic minorities, particularly Gypsies, and also by immigrants. The fundamental reason they gave was the lack of confidence they could have in such people for doing a job. This was related to the statement that what is most highly valued in a worker is honesty. Honesty was seen as the first step to taking responsibility, and responsibility as something that permits workers to be trusted. Another reason related to the poor image some individuals can present.

On this point, it was also pointed out that some of the groups under study prioritize false needs, since they see work as just an obligation, which shows their lack of maturity and, once again, of responsibility. In the same fashion, with regard to the bad image previously mentioned, reference was also made to their being too "laid back", as they are lazy and casual and have a number of problems they ought to solve first.

Similarly, mention was made of the problems that may be faced by the disabled, as not all businesses are physically equipped to allow them to work and thus are technically unprepared to incorporate them. However, this was the group achieving most acceptance from those business people who had a handicapped person working in their enterprise.

The reasons given by employers for incorporating one or another of the groups under study into their staff were fundamentally connected to the assistance available, whether as tax relief, subsidies, or in other forms. There was very little altruism, and even a mention of the possibility of requiring a commitment to achieve a good image, on the part either of the workers or of the institutions that are responsible for them or sponsor them.

Moreover, they considered it evident that it is workers themselves, whatever group they may belong to, if any, who must make a commitment to, and take responsibility for, their work, show that they cause no problems and fulfil their duties like everybody else.

It is significant that the majority of the employers who agreed to collaborate in this study already had individuals from one or another of the groups under consideration working in their businesses. The level of satisfaction with them was high, although they have had to go through a series of adjustments in order to reach this degree of acceptance and normality. This refers to the problems that there have been and which they consider affect these groups, the first of which is the lack of a habit of working: some of them are just not accustomed to work. From this there can arise a problem of a lack of work experience in different sectors or of specific training for these sectors. An additional difficulty, noted as a secondary cause, are

the various personal or social problems these individuals may have. It is even worse if because of these situations they do not know how to fit into society.

Employers as a group also referred to a number of deficiencies in these groupings with respect to knowledge, skills, capabilities and abilities, social and work-related, considered vital or seen as desirable in the various types of job. In this respect, there are various levels of requirements. In general employers required people to have the necessary training for the work to which they wanted to gain access. This may seem self-evident, but at the lowest levels of employment, even casual work, it does at least require an ability to read and write. This to some degree demolishes the argument put forward by many individuals that, for example, to be a cleaner, you need to know how to clean, and that is all. The view of employers was rather more that to be a cleaner one also had to be able to read what it says on the bottle of cleaning fluid and understand what it means, so as to use it appropriately and not to become involved in personal accidents or damage objects.

Conclusions, Tools and Strategies for Consideration

The majority of the individuals in the various vulnerable groups participating in this study suffered from a number of educational, work-related, attitudinal and social deficiencies that prevented them from reaching an adequate condition to get access to a job. Their chances of gaining employment were further reduced because in addition very few had even the minimum specific vocational training required by most jobs available. Some of these individuals, aware of their educational and vocational deficiencies, attempted to get casual employment which they supposed would require little training or professionalization. However, as shown by the evidence, this is an error, as even for casual work one has to be trained.

It is thus a question of designing training and incorporation into the world of work on the basis of filling these gaps in capacity, in a way that must be flexible, broad-ranging and participation-based. The challenge in this idea is that, starting from the capabilities of each person and their efforts, there should be a two-way commitment. On the one side, it would be from individuals through projects or routes for inclusion that would be personal and guided. On the other, it would be from bodies, whether from the administration supporting them, or from the enterprises or institutions giving them work and receiving assistance for offering a contract to the individual concerned.

Such personal inclusion routes, as arrangements involving both financial assistance measures and training or orientation actions, including social skills, should have a clear and precise sequence, with well defined objectives for differing phases (welcome, pre-training, training, work experience, and so forth). Their methodology and design should be flexible, so as to leave room for a diversity of require-

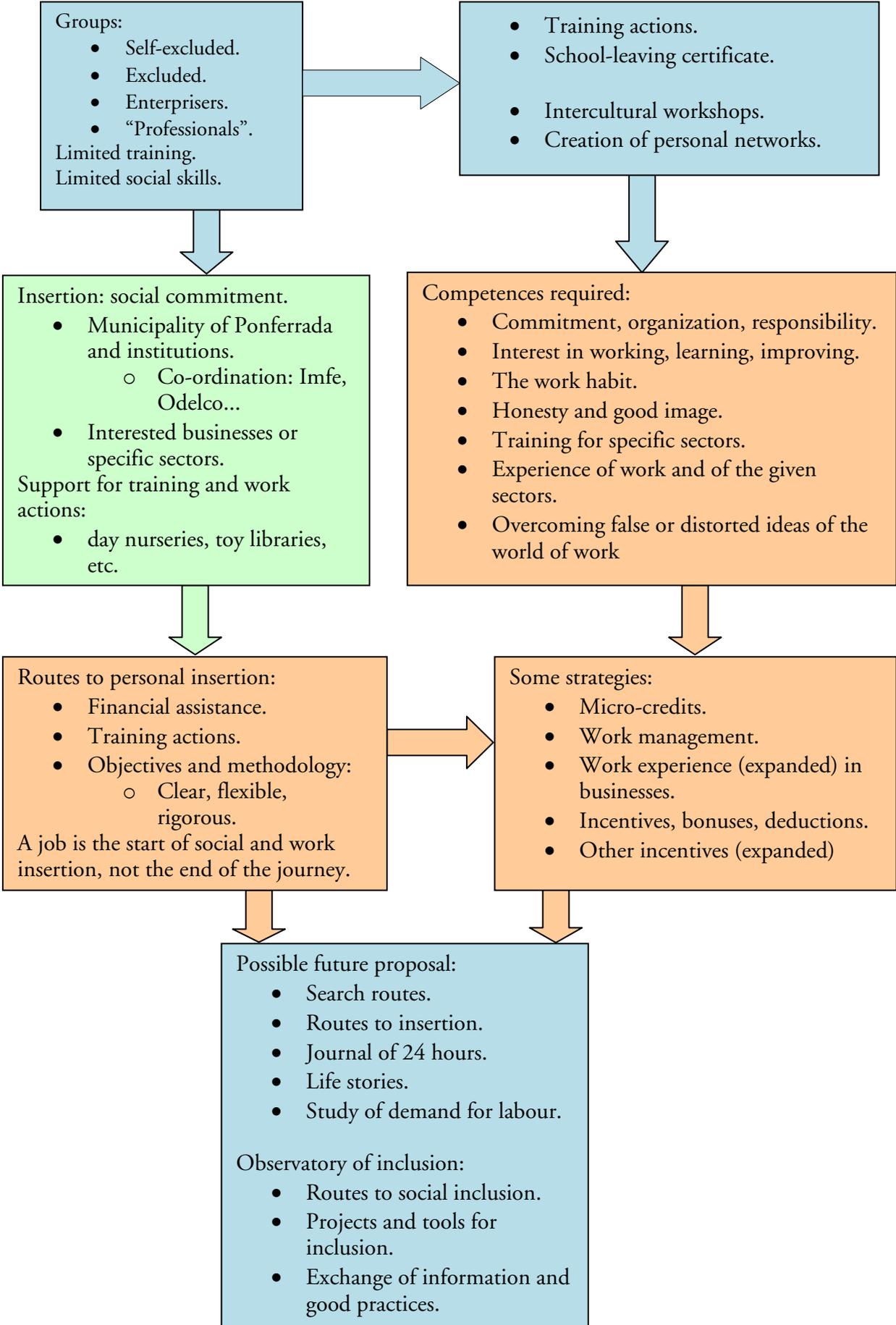
ments, in which getting a job should not be the end of the route, but rather the normal way of beginning social and work integration. They should include a possibility of direct access to employment, incorporate market surveys, and, in brief, act as an integrating strategy that will supply all the missing capacities of groups at risk of social exclusion.

Furthermore, it must be kept in mind that the current labour market is strongly governed by supply and demand and highly competitive. The most underprivileged groups are most likely to generate enclaves of exclusion from this market. This limits the extent to which a number of groups can gain access with equality of opportunities to a decent and properly paid job. Hence mechanisms for intermediation must be created, whose principal task is to offer employers and employees the minimum conditions to bring these two groups together. In the face of an attitude that may be termed centrifugal on the part of the two groups, which raise their requirements and have little flexibility in their demands, there should be a centripetal force from labour intermediaries who should seek a balance between those parties involved.

To conclude, from the analysis of the data, a series of tools and strategies for consideration emerge, shown in condensed form in the following general outline of the study.

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Figure 4. General Outline of the Study.



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Nutritional Status in Elderly People Living in Retirement Homes in the Czech Republic

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Introduction

The population of the Czech Republic (CR) is approximately 10 million inhabitants. It presents 2.3% of the extended EU population. In the Czech Republic the older population percentage is rapidly increasing due to the increase in life expectancy (M 73 yrs, F 79 yrs) and an extremely low birth rate, which has existed since the 1990's (fertility rate increased slightly from minimum 1.13 in 1999 to 1.44 in 2006). In 2007, 15% of inhabitants were aged 65+ (more than 1.5 mil.), by 2030 the 65+ population is expected to reach 22.8%, and by 2050, it is expected to be 31.3%. The proportion of persons in the highest age group (85+) is growing the most rapidly and increases in life expectancy, in both sexes, is expected to continue, with estimated life expectancies of 84 years in males and 88 years in females by 2065. The relative share of seniors will unevenly increase in coming decades due to natural ageing of the early 1970's "population boom," which was a direct consequence of pro-birth measures linked to social policies of political "normalization". The age structure in the CR, measured by the age preference index, is currently on par with the EU average, however, if present trends persist, the population of the CR will gradually become one of the oldest in Europe.¹ Health insurance of pensioners, in the CR, is financed from the state budget. Traditionally, provision for health and social care was concentrated in modern institutions (hospitals, elderly homes, residential nursing homes, etc.). It is only recently that small steps, involving new trends of extramural care (e.g. home care) have been taken and political support for independent living and family care has only recently, been declared. Nonetheless, rising financial stress on the health care budget and persistent mental and organizational stereotypes and traditions

¹ Institute of Health Information and Statistics of the Czech Republic, <http://www.uzis.cz> (July 16, 2010).

(giving priority to large professional health and social care institutions instead of small independent outpatient providers or lay care) have caused implementation of reforms to lag behind practical needs. During the 1990's, decentralization and privatization led to diversification of providers, especially in out-patient health care, nursing care, and social services. The senior population is heterogeneous when viewed from health, mental, social and/or economic perspectives; however, the inequalities have not yet been systematically studied, despite the high political value of equity. The only exception may be the regional differences in life expectancy, mortality, and accessibility to health care, which have been systematically monitored by the national health statistical system.²

Nutritional status of the elderly is a basic determinant of health and disease. Based on our experiences, the majority patients 75 years of age and older, admitted to hospital, are undernourished. For one third of all admitted patients, in this age group, malnutrition or water and electrolyte disturbances represent basic etiopathogenic factors, which are associated with other morbidities. Undernutrition in the elderly develops due to reduced intake of food, a natural part of the aging process, and decreased physical activity. Stress metabolism associated with major surgery or critical illness e.g., severe infection, may be the reason for disease-related undernutrition in all patients regardless of age, whereas in elderly patients, multi-morbidity and reduced reserve capacity may increase the risk for undernutrition in excess of that seen in younger patients.³ A study by German et al.⁴ found a significant association between depression and risk for undernutrition among hospitalized elderly patients. Overall, 17% of hospitalized elderly patients were both depressed and at risk for undernutrition as assessed using a self-reporting questionnaire.⁵

Experience has shown that socioeconomics is not the main problem with regard to undernutrition in the elderly. Regardless of whether the elderly are living in prosperous families, or, as is more common for the elderly, living in retirement homes and the other social institutions, undernutrition is still an issue. A consequence of undernutrition is reduced protein synthesis, which weakens the immune system and puts the elderly at increased risk of infections (e.g. bronchopneumonia,

2 Preliminary National Report on Health Care and Long-term Care in the Czech Republic, http://www.mpsv.cz/files/clanky/1343/report_health_care.pdf (July 16, 2010).

3 Ilana Feldblum, Larisa German, Natalya Bilenko, A Shahar, R Enten, D Greenberg, Ilana Harman-Boehm, Hana Castel, Danit R Shahar, „Nutritional Risk and Health Care Use before and after an Acute Hospitalization among the Elderly“, *Nutrition*, 25 (2009), pp. 415–420.

4 Larisa German, Ilana Feldblum, Natalya Bilenko, Hana Castel, Ilana Harman-Boehm, Danit R Shahar, „Depressive Symptoms and Risk for Malnutrition among Hospitalised Elderly People“, *J Nutr Health Aging*, 12 (2008), pp.313–318.

5 Ilana Feldblum, Larisa German, Hana Castel, Ilana Harman-Boehm, Natalya Bilenko, Miruna Eisinger, Drora Fraser, Danit R Shahar, „Characteristics of Undernourished Older Medical Patients and the Identification of Predictors for Undernutrition Status“, *Nutritional Journal*, 6 (2007), pp. 1–9.

urinary infections). Additionally, wound and fracture healing can also be prolonged. Malnutrition is also related to dehydration. The consequences of dehydration initially present as poor perfusion of organs, which is associated with increased risk of renal failure, urinary tract infections, cerebral apoplexy, and hepatic lesions. The second consequence is higher blood viscosity, which is associated with increased risk of thrombosis, pulmonary embolism, heart attack, cerebral apoplexy, and renal failure.⁶ Currently, there is lack of studies regarding the nutritional status of frail elderly in the Czech Republic. Elderly people can live at home alone, or with their immediate or extended family (for the purpose of this study these types of living arrangements are referred to as “residential settings”) or in retirements homes, rest homes, nursing homes or senior housing (these types of living arrangements are referred to as “institutional facilities”). The goal of our study was to evaluate the nutritional status of elderly individuals admitted to hospital. Additionally, we compared the nutritional status of those coming from family homes with those coming from institutional facilities.

Methods

The study sample consisted of 281 patients (101 men and 180 women) older than 70 years, who were admitted to the 2nd Department of Internal Medicine, University Hospital, Královské Vinohrady during a three month period (1.1.2006 – 31.3.2006). Patients with any stage of malignant tumor were excluded from the study. All basic data were collected by well-trained internists within 2 days of admission and 1 day before discharge from hospital. The anthropometric measurements were taken by trained staff and included weight, height and body-mass index (BMI), which was estimated by dividing weight (kg) by height² (m²). Blood samples were obtained at admission and before discharge and were analyzed by the Department of Biochemistry and Pathobiochemistry of the University Hospital, Královské Vinohrady. Two groups of patients were compared: patients living in institutional facilities for seniors (e.g. retirement homes) and elderly patients who lived in residential settings. The difference between groups was measured using Fishers Exact Test and the Wilcoxon Two-Sample Test. Data are expressed as means \pm SDs for continuous variables and as percentages for categorical variables. Intergroup differ-

6 Michal Anděl, Pavel Dlouhý, Jolana Rambousková, Dana Kubisová, Pavel Těšínský, Pavel Kraml, *Nutritional Problems and Nutritional Support in Elderly* (Problematika výživy a nutriční podpora ve stáří). In: Michal Anděl, Luboš Sobotka, Pavel Těšínský, Zdeněk Zadák, Influence of the nutrition and intensive medical care at the organs function and postoperative status (Vliv výživy a intenzivní metabolické péče na orgánové funkce a pooperační stavy) Hradec Králové, Nucleus (2003), pp. 98–100.

ences and correlations were tested, and P values of less than 0.05 were accepted as statistically significant.

Results

The study group consisted of 281 patients aged ≥ 70 years (101 male and 180 female) who were admitted to hospital. Age range for patients is presented in Table 1. Table 2 shows patient living/care arrangements prior to hospitalization and table 3 shows the patient living/care arrangements after discharge. Mean body mass index (BMI) was 26.71 ± 5.47 kg/m² in patients coming from a residential setting, 27.25 ± 6.81 kg/m² in patients coming from institutional facilities and 23.77 ± 5.36 kg/m² in patients transferred from another department. The mean serum albumin concentration on admission was < 30 g/l in 22.3% of patients coming from a residential setting and 34.1% of patients coming from institutional facilities (Table 4). Blood albumin concentrations on hospital discharge are shown in table 5. There was significant difference between the group of patients discharging to a residential setting and patients discharging to institutional facilities.

Table 1. Age range of study participants.

| Age (years) | Male | Female | Total |
|--------------|------------|------------|------------|
| 70–74.99 | 35 | 29 | 64 |
| 75–79.99 | 24 | 63 | 87 |
| 80–84.99 | 22 | 44 | 66 |
| 85–89.99 | 11 | 27 | 38 |
| 90–94.99 | 9 | 14 | 23 |
| ≥ 95 | 0 | 3 | 3 |
| Total | 101 | 180 | 281 |

Table 2. Living arrangements prior to hospitalization.

| | Male | Female | Total |
|--------------------|------------|------------|------------|
| Residential | 83 | 153 | 236 |
| Institutional | 15 | 24 | 39 |
| Another department | 4 | 2 | 6 |
| Total | 102 | 179 | 281 |

Table 3. Living arrangements after hospitalization.

| | Male | Female | Total |
|--------------------|------|--------|-------|
| Residential | 67 | 116 | 183 |
| Institutional | 12 | 30 | 42 |
| Another department | 14 | 17 | 31 |
| Died | 9 | 16 | 25 |
| Total | 102 | 179 | 281 |

Table 4. Blood albumin on hospital admission (% of patient with low and normal values) SD, standard deviation.

| | Alb < 30 g/l | Alb ≥ 30 g/l | p-value |
|---------------|--------------|--------------|---------|
| Residential | 22.3 | 77.7 | 0.008 |
| Institutional | 34.1 | 65.9 | |

Table 5. Blood albumin on hospital discharge (means and SD).

| | albumin (g/l) | SD | p-value |
|------------------------|---------------|-------|---------|
| Residential (n = 178) | 34.624 | 5.946 | 0.003 |
| Institutional (n = 41) | 30.304 | 6.924 | |

Discussion

We decided to compare patients coming from residential setting and those coming from institutional facilities because there is evidence for nutritional problems in frail, institutionalized elderly residents.^{7,8}

Undernutrition as measured by BMI and albumin serum concentration is common in those admitted to a subacute-care facility. A study by Poulsen⁹ found undernutrition in 41% of patients at admission to a geriatric clinic using a BMI (kg/m²) cut-off of 22. Morley and Thomas¹⁰ attribute the “anorexia of aging” to a disturbance in the ability to regulate food intake. The poor nutritional status of the elderly can be attributed to multiple factors. With increasing age, appetite is reduced, physical activity diminishes, and fat-free body mass decreases even in

7 Daniela Kulnik, Ibrahim Elmadfa, „Assessment of the Nutritional Situation of Elderly Nursing Home Residents in Vienna“, *Ann Nutr Metab*, 52(suppl 1) (2008), pp. 51–53.

8 David R Thomas, Carolyn D Zdrowski, Margaret-Mary Wilson, Kelly C Conright, Cecelia Lewis, Syed Tariq, John E Morley, „Malnutrition in Subacute Care“, *Am J Clin Nutr*, 75 (2002), pp. 308–313.

9 Ingrid Poulsen, Ingalill Rahm Hallberg, Marianne Schroll, „Nutritional Status and Associated Factors on Geriatric Admission“, *J Nutr Health Aging*, 10 (2006), pp. 84–90.

10 John E Morley, David R Thomas, “Anorexia and aging: pathophysiology” *Nutrition*, 15 (1999), pp. 499–503.

absence of an overt catabolic illness. Despite the high prevalence of malnutrition in the elderly and the known association between malnutrition and poor clinical outcomes, malnutrition often goes unrecognized and untreated during hospitalization. This is partly because routine nutritional tests, in current use, are often not done because of time constraints and, in part, because of the frailty of geriatric patients. Anthropometric measurements are crucial part of nutritional assessments and are considered the most significant part of the mini nutritional assessment (MNA). Low serum albumin concentration, diabetes mellitus, infections, and malignancy have been found to be independent risk factors for death.¹¹ In this study, blood albumin levels were used in the assessment of nutritional status and albumin levels ≤ 30 g/l was taken as the cut-off point for undernutrition. Most patients came from a residential setting and 77.7% of them had blood albumin levels ≥ 30 g/l. 65.9% of patients coming from institutional facilities had blood albumin levels ≥ 30 g/l. More than one-half of the subjects admitted to subacute care had low serum albumin concentrations. Severity of protein-energy undernutrition, as indicated by a low serum albumin concentration or a history of recent involuntary weight loss, is a strong independent risk factor for life-threatening morbidity after discharge from a rehabilitation facility, even when the severity of illness is controlled.¹² In a Swedish study, 29% of patients admitted to a long-term-care geriatric hospital were malnourished at admission.¹³ Serum albumin concentration is inversely related to mortality risk in a graded manner; the estimated increase in the odds of death ranges from 24% to 56% for each 2.5 g/l decrement in serum albumin concentration.¹⁴

Conclusions

In this study, BMI did not differ between patients coming from residential settings and patients coming from institutional facilities. Thirty percent of all patients admitted to hospital had biochemical signs of decreased protein synthesis (data not shown). Low blood albumin levels were found in 34.1% of patients from institutional facilities and 22.3% of patients coming from residential settings. Malnutri-

11 Nadya Kagansky, Yitshal Berner, Nira Koren-Morag, Luiza Perelman, Hilla Knobler, Shmuel Levy, „Poor Nutritional Habits are Predictors of Poor Outcome in Very Old Hospitalized Patients“, *Am J Clin Nutr*, 82 (2005), pp. 784–791.

12 Dennis H Sullivan, Robert C Walls, Melinda M Bopp, “Protein-energy undernutrition and the risk of mortality within one year hospital discharge: a follow-up study” *J Am Geriatr Soc*, 43 (1995), pp. 507–512.

13 J Larsson, M Unosson, A-C Ek, L Nilsson, S Thorslund, P Bjurulf, Effect of dietary supplement on nutritional status and clinical outcome in 501 geriatric patients--a randomized study. *Clin Nutr*, 9 (1990), pp.179–184.

14 Philip Goldwasser, Joseph G Feldman, Association of serum albumin and mortality risk, *J Clin Epidemiol*, 50 (1997), pp. 693–703.

tion and metabolism disorders represent a fundamental cause of hospitalization in the elderly. These patients' often require long-term hospitalization as well as substantial post-hospitalization care. Such care represents a financial burden for hospitals and institutional care facilities.

There is evidence of poor nutritional status among residents in institutional facilities. There have been no studies comparing nutritional statuses, relative to regional differences, in institutional faculties (i.e. large vs. small towns, rural vs. urban populations). It is precisely the absence of these studies that differentiates the Czech Republic from many other developed or developing countries.¹⁵ For these reasons, we would like to focus our future studies on defining the nutritional status of elderly patients who reside in institutional facilities. We plan, over the next years, to carry out an assessment of the nutritional status of elderly living in institutional facilities and analyze regional differences. We would like to compare two groups: the first group of elderly would be from Prague and the second group would be from a small city.

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15 Stephanie Lesser, Lioba Pauly, Dorothee Volkert, Peter Stehle, Nutritional Situation of the Elderly in Eastern/Baltic and Central/Western Europe – The Ageing Nutrition Project“ *Ann Nutr Metab*, 52 (suppl) (2008), pp. 62–71.

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Health Promotion Programs for the Elderly in Greece, the “Health Pro Elderly” Project

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Introduction

The ageing of the population and the increase in the incidence of chronic diseases, combined with limited resources for health care, led researchers and policy makers to search for health promotion alternatives. Defining Health Promotion as the process of enabling people to increase control over their health in order to improve it¹ and considering Healthy Ageing as an approach which recognizes that growing older is a part of living fostering a positive attitude through life to growing older², “Health pro Elderly” project was designed and realised in order to develop evidence-based guidelines and recommendations about action in European, National and Local level.

European reality reveals an unprecedented demographic change characterised by a remarkable ageing of the population, as a result of the general increase in the standard of living as well as of the whole progress of health sciences and medical technology. Proportionally, in Greece, the expectancy of life rose from 74, 6 years for males and 79, 4 for females in 1990 to 75, 42 and 80, 54 respectively in 2000. Besides, in 2000, the population aged over 65 was 16.6%, while in 2005 was 18%³ and in 2050 it is expected to reach the percentage of 31, 5% of the general population⁴. The increase of life expectancy, combined with the increase in the ageing index has important social and political implications, as fewer people of productive

1 WHO, *Health Promotion Glossary* WHO/HPR/HEP/98.1 (Geneva, 1998), pp. 1–2.

2 WHO, *A Glossary of Terms for Community Health Care and Services for Older Persons*. WHO/WKC/Tech.Ser./04.2. (Geneva, 2004), p. 31.

3 National Statistical Service of Greece, *Statistical Yearbook of Greece and Monthly Statistical Bulletin* (NSSG Census, 2001).

4 Eurostat, *EU25 population aged 65 and over expected to double between 1995 and 2050* (Eurostat Press Office, 129/2006).

age will support the increasing demands on the health care system. Substantial adjustments and provisions in health care systems are required. Health promotion and prevention need to be developed in order to reduce the necessity for cure and care with respect to Health as a basic human value and an important resource for every day life.

In this context Health Promotion Programs for the Elderly become very important. In most EU countries, many health promotion activities for seniors take place, but they are not always properly evaluated or sustainable. The “Health Pro Elderly” project aims to identify criteria that make health promotion programs successful and provide evidence for sustainability.

Health Promotion for the Elderly

It is possible to improve the quality of life of older people by empowerment, physical and mental activity. Older people can – with successful health promotion interventions – be empowered to lead a healthy life, increase their social contacts, stay physically active and live independently.

Different types of health promotion activities for older people, including environmental adaptation, which make active ageing possible represent a new and innovative field that is vital for the future. There are various individual projects and programmes in EU-member states that offer health promotion activities on a local or regional level. However, they are frequently not known on a national or international level. Besides, limited funding, lack of mainstream provision and no coherent policies in this field undermine the continuity and sustainability of the programs despite the expertise and the Know-how of the involved staff.

The evaluation of existing health promotion programs, projects and initiatives is essential as it can contribute a lot to the determination of the elements that make a current health promotion practice successful and will serve as models of good-practice in the field of health promotion for older people.

An essential point of the evaluation of health promotion interventions for the elderly is that they involve a great number of stakeholders with different interests, priorities and understandings of what can be characterised as important and what not. For instance, users, carers, professionals, funding institutions and researchers have differences in their point of view about relevant health promotion initiatives.

Regarding existing health promotion programs and projects in European level it is obvious that in their majority they have a target group between 55 and 65 years of age and many of them define their target group with certain group characteristics. Many of them include invisible older people, considering as invisible a group basically economically dependent and passive, neglected by politicians and the official state that generally focuses on younger groups of population. Besides, the majority

of existing health promotion initiatives focuses on one aspect of health, the physical, mental, or social one and less on an holistic approach. Additionally, some of them consider healthy environments and structures as an important aspect of health promotion for the Elderly. Seldom initiatives include both, individuality and macro-society in their initial concept⁵. Besides, the majority of existing programs and projects are realised into community settings, particularly in urban areas and their stakeholders belong as a rule more to public sector, for instance ministries, municipalities, city councils, universities and educational institutions, health care infrastructures and less to non-profit and to private/profit sector. Regarding their goals, it is obvious that the majority of the projects aim at the development of personal skills and very few refer to a systemic approach focusing on individual's environments and supportive structures⁶.

All the stakeholders broadly support the involvement of the target group in all phases of health promotion initiatives. It is very important to involve the elderly as they can specify their own needs and determine the ways of approach within health promotion practice.

It is obvious that successful health promotion for older people is a complex issue and needs massive planning. During the phase of planning specific characteristics of the target group have to be considered as well as the documentation and the theoretical background which suits to the interventions, taking into consideration the goals and aims. Besides this, the determination of the proper setting for the intervention and the management and the financial structures is essential too. Proportionally, during the phase of implementation, the activation of older people is essential, combined with the stimulation of social and political networks. Finally, during the phase of evaluation, both qualitative and quantitative evaluation designs have to be used so as to assess both process and outcomes⁷.

The “Health Pro Elderly” Project

“Health Pro Elderly” is a Project realised within the Public Health Program of the European Commission, financed by European and National resources, from April 2006 until December of 2008. The project's partners come from eleven countries, including Austria, Czech Republic, Germany, Greece, Italy, Netherlands, Poland,

5 Gert Lang, Katharina Resch. 33 European Best-Practice Projects: A Case-Study Evaluation of Health Promotion for Older People, (Research Institute of the Red Cross, July 2008).

6 URL Health pro elderly, *Health pro elderly, Evidence-based Guidelines on Health Promotion for Older People: Social determinants, Inequality and Sustainability*.

7 Lang& Resch, (2008).

Slovenia, Slovakia, Spain, and United Kingdom. Red Cross of Austria was the overall co-coordinator and the independent Institute “Emmeerre “(Italy) has been put in charge of the Evaluation of the project. The project’s partners represented an interdisciplinary team involving professionals from university institutions (7), Red Cross Associations (4), non-university research institutions (2), nurses’ organizations (2) and Public Health organisations (2).

The overall aim of the project was to support Health promotion for older people via developing evidence-based guidelines and recommendations for action in European, National and Local level. While, General Objectives of the project included:

- a literature overview and the writing of relevant National reports, forming an Excel database;
- the collection of all relative terms in a glossary;
- the selection of a set of inclusion and exclusion criteria to choose and assess national health promotion programs for the elderly that serve as examples of good practice;
- the recognition of criteria that contribute to the success of health promotion programs;
- the composition of evidence based guidelines and recommendations for Health promotion for the Elderly and
- the dissemination of the knowledge produced of the project in National and European level.

The project was realized within five phases.

During the first phase (July 2006- January 2007), a literature review was compiled and the terminology used was gathered in a glossary, in order to create a **common base of communication, in English, given the different languages of the partners**. Besides, a set of inclusion and exclusion criteria for the selection of national health promotion models of good practice was composed.

During the second phase (January 2007- May 2007), the collection and compilation of several national health promotion models took place, according to eligibility criteria agreed on the first phase. These models formed a database of more than 160 items.

During the third phase (May 2007- January 2008), each partner selected three models of good practice and evaluated them in detail, according criteria focusing on vulnerability, sustainability and inequality. Relevant national reports were formed and then a European report was formed as well.

During the fourth phase (January 2008- May 2008), an international congress, in Warsaw, Poland was organized by Polish National Nurses Association. In that conference the results of the three previous stages were presented and the first draft of the recommendations and guidelines was formed.

During the last phase (May 2008- December 2008), the development of evidence-based guidelines and recommendations took place⁸.

All the material produced during the project have been located to the project's website, available at www.healthproelderly.com.

The Greek case

Greek project partners, throughout the literature search ascertained that the majority of the collected data reflected the situation in a local, of regional level and less in the national level. The overwhelming majority of studies and projects concerned KAPIs, open health care centers for the elderly and fewer community and residential homes for older people. Furthermore, there was a significant interrelatedness of different themes and issues in many sources of the literature. The whole number of the literature findings referred to the quality of life and health determinants in broad terms.

So, many of the sources emphasized on the quality of life of old people who suffer from mental disorders, especially people with Alzheimer's disease. Issues concerning lifestyle were proportionally common themes in literature. Nutrition, safety, and disease prevention were addressed in a considerable number of sources⁹.

All literature findings have been compiled in an excel-database available in the website of the project.

Among all the programs, projects and studies from Greece, three projects were selected according to the criteria of "Health Pro Elderly" project. These projects were all effectively developed and implemented. "Action programme for older people", "The involvement and the role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases" and "The role of Health Education in Improving Compliance with treatment for the Prevention of Cardiovascular Diseases" are the three case studies; each one was a Health Promotion intervention which took place in different urban municipalities in the greater Athens area and constituted an innovative and crucial initiative which dealt with older people and undertook health promotion action. These last two programmes were selected from the other programmes in the database because of their well-grounded theoretical approach and strategy. Additionally, these programmes were selected as they included empowerment, voice of older people and evaluation. On the other hand, the "Action programme for older people" was mainly selected because it has been running for more than 10 years (sustainability), it was accessible for all older people

8 URL Health pro elderly, (2009).

9 Athena Kalokerinou, Theodoula Adamakidou, Maria Damianidi, Vasiliki Roka, Venetia Velonaki, Panayota Sourtzi, *National Evaluation Report- Greece*. (Health Pro Elderly URL, 2008).

of the municipality where it took place and because of its transferability. All presented health promotion programmes have been properly evaluated and widely disseminated and took place within Open Care Centres for Older People (KAPI).

According Greek reality, KAPIs are centres that accept as members any older person over 60 years old. In KAPIs a small number of health and social care professionals, such as nurses/health visitors, social workers, physiotherapists, occupational therapists, home care assistants. Their role is to promote the health of older people in any available way. KAPIs are widespread throughout the country and are very popular with older people of both sexes. There are over 450 KAPIs today in Greece run by the local authorities; while in the everyday running of the centre older people are seriously involved as some of them are elected to participate in the administrative body of each centre¹⁰.

The first project, "Action Programme for older people" focused on maintenance and improvement of mobility, autonomy and self-care, via an exercise program. It has been implemented since 1997, in the municipality of Agios Dimitrios (greater Athens area). Mr Babanas A. and Ms Koureta K. have been the major contributors. The project has been based on previous related projects co-ordinated by the General Secretariat for Sports. These projects have been implemented in different KAPIs in different municipalities. The project is run and staffed by the local Primary Health Care Services. The target group of the project has been people older than 60 years old. The action programme for older people has been implemented in two phases. In the first phase, the elderly are informed through lectures and discussions about health related problems and the role of exercise in the improvement of their health. The second phase included the action programme, which takes place in a special room (gym) and in outdoor athletic areas, using appropriate exercise aids. The duration of the programme is 45 minutes each time and it has taken place twice a week. Each year the participants' physical state and mobility is evaluated. The entire project is evaluated every 5 years. The results of the project are the improvement of participants' joint functional ability and mobility; the improvement of neuromuscular control on the movements and of body balance; the adoption of healthier habits and less frequent use of physiotherapy^{11,12}.

The second project, "The involvement, and the role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases", has promoted the Senior Health Mentoring concept as a model for spreading out health promotion issues through Day Care Centres. Dr Velonakis E. and Dr Sourtzi P. were the

10 Kalokerinou et al., (2008).

11 Emanuel Papadakakis, Athanasios Babanas, Katerina Koureta, *Action Programme in older people*, in Proceedings: "Subjects of Gerontology and Geriatrics/ The current greek experience at the begging of third millennium" (Publishers: "Synedron: Dimiourgikes ekdosis", 2000), pp 43-48.

12 Anonymous, *Happy years, full of action and energy* (Energos Dimotis Notion Proastion, 2007), p12.

co-ordinators of the project, which took place in Open Care Centres for Elderly (KAPI) in two Municipalities in greater Athens area and was co-financed by the European Commission and by National funds. This project was designed as a pilot study, in order to examine the feasibility of developing the Senior Health Mentoring concept, which is referring to the involvement of older people themselves in health promotion activities, by reinforcing their existing experience with appropriate knowledge, as a model for spreading out health promotion issues. During the first phase of the project, a number of older volunteers were trained in teaching and communication principles, as well as contemporary nutritional information based on the Mediterranean diet. In the second phase of the project, the trained volunteers started spreading out their new knowledge in their respective KAPIs as well as in KAPIs of other municipalities in the greater Athens area. Following the successful evaluation of the project an information package was produced; this was sent out to all KAPIs in the country and has been used by health professionals in other KAPIs, until nowadays. The results of this project include high Senior Mentors satisfaction; changes in their own lives; useful published educational material and sharing of the knowledge with others as friends and relatives^{13,14}.

The third project, “The Role of Health Education in Improving Compliance for the Prevention of Cardiovascular Diseases”, focused on access to preventive activities and healthier lifestyles. Dr Varsamis E., Dr Velonakis E. and Dr Sourtzi P. were the co-ordinators of the project, which took place in two Open Care Centres for Elderly (KAPI), in the municipality of Nea Ionia (greater Athens area) and was co-financed by the European Commission and by National funds. This project was a health education programme with main objectives the access and adoption of healthier lifestyles towards cardiovascular risks in older people. The results of this intervention were compared with those in a control group of the other two KAPIs in the same city, where no health intervention was implemented. The results of the project included the reduction of body weight of the participants; a healthier lifestyle; more regular measurement of blood pressure and glucose and more regular visits to the physician^{15,16}.

13 Panayota Sourtzi, Anastasia Amanatidou, Emanuel Velonakis, Evaluation of a training programme for Volunteer Senior Health Mentors in Healthy Nutrition, *Primary Health Care* (Greek), (2003), volume 15, pp 108-115.

14 Emanuel Velonakis, Panayota Sourtzi, Anastasia Amanatidou, Panayota Kaligeri – Vithoulka, Fred Hunt, *Final report of the project: “The involvement and the role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases”* (Publisher: Hellenic Association of Gerontology and Geriatrics, 1999), pp 1-83.

15 Emanuel Velonakis, Panayota Sourtzi, Nikolaos Komitopoulos, Dimitrios Ioannidis, Eustratios Varsamis, 1999, A health promotion programme for the prevention of cardiovascular diseases in the elderly. *Health Prom. & Educ.*, (1999), 37(1): 26-29.

Conclusions

The lack of resources and personnel could be balanced by promoting policies that will advance Healthy Ageing. “Health Pro Elderly” as part of a EU-wide health promotion policy contributes to that direction. In this context Greek reality reveals that organized health promotion endeavors take place in Greece but in their majority they are implemented in the KAPIs, mainly in urban areas. This fact indicates inequalities in health. Besides, the selected three models of best-practice in health promotion for the elderly, as incorporated in “Health Pro Elderly” project, aim to promote health and prevent certain diseases and disability via interventions focusing on individuals’ behavior and attitude without dealing with macro-society’s relevant factors.

On the other hand, the material developed during these projects, such as valuable handbooks and leaflets, can be used for wide dissemination of the experience obtained within these projects and help out any one interested in implementing such programmes or in developing them further.

In broad terms, with “Health Pro Elderly” project a variety of health promotion activities all over Europe have shown their effect on improving the quality of life of older people, indicating the importance of such initiatives and the necessity for the sustainability and transferability of them despite the limited resources and the lack of mainstream provision. These projects have built up Know-how and expertise and have stressed some key- points in order to provide the basis for the development of successful health promotion activities for the elderly. Among these key-points belong:

- the information campaigns focusing on the positive effects of the initiatives presented;
- the development of national health promotion programmes for the elderly respecting their heterogeneity;
- the maintenance of successful programmes in order to meet the needs of older groups of the population;
- the creation of networks in national and local level, supporting the exchanges of information between the stakeholders;
- the enhancing of the importance of continuing training for the involved professionals in order to have the knowledge, skills and tools demanded for effective and productive health promotion interventions;
- the supporting of relevant research activities and

16 Eystratios Varsamis & Emmanuel Velonakis, *Final report of the project The role of Health Education in Improving Compliance for the Prevention of Cardiovascular Diseases*, (1999), pp 1–94.

- the promotion of the dissemination of models of good practice in health promotion for the elderly¹⁷.

In conclusion, “Health Pro Elderly” project constitutes an essential health promotion initiative for the elderly, which contributes decisively to the whole effort of health promotion, so as to relieve the Health Care systems of the Members States of the European Union. The lack of sources and personnel could be balanced with potential action in this field through a common policy, strategies, guidelines and recommendations for priority actions for Healthy Ageing.

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¹⁷ Lang& Resch, (2008).

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Environmental Changes and Social Vulnerability in an Ageing Society

Portugal in the Transition from the 20th to the 21st Centuries

Maria João Guardado Moreira

Introduction

One of the main structural changes faced by human societies is demographic ageing, which has a strong impact on health systems and quality of life. Dependence and disability do not constitute an inevitable consequence of human ageing, but situations of fragility and vulnerability increase with age. In this scenario, the need for assistance emerges as one of the most urgent problems, on which the future of sanitarian and social policies in all developed countries will depend.

The majority of variations observed in the individual ageing process is due to social and environmental factors. The functional and cognitive deterioration that comes with age is a consequence of getting old, but it depends on individual lifestyles and environmental characteristics. Interferences in one of them will cause major global benefits, and guarantee higher independence levels, better quality of life and improved health status. Social and environmental factors can be used as predictors for health conditions, functional and cognitive autonomy, wellbeing and satisfaction in ageing. Reduced income, low educational level, and situations of loneliness may also be identified as predictive factors of higher and premature health deterioration. Better knowledge of environmental and social change effects on people will allow for better understanding of the process of vulnerability and of multiple dependency situations. The adaptation of social structures must be a priority in all ageing societies.

Portugal will also have to find answers to these challenges, despite being in a context of disadvantage due to a structurally weak health system. Besides, the ageing process is due to dissimilar situations that reflect socio-economic and environmental disparities, on which the case study for this paper will be based.

The main objective of this study is to understand the process of vulnerability and multiple dependency situations caused by changes in the Portuguese demographic structure, mainly regarding old people, as concerns the following aspects: a) levels of well-being in ageing regions determined by a statistical indicator that sums up and stratifies populations under so-called “global indicators of demographic, economic and social wellbeing”, for every region of Portugal (continent) between 1993 and 2004 (this indicator includes different variables such as demographic indicators, the offer of health resources /services and economic and social characteristics; b) specific health care and long-term care provision (health statistics, National Network for Integrated Continuous Care).

Discussion of results: a combination of analyses to determine levels of regional differences in what concern vulnerability and dependency of elderly people. To overcome differences and respond to change in the social structures new health policies have to be introduced, which includes the commitment of political sectors, economic leaders and common citizens.

The Demographic Dynamics

The evolution of the Portuguese population from the second half of the 20th century is characterised by a new demographic model of moderate growth. The constant decrease of fertility, which in 2007 amounted to 1.33 children per woman¹, and the migratory fluxes explain most of the growth dynamics (from 2002 to 2007, 9% in terms of natural growth and 91% from migration). This led to some unprecedented social and demographic changes.

In the European context, the process of the demographic transition in Portugal was slow and late, but in only three decades (1975-2000) new and radical trends emerged vis-à-vis life and death and social living patterns. A decrease of growth in the 1970s and 1980s and in the 1990s the growth was due mostly to migration. The ageing population was a result of low fertility rates and a growing lifespan expectation. In 1900, the population under 15 years was 33.7 % and over 65 years 5.7%. In 2007, elderly people surpassed young people by 17.3% against 15.4% respectively, which stands for 122 elderly per 100 young. However, it is particularly the population over 80 years that has increased in percentage and pace, so that in 2007 it amounted to 4.1% of the total population². This trend is expected to be strengthened in the next years according to a projection by the National Institute for Statistics (Portugal). In 2060 young people will not represent more than 11.9% of the total population, while elderly people will reach 32.3%.

1 Maria José Carrilho, Lurdes Patrício, “A Situação Demográfica Recente em Portugal”, *Revista de Estudos Demográficos*, 44 (2008), p. 45.

2 Statistics, www.ine.pt.

The ageing process is particularly significant in rural districts, due to migration to urban areas and abroad, leading to an unsymmetrical distribution of populations. The decrease of young people and the increase of the elderly population mimic the duality between more economically developed regions and rural areas. At regional level, the ageing phenomenon reflects the division between regions that are economically more dynamic and attractive, on the one hand, and, on the other hand, regions that are characterised by structural backwardness, economic stagnation and social weakness, the exodus of large groups of the population and peripheral territoriality. On the whole, these regions become incapable of attracting investment and of using the potential of endogenous resources to keep populations.

Elderly people are not only more in number than before. They also live longer. The life expectancy has increased twelve years for men and fourteen years for women between 1960 and 2007. This is a result of the epidemiological and sanitary transition, which not only reduced the impact of infections, such as respiratory and digestive diseases, but also caused a rise in degenerative diseases such as tumours and circulatory disorders. While in 1960, death caused by degenerative diseases amounted to 35%, in 2005 the number had risen to 55.6%. (Table 1).

Table 1. Portugal: Main Causes of Death (2005)

| | 65-79 years | 80+ years | Total |
|-----------------------------------|-------------|-----------|-------|
| Circulatory System | 32.4 | 42.5 | 34.1 |
| Tumours | 27.6 | 12.6 | 21.5 |
| Respiratory System | 9.2 | 13.9 | 10.5 |
| External Causes | 2.9 | 1.7 | 4.2 |
| Digestive System | 4.5 | 3.0 | 4.3 |
| Endocrinal and metabolic diseases | 6.1 | 4.6 | 4.8 |
| Infectious diseases/AIDS | 1.6 | 1.0 | 2.1 |
| Non Specified | 9.6 | 13.2 | 11.8 |

Source: INE, Health Statistics 2005, 2006

Social change, demographic behaviour and some vulnerability factors

Ageing has implications not only for demography, but also for the society and the health system. It has transformed the familial institution and the intergenerational bonds of solidarity. The nuclear family with less children and a growing number of elderly transforms the natural balance of traditional demography. A context of deprivation and short-lived marriages further contributes to the progressive degradation of the traditional familial solidarity networks. The change in role models and the

fact that more women are working also result in a reduction of elderly care, a greater isolation of elderly people and the absence of informal care, since women used to be the main informal health care providers.

The vast majority of elderly people live as couples, as husband and wife, but men usually die first. This affects how this group experiences familiar life. To live alone is more common among elderly people, especially in the case of women living as widows, no matter which region they live in.³ In 2006, 28.8% of women over 65 years lived alone, compared to 9.4% of men living alone. This trend shows a tendency to increase the gap between men and women. In 2006 a higher percentage of the elderly lived either with a spouse (44.2%) or alone (20.7%).⁴

Among the elderly who lived alone, besides being women and living on their own, the majority had retired from productive activities. In general terms, elderly people have low education levels, the women even lower than men: 64.7% of women compared to 41.3% of men had had no education at all.⁵

The health system also faces new challenges due to the ageing population. The increase of the average lifespan is generally matched by a rise in physical and/or psychic dependency, which causes a lack of mobility and of autonomy, an increase in chronic diseases evolving slowly over time. This causes a rise in the numbers of consumers of specific health care systems and of their demands in terms of quality and complexity of health care.

By observing the average healthy life expectancy, we can estimate the number of years that men and women may expect to live without disabilities (Table 2). Although women have a higher life expectancy than men, the latter may expect to live longer without physical disabilities. This suggests the need for more health care, since ageing is to a large extent a female phenomenon.

Table 2. Healthy life expectancy (2006).

| | Male | Female |
|-----|------|--------|
| E0 | 59.6 | 57.6 |
| E65 | 6.8 | 5.9 |

Source: <http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics> (checked November 11, 2008).

³ Sofia Leite, “Famílias em Portugal: breve caracterização socio-demográfica com base nos Censos 1991 e 2001”, *Revista de Estudos Demográficos*, 33 (2003), pp. 23–38. In 2006, elderly men lived mostly as a couple (82.9%) while only 48.4% of elderly women of the same age lived with a spouse. (“Dia Internacional do Idoso – 1 de Outubro de 2007”, *Destaque*, www.ine.pt)

⁴ “Dia Internacional do Idoso – 1 de Outubro de 2007”, *Destaque*, www.ine.pt (opened December 18, 2009).

⁵ Employment Survey 2001 (INE, “O Envelhecimento em Portugal: Situação demográfica e sócia económica recente das pessoas idosas”, *Revista de Estudos Demográficos*, 33, (2002), p.194

According to the 1998/1999 National Health Survey, elderly women showed worse health conditions than men of the same age. However, both a high percentage of men and women perceived their health to be “poor” or “fair”, and 12.7% even considered it to be “very poor”. In the latest Health Survey (2005/06) women over 75 years perceived their health condition to be ‘poor or very poor’ (Table 3).

Table 3. Self-perception on health condition (%), sex and age, 2005/2006.

| | TOTAL | | | MALE | | | FEMALE | | |
|----------|--------------------|------|--------------------|--------------------|------|--------------------|--------------------|------|--------------------|
| | Very good/ Good | Fair | Poor/ very poor | Very good/ good | Fair | Poor/ very poor | Very good/ good | Fair | Poor/ very poor |
| All ages | 53.2 | 32.8 | 14.1 | 59.3 | 30.2 | 10.4 | 47.4 | 35.1 | 17.5 |
| >15 | 85.5 | 12.8 | 1.7 | 83.1 | 14.7 | 2.2 | 88.0 | 10.9 | 1.1 |
| 15-24 | 80.8 | 18.0 | 1.1 | 84.2 | 14.9 | 0.9 | 77.3 | 21.3 | 1.3 |
| 25-34 | 70.9 | 25.3 | 3.8 | 74.9 | 22.1 | 3.0 | 66.8 | 28.6 | 4.6 |
| 35-44 | 57.5 | 36.8 | 5.8 | 64.8 | 31.2 | 4.0 | 50.3 | 42.2 | 7.6 |
| 45-54 | 40.2 | 45.8 | 13.9 | 49.0 | 41.3 | 9.7 | 31.9 | 50.1 | 18.0 |
| 55-64 | 24.7 | 47.3 | 28.0 | 33.2 | 45.1 | 21.7 | 17.1 | 49.2 | 33.7 |
| 65-74 | 15.5 | 46.4 | 38.1 | 20.0 | 49.5 | 30.4 | 11.8 | 43.9 | 44.3 |
| 75-84 | 11.1 | 41.2 | 47.7 | 14.2 | 44.4 | 41.4 | 9.0 | 39.1 | 51.9 |
| 85 + | 13.2 | 46.4 | 40.4 | 21.2 | 42.3 | 36.4 | 9.3 | 48.4 | 42.3 |

Source: INSA/INE – Fourth National Health Survey (2005-2006).

Further aspects that may cause elderly people to be socially vulnerable are the poverty levels that affect a considerable proportion of this population group (Table 4). This affects not only the elderly living in single person households, but also other households, although the percentages for this group have shown a slight decrease in recent years due to the implementation of policies especially targeted at elderly people in the wake of Portugal’s integration in the EU. However, in 2007, the risk of poverty was high among the elderly, with a 26% at-risk-of-poverty rate. It was particularly high for elderly living on their own, being 37%, which is high above the average national percentage of 18%.⁶ The origin of this problem lies in the fact that Portugal presents a very high inequality rate in the distribution of incomes, particularly in rural areas where ageing rates are very high and elderly people tend to live on their own, and the pensions are low. This contributes to increase the dependency and vulnerability of those, who already live with disability caused by illness and ageing. In 2001 the national disability rate amounted to 6.2% of which the over 65 years represented 12.5%.⁷

⁶ EU-SILC 2007 (www.ine.pt, opened February 08, 2009).

⁷ INE, “O Envelhecimento em Portugal: Situação demográfica e sócia económica recente das pessoas idosas”, *Revista de Estudos Demográficos*, 33, (2002), p.192.

Table 4. At-risk-of-poverty rate before social transfers (%), by sex and age group.

| Data reference period | Age group | Sex | At-risk-of-poverty rate (%) | At-risk-of-poverty rate (%) |
|-----------------------|-------------|-----|-----------------------------|-----------------------------|
| 2004 | 0–17 years | MF | 25 | 36 |
| | | MF | 17 | 32 |
| | 18–64 years | M | 16 | 30 |
| | | F | 18 | 34 |
| | 65 + years | MF | 29 | 82 |
| | | M | 29 | 82 |
| F | | 29 | 82 | |
| 2007 | 0–17 years | MF | 21 | 30 |
| | | MF | 15 | 31 |
| | 18–64 years | M | 14 | 30 |
| | | F | 16 | 32 |
| | 65 + years | MF | 26 | 85 |
| | | M | 24 | 83 |
| F | | 27 | 85 | |

Source: INE - Statistics Portugal, Statistics on Income and Living Conditions - EU-SILC.

The elderly are cumulatively affected by low educational levels, low income, physical and social isolation, and unfavourable health conditions. Poverty will then aggravate the social vulnerability and exclusion of the elderly.

Ageing and Wellbeing

As discussed elsewhere, the developmental model of Portugal privileged the western maritime regions, which caused the continued loss of demographic and economic vitality of the inland regions, which is replicated by the geographical distribution of ageing.

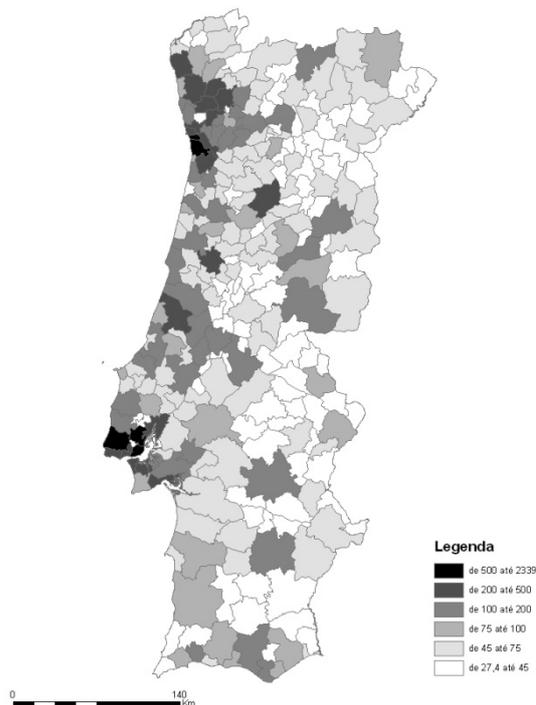
In a previous research project developed by the author and others⁸ a statistical indicator was developed to stratify a so-called “global indicator for demographic, economic and social well-being,” applied to all Portuguese regions between 1993 and 2004.⁹ The social, economic and demographic well-being indicators were used

8 This project was supported by the Portuguese Foundation of Science and Technology (project reference POCI/DEM/58366/2004, “Regionalidade Demográfica e Diversidade Social”). The project was classified with Very Good (2005–2008) and its main conclusions await publication (Teresa Rodrigues et alii, *Regionalidade Demográfica e Diversidade Social* (Porto, 2009).

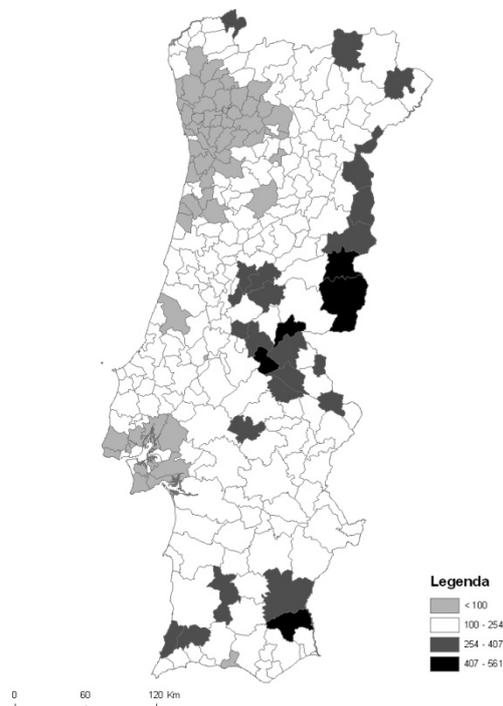
9 L. Chorão, L. Pereira, “Avaliação de qualidade de vida e bem-estar”, in Teresa Rodrigues et alii (ed.), *Regionalidade Demográfica e Diversidade Social* (Porto, 2009), pp.129–151.

Map 1. Global indicators of demographic, economic and social wellbeing and ageing ratio

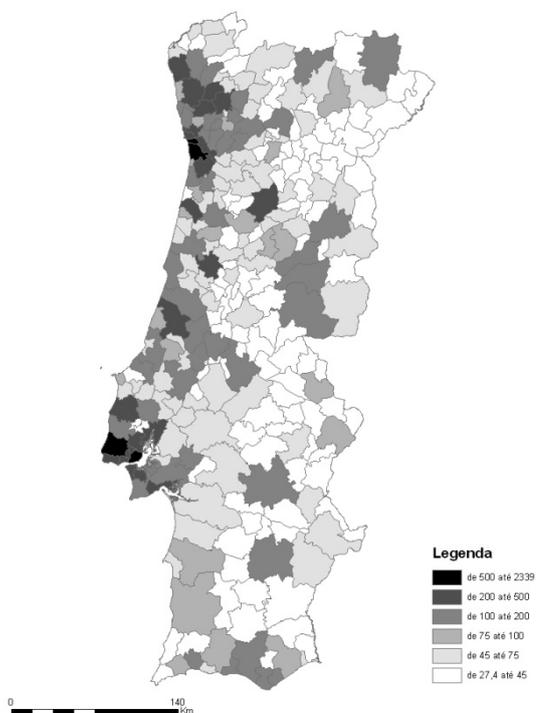
Wellbeing Index - 1993



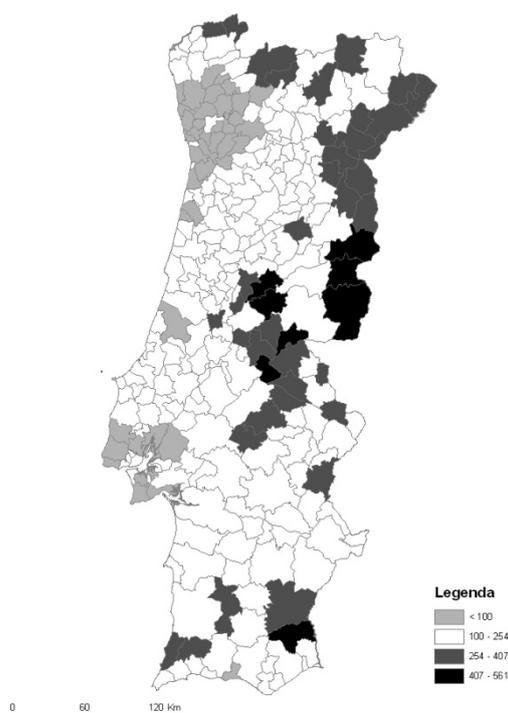
Ageing Ratio. 2001



Wellbeing Index - 2004



Ageing Ratio. 2007



Source: L., Chorão, L. Pereira, “Avaliação de qualidade de vida e bem-estar”, in T. Rodrigues et alii (ed.), *Regionalidade Demográfica e Diversidade Social* (Porto, 2009), pp.129–151; Ageing Ratio, map organized by the author.

to convert automatically the Portuguese regions (*concelhos*) into homogenous population groups.

When compared to the “global indicators of demographic, economic and social wellbeing”, the ageing indicator shows a global decrease of the well-being indicator values¹⁰ and it gives relevance to the ageing process. While in 2001, 22% of the regions (*concelhos*) showed an ageing indicator below 100, in 2007 the percentage had decreased to 15.6%. Further, there is some matching of regions (*concelhos*) with the worse/better wellbeing indicators and the higher/lower indicators for ageing (Map 1). This causes a further unequal distribution among regions and a gap between the interior regions and the coastal regions. The former are essentially rural and medium-sized urban centres which tend to function as developmental regional foci are exceptional. The coastal regions are economically and demographically more dynamic.

The differences in regional development, in wealth distribution, in availability of services, and in well-being levels may again contribute to further worsen the inequality and vulnerability of elderly populations who are already affected by the consequences of unequal distribution of health equipments which are concentrated in urban areas¹¹.

Social Change / New Health Policies

The ageing of the population has transformed the morbidity and mortality patterns. The main causes of morbidity and mortality are nowadays linked to chronic diseases that evolve slowly in time (Table 1). These cause the last years of life to be experienced as years of disability, of lack of autonomy and dependency (in several stages). These are the patients that have increased in number. They have more complex problems and therefore they require a more complex organizational structure with articulated multidisciplinary responses at several assistance levels.

The Portuguese national health care system includes a network of Health Care Centres for primary health care which however, has shown difficulties in adapting to the new demographic realities: few operational and specific answers to health care needs; poorly organised in geographic and demographic terms and in terms of

10 L. Chorão, L. Pereira, “Avaliação de qualidade de vida e bem-estar”, in T. Rodrigues et alii (ed.), *Regionalidade Demográfica e Diversidade Social* (Porto, 2009), pp.129–151.

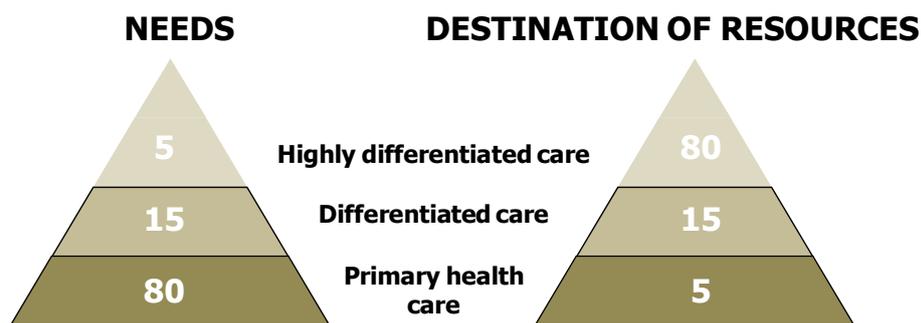
11 Cf. Paula Santana, “Poverty, social exclusion and Health”, *Social Science and Medicine*, 55, (2002), p. 132–145; Paula Santana, “Ageing in Portugal: regional inequities in health and health care”, *Social Science and Medicine*, 50, (2000) p. 1025–1036.

the health professional / family /user ratio; without proximity and long-term care; with no links to other activities or social protection.¹²

The location of health care units and of medical staff is quantitatively and qualitatively a disadvantage for the elderly in rural regions. They find it more difficult than the elderly in urban areas to use the health care system due to their low income, morbidity problems, and costs associated to travel.¹³ We can therefore conclude that accessibility, quality and equity are not guaranteed for the elderly, the chronically ill, the dependent or people facing terminal life situations.

Furthermore, the organisational characteristics of the health care system are still excessively centralized to the hospitals (for acute and curable illnesses). Chronic patients are subjected to a curative model that is maladjusted to their situation and thus they loose quality of life and have to face very high health care expenses. The resources are poorly used in that frequently the same sophisticated expensive unnecessary diagnostic and treatment means are used repeatedly, with little or no advantage for the patient¹⁴.

Figure 1. Expenditures (%).



Source: Maria João Guardado Moreira, Ana Paula Sapeta, “Portugal: Ageing and new health policies” (2005).

In recent decades (in the 1980s and 1990s) there has been a maladjustment between how resources are used and effective needs of the health care system (Figure 1). It is

12 Maria João Guardado Moreira, Ana Paula Sapeta, “Portugal: Ageing and new health policies”, paper presented in the meeting *Saúde e mudança social nos países europeus/ Health and social change in european countries*, organised by Phoenix TN – European Thematic Research Network on Health and Social Welfare Policie 213854_1_PT_Erasmus and Department of Political Studies, FCSH da UNL, 26 Septembre 2005.

13 Cf. Paula Santana, “Ageing in Portugal: regional iniquities in health and health care”, *Social Science and Medicine*, 50, (2000), p. 1025–1036.

14 Maria João Guardado Moreira, Ana Paula Sapeta, “Portugal: Ageing and new health policies”, paper presented in the meeting *Saúde e mudança social nos países europeus/ Health and social change in european countries*, organised by Phoenix TN – European Thematic Research Network on Health and Social Welfare Policie 213854_1_PT_Erasmus and Department of Political Studies, FCSH da UNL, 26 Septembre 2005.

therefore necessary to use financial resources in an effective way, since in 2006 public expense on health care (GDP percentage) rose to 70.6% and represented 10.2% of the total public expense¹⁵, which is above the average of OECD countries (8.9%)¹⁶.

Legal provision was made to improve primary health care in 2005 through a Council of Ministers Resolution (nr 86/2005) with the aims to: reconfigure the health centres as pivotal for the entire primary health care system (an emphasis on health care services in the community); implement the family health care units; implement the local health care units. This document further presents the structuring principles for the health care of elderly and dependent people through a commission constituted for that effect: *Comissão Para o Desenvolvimento dos Cuidados de Saúde às Pessoas Idosas e às Pessoas em Situação de Dependência*. It is widely acknowledged that the lack of local long-term health care is the weak spot of the Portuguese national health care system, which falls short of the World Health Organisation and Council of Europe recommendations highlighting palliative care as the health politics first priority. The *Misericórdias* (Charity organisations) and some NGOs have been the only local long-term health care providers in Portugal.

2006 witnessed the approval of the *National Network for Integrated Continuous Care* (RNCCI), to be implemented over a ten-year period (2006-2016), with the aim of providing integrated continuous care services (convalescence, medium and long-term care, palliative care). This network is based on the co-operation between the Ministry of Health, the Ministry of Labour and Social Solidarity and social and private sector stakeholders. Geographically there are three levels of co-ordination: central, regional and local. Access wise there will be integrated co-ordination involving the hospital (discharge teams) and community care allowing early referrals; ongoing monitoring to match needs to care provision, locally and regionally.

Conclusions

Ageing is one of the most important phenomena of the recent Portuguese demographic evolution. It implicates social and health consequences which, when taken together and considered in their dual roles, determine the need for policies that will bring about the reform of the social and health systems. The increase of health care consumers determines the development of policies that will support and protect families' roles as health care providers and that will create local health care struc-

15 European Commission, *Joint Report on Social Protection and Social Inclusion 2009* (ec.europa.eu/employment_social/spsi/docs/social_inclusion/2009/cf_portugal_final_pt.pdf).

Downloaded April, 05, 2009.

16 *OECD Health Data 2008* (<http://www.oecd.org/dataoecd/43/2/40905146.pdf>).
Download May, 31, 2009.

tures, services and teams. All these policies will have to take into account the characteristics of the elderly population, which constitutes one of the most vulnerable groups, since a large majority has low income, low educational level, and poor access to health care.

The major challenges for policy makers and to the citizens in general, will be to identify the adjustments needed to the ageing population. In the long term, it will be crucial to guarantee that everybody has access to health care (including chronic and dependent patients); that geographical inequalities in access to health care are corrected; and that high-quality health care is accessible to all; besides working towards the financial sustainability of health care and social services (desirably integrated into a unique system). In the medium term, long-term and local care will have to be reorganised to improve national provision of palliative care units, to implement family health units (family, doctor and nurse) and create intermediate structures of multidisciplinary teams of medical care (doctor, nurse, social service mediator, psychologist, physiotherapist etc). It is further essential to promote long-life learning programmes for health professionals (at graduate and post-graduate educational levels and long-life learning). Concrete measures and support for families to help them care for elderly people/patients will also have to be developed. Finally, to respond to the social consequences of ageing parallel social policies are needed to complement social protection actions already in place¹⁷ in order to correct inequality conditions lived by elderly people.

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¹⁷ For instance Old Age Pensions, Invalidity and Old Age Social Pension, Solidarity Supplement for the Elderly.

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Regional Dynamics and Social Diversity – Portugal in the 21st Century

Teresa Ferreira Rodrigues

Introduction

Through its history Portugal always presented regional differences concerning population distribution, as well as fertility and mortality trends. Local specificities related to life and death levels reflect diverse socioeconomic conditions and also different health coverage. We will try to diagnose the main concerns and future challenges related to those regional differences, using quantitative and qualitative data on demographic trends, well-being average levels and health services offer. We want to demonstrate that this kind of academic researches can be useful to policy makers, helping them: (1) to implement regional directed policies; (2) to reduce internal diversity; and (3) to improve quality of life in the most excluded areas.

Our first issue consists in measuring the link between Portuguese modernization and asymmetries on social well-being levels¹. Today Portugal faces some moderation on population growth rates, a total dependency on migration rates, both external and internal, as well as aged structures. But national average numbers are totally different from those at a regional level, mainly if using non demographic indicators, such as average living patterns or purchase power².

The paper begins with a short diagnosis on the huge demographic and socioeconomic changes of the last decades. In the second part we analyze the extent of the link between those changes and regional convergence on well-being levels. Finally, we try to determine the extent of regional contrasts, their main causes and the relationship between social change and local average wealth standards, as well as the main problems and challenges that will be under discussion in the years to come, in what concerns to health policies.

In practical terms we used two different databases and two specific methodologies. A first diagnosis is based on the results of a cluster analysis, crossing official information from: i) population census for the years 1960, 1970, 1981, 1991, 2001 and

1 Veiga, 2004.

2 Rodrigues, 2009.

also 2005 estimations, all from National Statistical Institute³; and ii) vital demographic statistics on births, deaths and migrations from 1991 to 2007. The 278 Portuguese mainland municipalities⁴ were aggregated in five groups, according to their specific demographic dynamics for the last decades (1960–2007).

On a second moment, a main component analysis was done, supported by economic and social data at municipal level⁵. Besides including a few demographic indicators, it mainly covers average health resources and services offer, income and educational rates and other economic and social indicators. Using more than 92% of all available variables (38 in 1993 and 54 in 2004)⁶, we created a statistical indicator named “global indicator of demographic, economic and social well-being”, that sums up and allows stratification of all municipalities in all cases⁷. In a third moment, we cross-checked demographic dynamics with well-being results and tried to establish the interaction between them, in order to: i) fully understand the extent of the relationship between social change and social well-being levels; ii) relate them to health investment; and iii) evaluate the need to implement regional pointed out policies, which may reduce diversity between Portuguese social groups and geographic regions.

Portugal: Long Term Facts and Trends

Portugal faced huge changes since mid 70’s, most visible in three main areas: a) political changes, as it became a democratic regime in 1974 and an EU member since 1986; b) economic changes, mainly related to a moderate industrialization process and to an asymmetrical urban growth, (leading to coastal concentration, the rise of metropolitan areas and countryside desertification); c) relevant social changes, associated with a huge improvement on both average educational levels

3 Instituto Nacional de Estatística (INE).

4 Administrative units, corresponding to mainland Nuts IV and excluding Madeira and Azores islands, due to lack of partial information on well-being rates.

5 Provided by *Markttest* since 1993. We selected the first and latest series, 1993 and 2004 (*Salex Index*).

6 In 1993: 38 variables → 3 major components, Y_k , $k=1, 2, 3$ (explain 94% of total inertia); In 2004: 54 variables → 4 major components, Y_k , $k=1, \dots, 4$ (explain 92% of total inertia).

| Main Component | 1993 | 2004 |
|----------------|------|------|
| Y1 | 85% | 81% |
| Y2 | 6% | 6% |
| Y3 | 3% | 3% |
| Y4 | ---- | 2% |

7 Chorão, Pereira, 2009.

and quality of life. Family structure and life style also suffered huge transformations.

In the transition from the 20th to the 21st centuries the country faces the challenges and opportunities associated to those changes. They were followed by: (i) some moderation on demographic growth rates; (ii) the harmonization on life and death annual tolls; meaningful migrations to the coastal areas and urban centres; high levels of life expectancy; ageing phenomenon. Nowadays, 80% of the country presents negative natural population growth rates and ageing structures⁸. They are explained by low fertility levels (less than 1,4 children per woman), the increase of life expectancy (75,2 years for men and 81,6 for women)⁹ and by the existence of 75,000 more people aged 65 plus than those under 15 years old (15,6%/17.0%) (Table 1)¹⁰

Table 1. Global Annual Demographic Trends (%).

| Inter-census periods | Natural Rate | Total Rate | Migration Rate |
|----------------------|--------------|------------|----------------|
| 1960–1970 | 1.15 | -0.21 | -1.36 |
| 1970–1981 | 0.85 | 1.29 | 0.44 |
| 1981–1991 | 0.34 | 0.03 | -0.31 |
| 1991–2001 | 0.08 | 0.45 | 0.37 |
| 2001–2007 | 0,03 | 0,37 | 0,34 |

Source: Estatísticas Demográficas, 1968, p. LXX, 1970–2001; X^o to XIV^o Recenseamento Geral da População Portuguesa, 1960 to 2001; Estimativas da População 31/XII/2005.

A deeper analysis show us several ways of transition to modernity, which occurred somehow later than in most European countries¹¹. Those realities are only consequential when analyzed at a regional level and when related to non demographic indicators. We can therefore discuss if the country, that became spatially unequal in what concerns to human distribution, is or isn't more homogeneous concerning quality of life and social well-being. This will allow us to understand the real aim of contemporary social changes. For the selected years of 1900, 1950, 2001 and 2007, and using Population Census data, we calculated the relative proportion of residents for all the existing NUTS III, in order to measure their evolution during the 20th century.

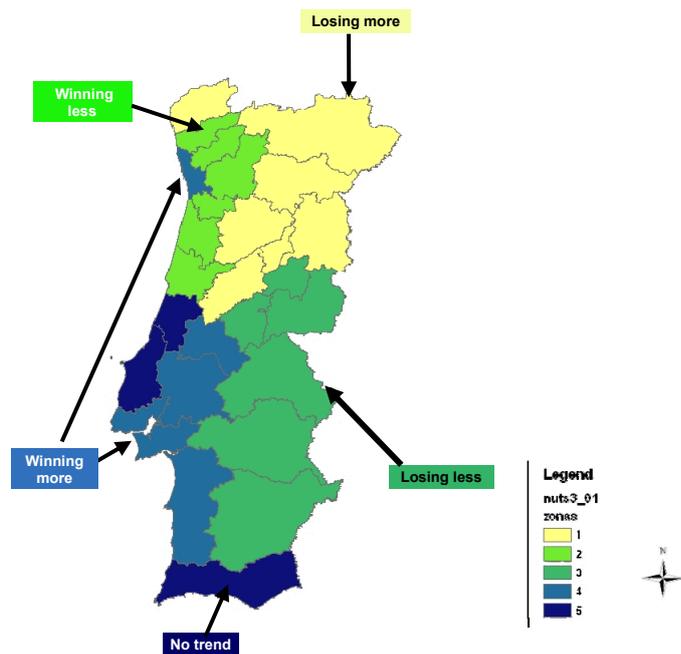
8 Carrilho et al., 2007.

9 EUROSTAT, b) 2008.

10 In what refers to World's ageing ratio, Portugal ranks 8th (PRB, 2009); EUROSTAT, a) 2008.

11 Rodrigues, 2008.

Map 1. Portuguese Regional Demographic Profile, 1900–2007.



Source: Rodrigues, 2001.

By the end of the 20th century Portugal can be considered a country divided in five different groups of municipalities in terms of demographic cohesion.¹² Map 1 presents winning and losing areas, in what concerns human concentration. Our conclusions are based on former research¹³, which measured at what extent homogeneous demographic behaviours were related to geographic situation. (Table 2) The first group of municipalities reveals a positive situation, although it represents only 3.3% of the total. Their leadership is consistent: they grow faster than all the others, benefiting from internal and external positive migratory rates; they possess the higher active population rate and also the higher natural rates. Group 2, representing 11% of all municipalities, shows both natural and migratory medium rates, although with positive demographic dynamics. But almost 86% of Portuguese municipalities presented recessive behaviours for the concerned period. They lost inhabitants due to negative natural and migratory trends, with higher rates in the 60's and in the 80's.

12 Based on a cluster analysis, using “non hierarchic” criteria (K-means) (MAROCO, 2007).

13 Moreira e Rodrigues, 2008.

Table 2. Municipalities – demographic dynamics (1960–2001).

| Groups | Characteristics |
|-----------|--|
| 1 3.3 | Higher natural and migratory dynamics Preferable destination for nationals and foreigners Mainly situated in Lisbon's surroundings No changes occurred in these decades |
| 2 10.9 | Municipalities from Lisbon and Oporto's surroundings and main Algarve's coastal cities. Favourable natural increase rates. Migratory rates loose importance. |
| 3 85.4 | Recessive trends Group A - less recessive. Negative migratory rates, but positive natural ones. Group B – more recessive. Looses inhabitants. Almost all variables present negative results. |

Source: Based on Moreira, Rodrigues, 2008.

Looking nowadays for a regional convergence...?

In the last decades regional differences are declining in what concerns to demographic collective behaviours, but asymmetries on geographic distribution are increasing, as well as the differences between socioeconomic groups. In order to evaluate the extent of these phenomena, we created a statistical index, which we believe is able to sum up and allow stratification for all administrative units. The analysis by main components¹⁴ automatically sorted all 278 continental municipalities¹⁵ by homogeneous groups and a ranking, according to their average socioeconomic and development trends for the years 1993 and 2004. Our conclusions follow those pointed by several national and international reports, although based in different variables¹⁶. From 1993 to 2004 we observe a global negative slope on index values, the emergence of a few rich and dynamic regions and an increase in regional differences. As it happens with population distribution, Portuguese economic and

14 Bouroche, Saporta, 2002.

15 It only refers to continental Portugal. There is no available data on the 30 municipalities of Madeira and Azores.

16 Such as OECD and INE (Chorão, Pereira, 2009).

social development model was built during the 20th century base based on coastal concentration of population, economic structures, urbanization and investment on goods and services, both from public and private sectors.

At the beginning of the 21st century, Portugal hasn't yet assured the homogenization as far as well-being standards are concerned.¹⁷ (Table 3, Table 4, Map 2, Map 3, Map 4)

Table 3. Well-being Index by Municipalities: Homogeneous Groups in 1993.

| Group | Number | Municipalities | Well-being Index |
|-------|--------|---|------------------|
| 1 | 1 | Lisboa | 2339.0 |
| 2 | 1 | Porto | 950.5 |
| 3 | 1 | Loures | 691.5 |
| 4 | 1 | Sintra | 584.7 |
| 5 | 1 | Vila Nova de Gaia | 518.0 |
| 6 | 5 | Almada. Amadora. Cascais. Coimbra e Oeiras | 385.1 |
| 7 | 3 | Matosinhos. Braga e Guimarães | 335.7 |
| 8 | 15 | Aveiro. Barcelos. Barreiro. Gondomar. Leiria. Maia. Seixal. Santa Maria da Feira. Santo Tirso. Setúbal. Torres Vedras. Viana do Castelo. Vila Franca de Xira. V.N. de Famalicão e Viseu. | 231.6 |
| 9 | 55 | Abrantes. Águeda. Albufeira. Alcobaça. Alenquer. Amarante. Anadia. Beja. Bragança. Caldas da Rainha. Cantanhede. Castelo Branco. Chaves. Covilhã. Espinho. Estarreja. Évora. Fafe. Faro. Felgueiras. Figueira da Foz. Fundão. Guarda. Ílhavo. Lamego. Loulé. Lousada. Mafra. Marco de Canaveses. Marinha Grande. Moita. Montijo. Olhão. Oliveira de Azeméis. Ourém. Ovar. Paços de Ferreira. Palmela. Paredes. Penafiel. Pombal. Ponte de Lima. Portalegre. Portimão. Póvoa de Varzim. Santarém. Santiago do Cacém. Seia. Silves. Tomar. Torres Novas. Valongo. Vila do Conde. Vila Real e Vila Verde | 119.3 |
| 10 | 192 | All the other municipalities of continental Portugal | 49.2 |

Source: Chorão. Pereira. 2009.

¹⁷ This solution presents for both years a R2 = 0,993, which explains 99.3% of total variability, and a semi partial R2 = 0,0007. The results reflect *the k-means* application of gravity centre to the 10 municipality groups identified by Ward's method.

Table 4. Well-being Index by Municipalities: Homogeneous Groups in 2004.

| Group | Number | Municipalities | Well-being Index |
|-------|--------|---|------------------|
| 1 | 1 | Lisboa | 2118.7 |
| 2 | 1 | Porto | 857.5 |
| 3 | 1 | Sintra | 707.5 |
| 4 | 1 | Vila Nova de Gaia | 562.3 |
| 5 | 3 | Cascais. Loures e Oeiras | 428.6 |
| 6 | 3 | Braga. Coimbra e Matosinhos | 385.0 |
| 7 | 3 | Almada. Amadora e Guimarães | 350.2 |
| 8 | 12 | Barcelos. Gondomar. Leiria. Maia. Odivelas. Santa Maria da Feira. Seixal. Setúbal. V.N. de Famalicão. Viana do Castelo. Vila Franca de Xira e Viseu | 273.4 |
| 9 | 52 | Abrantes. Águeda. Albufeira. Alcobaça. Alenquer. Amarante. Aveiro. Barreiro. Beja. Bragança. Caldas da Rainha. Cantanhede. Castelo Branco. Chaves. Covilhã. Évora. Fafe. Faro. Felgueiras. Figueira da Foz. Fundão. Guarda. Loulé. Lousada. Mafra. Marco de Canavezes. Marinha Grande. Moita. Montijo. Olhão. Oliveira de Azeméis. Ourém. Ovar. Paços de Ferreira. Palmela. Paredes. Penafiel. Pombal. Ponte de Lima. Portimão. Póvoa de Varzim. Santarém. Santo Tirso. Sesimbra. Silves. Tomar. Torres Novas. Torres Vedras. Valongo. Vila do Conde. Vila Real. Vila Verde | 137.7 |
| 10 | 201 | All the other municipalities of continental Portugal | 47.9 |

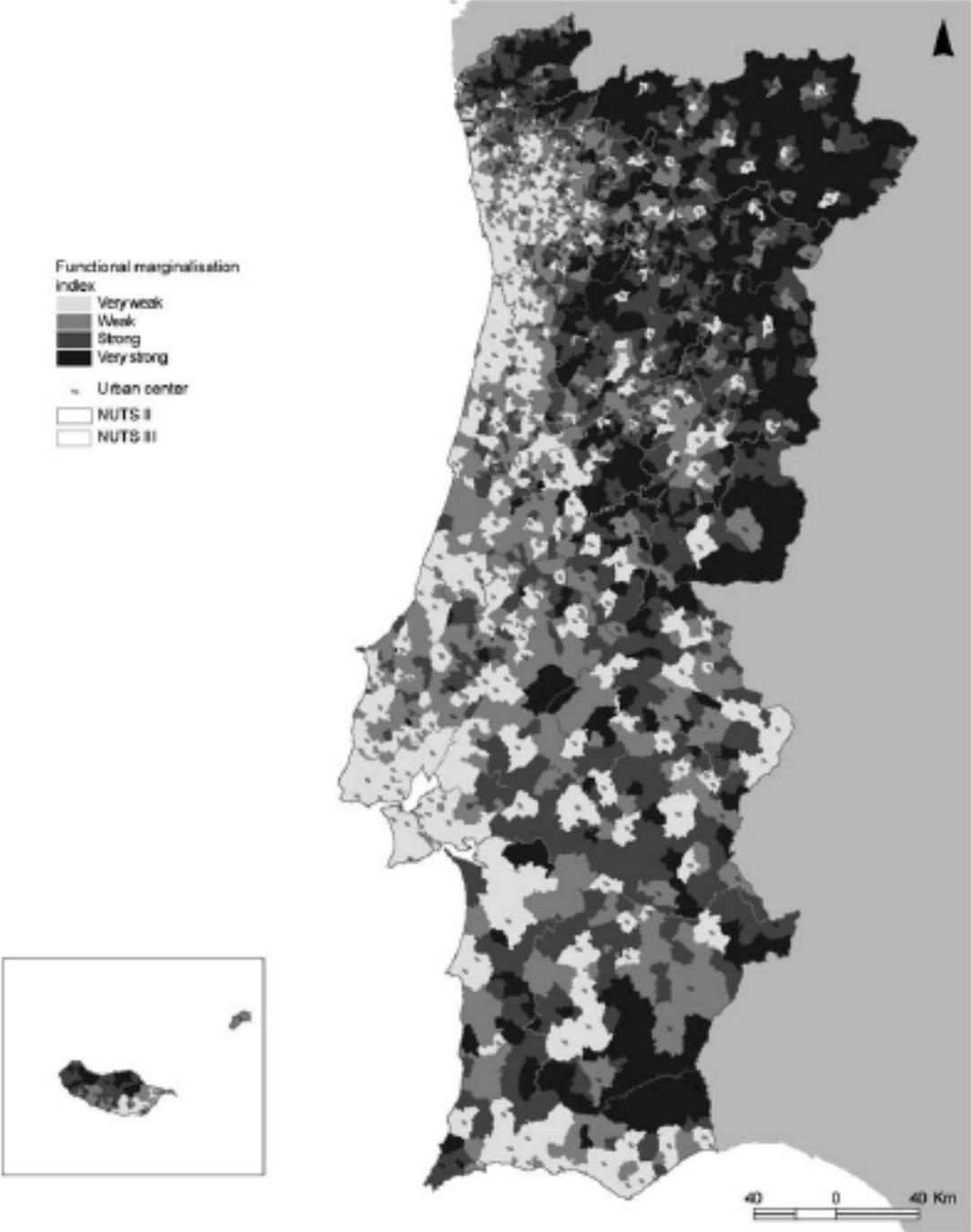
Source: Chorão. Pereira. 2009.

In fact, the convergence on national demographic behaviours doesn't reflect the homogenization on well-being standards. There is a clear coincidence between most positive/negative population variations and better/worse life standards. Demographic trends, economic dynamics and public services offer are positively linked. Public services concentration is induced by central policies on education and health systems, as well as well-being infrastructures. This fact explains the reason why population tends to be increasingly concentrated in Lisbon (AML) and Oporto's (AMP) Metropolitan Areas¹⁸, as well as in the coastal regions. Six municipalities represent 25% of all national purchase power: Lisbon, with 10.8%. followed by Oporto (3.7%), Sintra (3.5%), Vila Nova de Gaia (2.6%), Cascais (2.4%) and Oeiras (2.0%).¹⁹ They all belong either to AML or AMP. Apart from the strongest eco

18 *Áreas Metropolitanas*: administrative units with some political autonomy, formed by several municipalities, which figures as a political intermediate structure, with some financial and administrative autonomy. AML (Área Metropolitana de Lisboa) includes 18 municipalities: Alcochete, Almada, Amadora, Barreiro, Cascais, Lisboa, Loures, Mafra, Moita, Montijo, Odivelas, Oeiras, Palmela, Seixal, Sesimbra, Setúbal, Sintra, Vila Franca de Xira. AMP (Área Metropolitana do Porto) includes 9 municipalities: Espinho, Gondomar, Maia, Matosinhos, Porto, Póvoa do Varzim, Valongo, Vila do Conde, vila Nova de Gaia (Fernandes, Alves, 2009).

19 *Sales Index*, 2006, Markttest, 2009.

Map 2. Portugal, 2002 Functional Marginalisation Index.



Source: OECD. 2008

conomic points, a few medium sized historical urban municipalities grow in the inner part of the country, attracting inhabitants and public and private investment (Beja, Évora, Castelo Branco, Guarda, Bragança).

Most of rural municipalities stand at the bottom in the ranking and are losing more quality of life than all the others. There are a few cases of loss in terms of quality of life in urban municipalities, mainly in those ones near the two biggest cities - Lisbon and Oporto. A large part of the country faces problems in terms of

development, but that can be explained by the decrease of their “index of global demographic, economic and social well-being” from 1993 to 2004. In those areas the negative consequences of ageing structures are more noticeable.

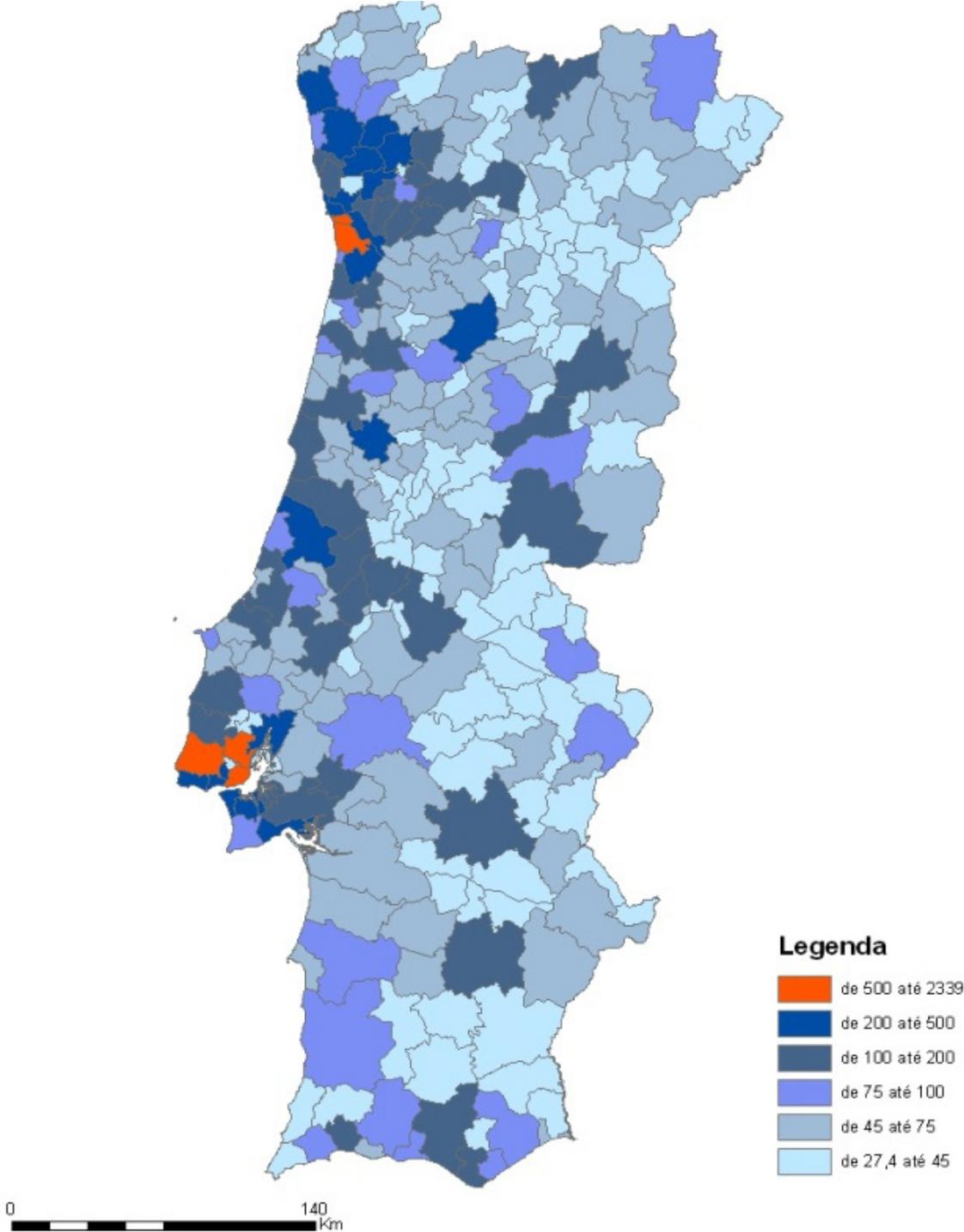
At the beginning of this new century, the unbalance in terms of the spread of Portuguese population can be, to a large extent, explained by the scarce relationship between real needs and the offer of social resources.

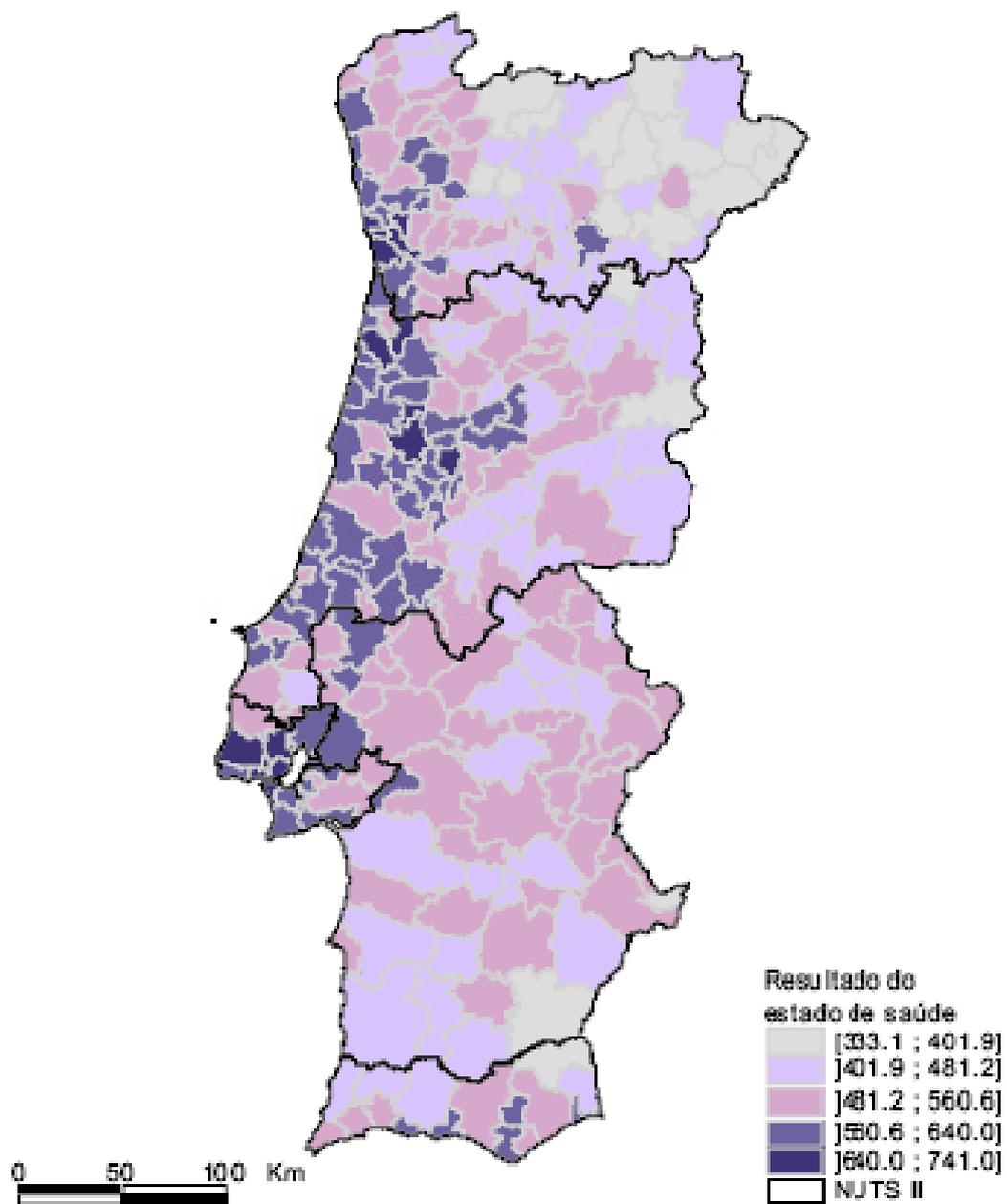
A particular case study: national health system...

Portugal presents a human and social development model built upon the basis of population, economic, urbanization, goods and services concentration in the Atlantic coast. As expected, the comparative reading of the results of 1993 and 2004 shows that Lisbon has the highest values of our well-being index. Oporto and its surrounding municipalities follows Lisbon in the rank of the regions with higher urban rates. We can confirm the there are differences between the coastal areas and all other Portuguese regions as far as the mainland is concerned. However we already saw that there are municipalities in the inner part of the country that present indexes of well-being similar to those of coastal regions; those municipalities really differ from many other depressed ones in the neighbourhood. One would like to know if that might be due to the quality of local health services. If we compare our well-being index results with a health status indicator²⁰, one concludes that there are huge similarities between the two indicators, namely in what concerns to the inner municipalities, with a few exceptions for the most significant urban/political and administrative units (Map 3). Those differences are nowadays greater than they were ten years later, which means that the inequalities are far from being solved. in what concerns to both health and quality of life services (Map 4).

20 Several authors have proved a strong association between poverty and low health status. This last concept includes the analysis of social and economic data and individual assumed perceptions (Santana, 2005).

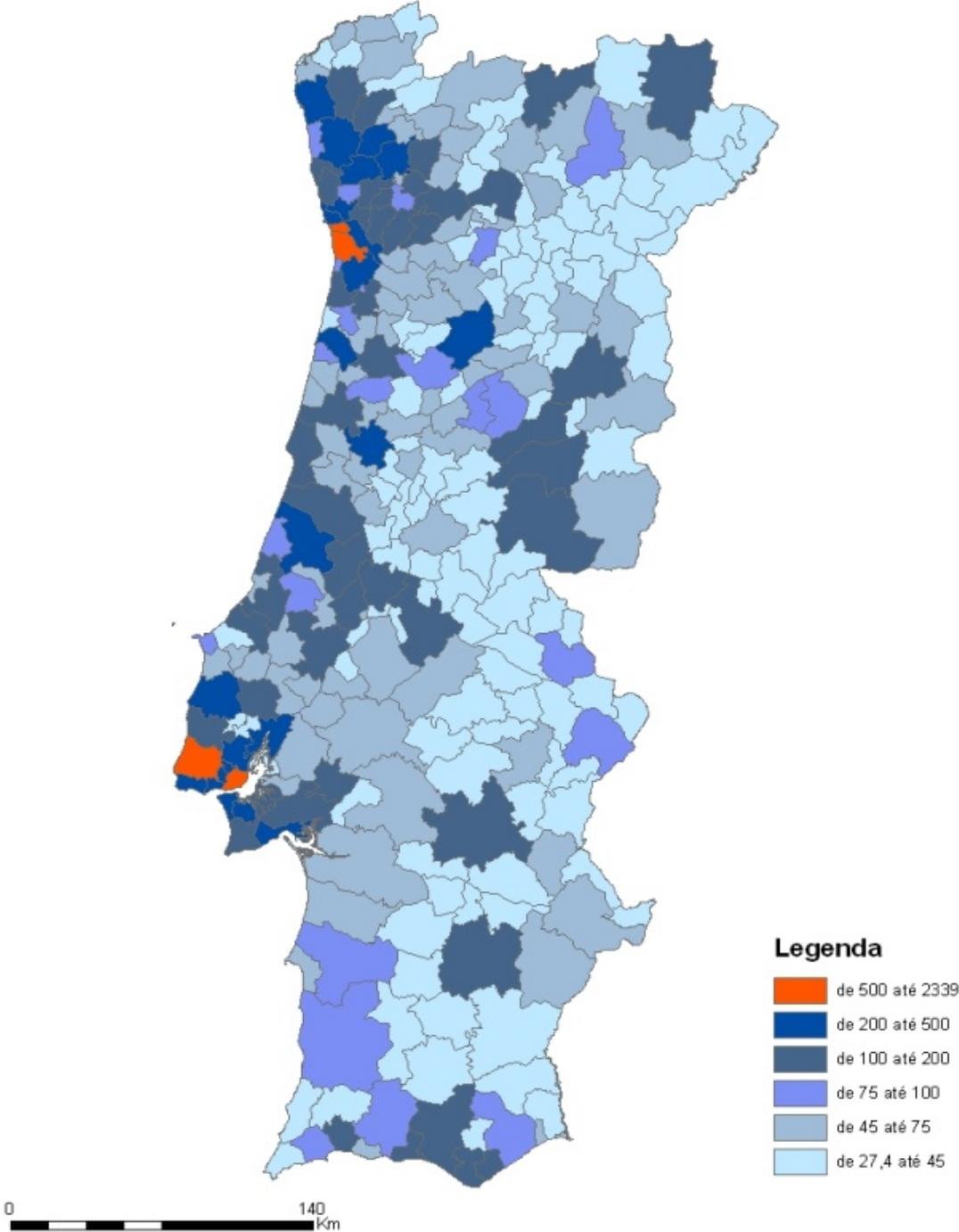
Map 3. Portugal, 1993 Well-being Index and Health Status Situation.

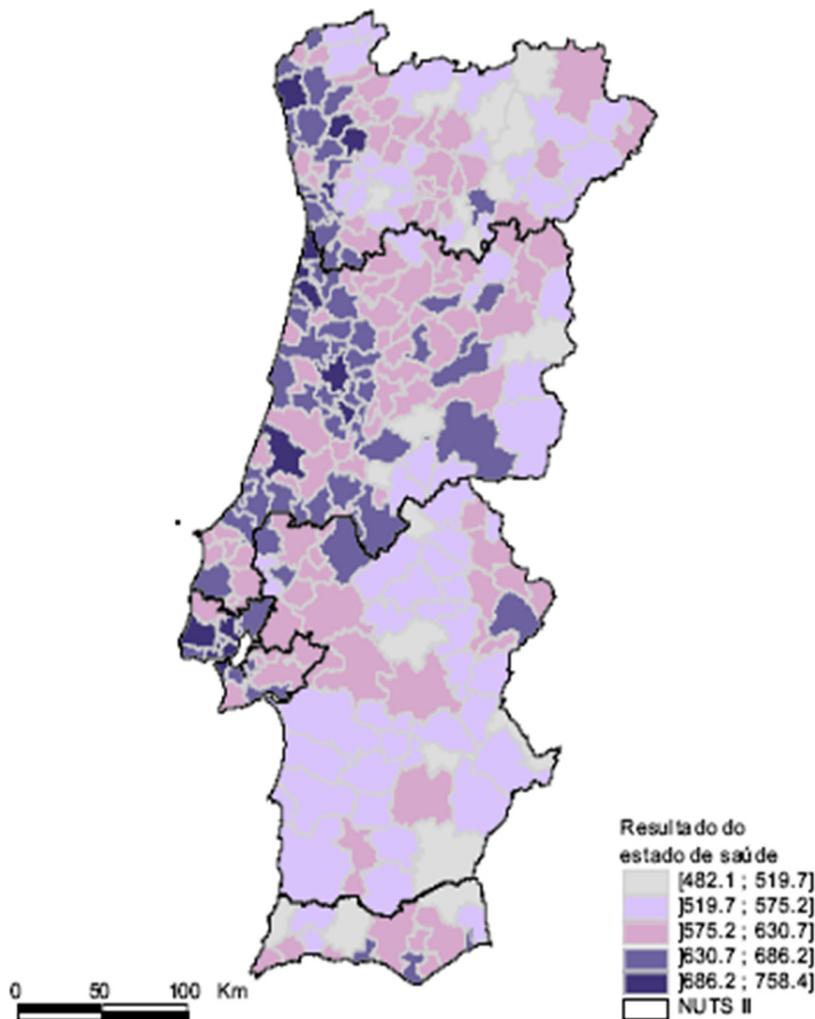




Source: Chorão. Pereira. 2009; Santana. Vaz. Fachada. 2004.

Map 4. Portugal. 2004 Well-being Index and Health Status Situation.





Source: Chorão. Pereira. 2009; Santana. Vaz. Fachada. 2004

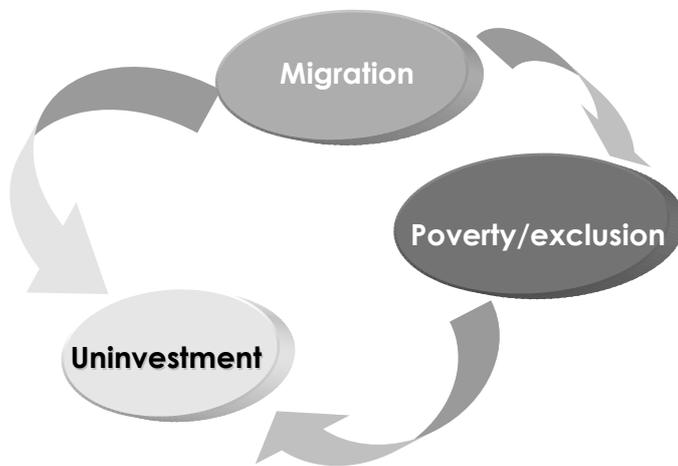
During the 90's, the improvement regarding general well-being in Portugal. was closely followed by the concentration of healthcare “best” services²¹. If we compare data from Table 3 with data from Table 4, a few remarks call our attention. In 1991/1993, 52.3% of all administrative units had health levels well below national average, mostly in rural and inner *municipalities*. Well-being rates were even more concentrated, with a total of 76% below national average. But the “depressed municipalities” represented less than 30% of national residents, in both cases. By 2001/2004, 65% of all administrative units present health levels below national average (rural and inner country). By 2004, 73% of all municipalities stand below national average, although depressed municipalities are more depressed than ever and represent less than 25% of national residents. These municipalities loose residents and become at the same time less attractive to migration and to economic investment. i.e., they risk loosing quality of life and purchase power in the near

21 Santana, 2005

future. Less consuming standards lead to less population and, on a second step, to less public and political investment on infrastructures.

From 1991 to 2004 only 14 municipalities belonging to the non depressed areas showed negative variations, both in well-being and health care indicators. The new emerging offer on health services tend to concentrate in the most populous areas, but some of these municipalities experienced, nevertheless, a deterioration of position in the well-being ranking. Life quality patterns risk to be affected by huge demographic growth rates, due to immigration, which lead to various problems, like the ones seen in the suburbs of Metropolitan Areas of Lisbon and Oporto (Figure 1)²².

Figure 1. Portugal, Well-being and Health care investment.



Source: Author's own elaboration.

We know that health status levels are influenced by local demographic structure and local economic and social average standards. Portuguese National Health Service seems unable to deal with regional specific needs and the same happens with private health care institutions. The problem lies in the lack of consistence between resident's demographic and economic profile and health treatments specialized offer. Rural inner areas show higher elderly rates and a major dependency on public health services, as people living there have lower incomes. At the same time more and better health care options pop up in urban centres. It seems that those who can pay get a better health care, even in places where there seems to exist less quantity and quality of services. Only centralized policies can solve or reduce health care differential conditions, although adjusted to local specific realities.

²² Some of those municipalities loose their relative position from 1993 to 2004 (Moreira, Rodrigues, 2008).

Geographic homogenization is, therefore, far from being a reality in 21st century Portugal. The unbalance in terms of the spread of Portuguese population throughout the territory can be, to a large extent, explained by the insufficient relation between real needs and the offer of social resources (in which healthcare has the lead role).

Conclusion

The purpose of this study was to analyze to what extent changes in regional demographic dynamics reflect and influence well-being average standards, using health status as an example of Portuguese lack of *good practices* on local policies. International reports, such as OECD's *Territorial Reviews: Portugal*²³, underline the risks associated to diversity on economic and demographic dynamics, caused by different local capabilities to implement economic modernization. The focus is set on the urgency to implement regional differentiated policies, considered the best way to support endogenous dynamics of innovation and ensure sustainable development. Portuguese future social development will rely on a better distribution of structural investments, under the impulse of EU Cohesion Policy. Portugal is a good example of how new types of regional policies can contribute to national development, in a small, yet diverse, country, with weak population growth rates and limited public spending capability, marked by a long tradition of centralized governance and no elected political regional power.

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23 OECD, 2008

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Vulnerable populations and inequalities in sickness and in health: The rehabilitation of the disabled and/or invalids of the Spanish Civil War

María-Isabel Porrás-Gallo

Introduction

The way in which the notion of vulnerability has been defined in different ways throughout history and how different vulnerable populations have been identified in each historical period, have been the main aim of the Phoenix Tn Workshop Vulnerable populations and welfare reforms (Paris, 2008, March 28th–29th)¹. Although one of these previously acknowledged vulnerable populations consisted of those who suffered the impact of warfare, there is no doubt that the development of the First World War gave rise to a new vulnerable population: the disabled and invalid of that war. Faced with this problem, each country and its medical community tried to find a solution to encompass current international ideas favourable to the rehabilitation of the disabled and/or invalids, as well as to adapt to the individual circumstances of each of the countries concerned². As historiography has shown, the rehabilitation of civil and military

1 The main results of this interesting Phoenix Tn Workshop has been collected in Patrice Bourdelais and John Chircop, eds., *Vulnerability, Social Inequality and Health*, (Lisboa, 2010).

2 An idea of the different solutions adopted can be gained by consulting the following bibliography: Heather R. Perry, “Re-Arming the Disabled Veteran. Artificially Rebuilding State and Society in World War One Germany”, in Katherine Ott, David Serlin and Stephen Mihm, eds., *Artificial Parts, practical lives. Modern Histories Prosthetics* (New York & London, 2002), pp. 75–101; Deborah Cohen, “Will to Work: Disabled Veterans in Britain and Germany after the First World War”, in David A Gerber, ed., *Disabled veterans in history* (Michigan, 2000), pp. 295–321; Deborah Cohen, *The War come home: Disabled veterans in Britain and Germany, 1914–1939*. (Berkeley, 2001); Jeffrey S. Reznick, “Work-Therapy and the Disabled British Soldier in Great Britain in the First World War: The Case of Shepherd’s Bush Military Hospital, London” in David A Gerber, ed., *Disabled veterans in history* (Michigan, 2000), pp. 185–203; Julie Anderson, *War, disability and rehabilitation in Britain*, (Manchester and New York, 2011); Beth Linker, *War’s waste: rehabilitation in World War I*, (Chicago and London, 2011).

disabled and invalids received a considerable boost when it had to deal with the great number of victims which World War I caused in the different countries taking part in the conflict³.

Spain, although not a participant in World War I, benefited from the positive attitude to the rehabilitation of the disabled and/or invalids which was the key component of the medical model of disability prevailing at the time⁴. In the years immediately following World War I some doctors applied it to the disabled and invalids of the African War and to the case of those injured in work accidents⁵. This same philosophy was also evident when the Spanish Civil War broke out in 1936. The main aim of the present work is to show the response offered by the two opposing sides in the conflict to the problem of the disabled and invalids of the Spanish Civil War. We also intend to demonstrate the importance given to rehabilitation measures in each case, as well as to assess the role played by medical doctors, victims' associations and other sectors of society in dealing with the problem of the disabled and invalids of the Spanish Civil War, both during and, in

3 Among the many works devoted to this question, let us mention: Pascal Doriguzzi, *L'Histoire politique du handicap. De l'infirmes au travailleur handicapé* (Paris, 1994), pp. 89–121; Henri-Jacques Stiker, *Corps infirmes et sociétés* (first edition, Paris: Aubier Montagne, 1982), (Paris, 1997), p. 129; Roger Cooter, "The disabled body", in Roger Cooter and John V. Pickstone, eds., *Medicine in the Twentieth Century*. (Amsterdam, 2000), pp. 367–383, p. 372; Claude Hamonet, *Les personnes handicapées*, (Paris, 2004), p. 62; David A. Gerber, ed., *Disabled veterans in history* (Michigan, 2000), pp. 1–51; Richard Verville, *War, politics and philanthropy: the history of rehabilitation medicine* (Lanham, 2009).

4 More information about the medical model of disability can be found in: Colin Barnes, Geof Mercer and Tom Shakespeare, *Exploring disability: a sociological introduction* (Cambridge, 1999), pp. 20–27.

5 José Martínez Pérez and María Isabel Porras Gallo, "Hacia una nueva percepción social de las personas con discapacidades: Legislación, medicina y los inválidos del trabajo en España (1900–1936)", *Dynamis*, 26 (2006), 195–219; María Isabel Porras Gallo, "La Medicina y los Seguros sociales en el abordaje del problema de los inválidos del trabajo en España en la primera mitad del siglo XX", *História. Ciências, Saúde-Manguinhos*, 13–2 (2006), 393–410. There is also an English version: Medicine, social security and occupational disabilities in Spain in the first half of the twentieth century. Both of them can be found on-line in: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=0104-597020060002&lng=en&nrm=iso; María Isabel Porras Gallo, "Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX", in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525–539; María Isabel Porras Gallo, "Medicine and the social reintegration of the working disabled into the workforce in France and Spain", in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163–186; María-Isabel Porras-Gallo, "The role of the Spanish Red Cross in the establishment of a system of specialized health care for war disabled and invalids: from the colonial disaster to the African war", in Pilar León Sanz (ed.), *Health Institutions at the Origen of the Welfare Systems in Europe*, (Pamplona, 2010), pp. 131–149.

less detail, after the hostilities⁶. As will be shown, the treatment given and the benefits received in each case were different, especially after the end of the war. Indeed, the economic and health benefits given to the disabled and invalids of the National side were not extended by Franco's regime to those on the Republican side.

The Rehabilitation of the Disabled and/or Invalids in Spain before the Civil War

As mentioned above, the change of attitude towards disabled and invalids arising from the Great War and the social importance acquired by the professional rehabilitation of these disabled and invalids also affected Spanish society⁷ and, most particularly, Spanish doctors⁸. The latter were eager to apply the measures of rehabilitation both to war disabled and to the disabled and invalids caused by work accidents or any other causes⁹. Indeed, in 1918 Antonio Oller (1887–1937), chiefly

6 This topic has not been analysed in detail yet. A preliminary study is included in María Isabel Porras-Gallo, "Medicina, Guerra y reintegración social del inválido del trabajo en la España de la primera mitad del siglo XX", in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, Ideología e Historia en España (Siglos XVI-XXI)*, (Madrid, 2007), pp. 525–539.

7 Álvaro López Núñez, *Restauración social de los inválidos de la guerra*. (Madrid, 1916); Álvaro López Núñez, "La reeducación de los obreros inválidos del trabajo", *Anales del INP*, 10 (1918), 273–275.

8 Antonio Oller, "Algunos comentarios a la Ley de accidentes del trabajo", *Los Progresos de la Clínica*, 12 (1918), 372–380; Joaquín Decref Ruiz, "Cirugía de guerra", *Anales de la Real Academia Nacional de Medicina*, 39 (1919), 109–118; Joaquín Decref Ruiz, *La reeducación de inválidos para el trabajo* (Madrid, 1924); Manuel Bastos Ansart, "Los resultados de la Cirugía de rehabilitación en nuestros inválidos de guerra", *Anales de la Real Academia Nacional de Medicina*, 44 (1924), 602–610; Manuel Bastos Ansart, "El problema de los inválidos visto a través de observaciones hechas en el Instituto Nacional de Reeducación", *Anales de la Real Academia Nacional de Medicina*, 55 (1936), 209–232.

9 José Martínez Pérez and María Isabel Porras Gallo, "Hacia una nueva percepción social de las personas con discapacidades: Legislación, medicina y los inválidos del trabajo en España (1900–1936)", *Dynamis*, 26 (2006), 195–219; María Isabel Porras Gallo, "La Medicina y los Seguros sociales en el abordaje del problema de los inválidos del trabajo en España en la primera mitad del siglo XX", *História. Ciências, Saúde-Manguinhos*, 13–2 (2006), 393–410. There is also an English version: Medicine, social security and occupational disabilities in Spain in the first half of the twentieth century. Both of them can be found on-line in: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=0104-597020060002&lng=en&nrm=iso; María Isabel Porras Gallo, "Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX", in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525–539; María Isabel Porras Gallo, "Medicine and the social reintegration of the working disabled into the workforce in France and Spain", in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163–186.

responsible for the creation and establishment of the speciality of Work Medicine in Spain¹⁰, censured the state for ignoring the need for the rehabilitation of those injured at work, and called for the creation of a state institution to deal with the problem¹¹. This request was taken into account in the draft bill of 1919 which proposed to modify the 1900 law on workplace accidents, which made no provision for the professional rehabilitation of accident victims¹². However, this first attempt was unsuccessful¹³.

The request made by military surgeon Manuel Bastos Ansart (1887–1973) as a result of the worsening of the Moroccan War in 1921 and its consequent disabled and invalids met with greater success¹⁴. Faced with this problem this surgeon pointed out in the daily newspapers of Madrid the need to create specialised centres, including an “Institution for the rehabilitation of the wounded and disabled of the [Moroccan] campaign”¹⁵. Bastos considered this Institution to be essential to achieve the social reinsertion of war invalids, as well as the later

10 For more information about this topic, see: Ángel Bachiller Baeza, *Historia de la Medicina del Trabajo en España. La obra científica del Prof. Antonio Oller Martínez*. (Valladolid, 1984).

11 Antonio Oller, “Algunos comentarios a la Ley de accidentes del trabajo”, *Los Progresos de la Clínica*, 12 (1918), 372–380.

12 Proyecto de Ley leído por el Sr. Ministro de la Gobernación modificando la de 30 de enero de 1900 sobre accidentes del trabajo, *Diario de las Sesiones de las Cortes. Congreso de los Diputados*, 34 (18-11-1919). Apéndice 3º.

13 José Martínez Pérez and María Isabel Porras Gallo, “Hacia una nueva percepción social de las personas con discapacidades: Legislación, medicina y los inválidos del trabajo en España (1900–1936)”, *Dynamis*, 26 (2006), 195–219; María Isabel Porras Gallo, “La Medicina y los Seguros sociales en el abordaje del problema de los inválidos del trabajo en España en la primera mitad del siglo XX”, *História. Ciências, Saúde-Manguinhos*, 13–2 (2006), 393–410. There is also an English version: Medicine, social security and occupational disabilities in Spain in the first half of the twentieth century. Both of them can be found on-line in: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=0104-597020060002&lng=en&nrm=iso; María Isabel Porras Gallo, “Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX”, in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525–539; María Isabel Porras Gallo, “Medicine and the social reintegration of the working disabled into the workforce in France and Spain”, in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163–186.

14 María Isabel Porras Gallo, “Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX”, in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525–539; María Isabel Porras Gallo, “Medicine and the social reintegration of the working disabled into the workforce in France and Spain”, in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163–186.

15 Manuel Bastos Ansart, “Problemas de la guerra. La rehabilitación de inutilizados”, *El Sol*, 8-9-1921, p. 2.

rehabilitation of industrial accident victims in peacetime or as a result of illnesses or congenital defects. And that same year of 1921 saw the establishment of the Orthopaedic Surgery and Rehabilitation Clinic of the Military Hospital of Carabanchel (Madrid), with Manuel Bastos as its director¹⁶.

Under the influence of this favourable climate of opinion towards professional rehabilitation, the new Work Accident Law of 1922 included for the first time in Spain the professional rehabilitation of workplace invalids. To this end the Instituto de Reeducción Profesional de Inválidos del Trabajo (IRPIT) (The Institute of Professional Rehabilitation for Workplace Invalids) was set up in order to fulfil three aims: the functional readaptation, professional rehabilitation and social care of invalids (Royal Decree. Gaceta de Madrid, 5 March 1922). In order to satisfy these aims, three sections were established: medical, technical and administrative. Antonio Oller was appointed as director of the medical section. The work carried out by the IRPIT from the beginning of its activities in 1925 achieved international recognition.¹⁷ However, the negative effects of the 1929 crisis in the labour market caused the work of the IRPIT to be seriously compromised¹⁸.

The arrival of the Second Republic introduced reforms in the area of the rehabilitation of invalids and disabled. In fact, the new Work Accident Law of 1932 finally included the establishment of compulsory work accident insurance, and the

16 Manuel Bastos Ansart, *De las guerras coloniales a la Guerra Civil. Memoria de un cirujano* (Barcelona, 1969); José María Torres Medina, coord., *Gómez Ulla. Hospital Militar Central. Cien años de Historia 1896–1996* (Madrid, 1996), pp. 136–137; Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004), pp. 105–121, María Isabel Porras Gallo, “Medicine and the social reintegration of the working disabled into the workforce in France and Spain”, in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), 163–186, p. 175.

17 Julián Palacios Sánchez, “Evolución histórica”, in Julián Palacios Sánchez (coord.), *Historia del C.P.E.E. de Reeducción de Inválidos. Antiguo INRI*, (Madrid, undated), pp. 51–59; Julián Palacios Sánchez, *La institución pionera de la Rehabilitación en España*, (Madrid, 1990).

18 José Martínez Pérez and María Isabel Porras Gallo, “Hacia una nueva percepción social de las personas con discapacidades: Legislación, medicina y los inválidos del trabajo en España (1900–1936)”, *Dynamis*, 26 (2006), 195–219; María Isabel Porras Gallo, “La Medicina y los Seguros sociales en el abordaje del problema de los inválidos del trabajo en España en la primera mitad del siglo XX”, *História. Ciências, Saúde-Manguinhos*, 13–2 (2006), 393–410. There is also an English version: Medicine, social security and occupational disabilities in Spain in the first half of the twentieth century. Both of them can be found on-line in: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=0104-597020060002&lng=en&nrm=iso; María Isabel Porras Gallo, “Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX”, in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525–539; María Isabel Porras Gallo, “Medicine and the social reintegration of the working disabled into the workforce in France and Spain”, in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163–186.

organisation of professional rehabilitation around the newly created institutions: the Caja Nacional del Seguro de Accidentes del Trabajo (National Workplace Accident Insurance Fund) and the Clínica del Trabajo (Work Clinic)¹⁹. Into the latter, responsible from that time onwards for the functional rehabilitation of workers injured in accidents, were incorporated the majority of the doctors and professionals of the old IRPIT, and Antonio Oller became its director.

For its part, the old IRPIT, now divested of the responsibility for the rehabilitation of workplace disabled, underwent considerable transformations in its functions. In fact, from 5 June 1933, it came to be known as the Instituto Nacional de Reeducción de Inválidos (INRI) (National Institute for Rehabilitation of Invalids) and broadened its aims (Decree of 5-6-1933. Gaceta de Madrid, 7-6-1933). Its new function was the rehabilitation of invalids and disabled of any kind (illness, congenital defects, etc). Manuel Bastos was the new director of the Institute.

In view of what we have outlined above, when the Spanish Civil War broke out Spanish society already had the background provided by the rehabilitation work carried out previously in the different institutions mentioned: Manuel Bastos' Clinic in the military hospital of Carabanchel in Madrid, the IRPIT (Institute of Professional Rehabilitation for Workplace Invalids), the Clínica del Trabajo (Work Clinic), and the INRI (National Institute for Rehabilitation of Invalids).

Professional Rehabilitation and the Readaptation of Spain War Invalids

As was to be expected, the Spanish Civil War produced a growing number of disabled and invalids to which both the Republican Government and that of the National Zone had to offer a response. Still under the influence of the initiatives set in train in other countries during the Great War, and with the background of the experience acquired with the war disabled of the Moroccan War and, above all,

19 María Isabel Porras Gallo, "La Medicina y los Seguros sociales en el abordaje del problema de los inválidos del trabajo en España en la primera mitad del siglo XX", *História. Ciências, Saúde-Manguinhos*, 13-2 (2006), 393-410. There is also an English version: Medicine, social security and occupational disabilities in Spain in the first half of the twentieth century. Both of them can be found on-line in: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=0104-597020060002&lng=en&nrm=iso; María Isabel Porras Gallo, "Medicina, guerra y reintegración social del inválido del trabajo en la España del primer cuarto del siglo XX", in Ricardo Campos, Luis Montiel and Rafael Huertas, coords., *Medicina, ideología e historia en España (Siglos XVI-XXI)*. (Madrid, 2007), pp. 525-539; María Isabel Porras Gallo, "Medicine and the social reintegration of the working disabled into the workforce in France and Spain", in Laurinda Abreu and Patrice Bourdelais, eds., *The Price of Life. Welfare Systems, Social Nets and Economic Growth*. (Lisboa, 2008), pp. 163-186.

with workplace invalids, an attempt was made to establish measures (limited by the conditions) to face up to the situation in hand and the demands of those affected.

*From the demands of the League of War Disabled and Invalids to the
“Centre for Orthopaedic Surgery and War Wound Recovery”
of the Swedish-Norwegian Hospital of Alcoy*

On the Republican side these demands were channelled through the “League of the Disabled and Invalids of the War in Spain” and the different committees set up in some provinces and regions of Spain; but this matter was also dealt with by some Spanish doctors and others from outside who formed part of the International Brigades. In both cases, functional and professional rehabilitation were considered key points in responding to the problem of the disabled and invalids of the Civil War and their subsequent reintegration into society. The creation of the National League of War Disabled and Invalids in 1937 in Madrid reflected the favourable climate towards rehabilitation at that time, and the conviction that professional rehabilitation could change the status of the disabled. In fact, one of the main aims of the League was “to educate and re-educate the disabled physically and culturally”²⁰. The League insisted that they did not want to be “humiliated invalids or parasites”, but they wanted to be “educated, useful invalids, in spite of our disability”. For this reason one of their first demands was the setting up of “residences for education and rehabilitation as far as possible, to educate all those invalids who may require it”²¹. In their opinion, this demand should be urgently debated in the National Congress of the League which was soon to be held. The Congress took place in Valencia in August 1938, and was the official founding moment of the League, which from that moment on took the name of “League of War Disabled and Invalids of the Army of the Republic”²².

The need to carry out a broader and more detailed analysis of the problems of the war-disabled and the solutions they called for led to the setting up of different local Committees. In the absence of new data which may be produced by on-going research, we can confirm that some of them, such as the Liga de Euzkadi de Mutilados e Inválidos de Guerra (the Basque League of War Disabled and Invalids), or the Committees in Barcelona or Cartagena played an outstanding part right from the beginning of the conflict –a part which became even more important

20 Federación Española-Liga de Mutilados e Inválidos de Guerra, *Material para la discusión para el Pleno Nacional de la Liga de Mutilados e Inválidos de Guerra* (Madrid, 1937), p. 3

21 Ibid.

22 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976); Antonio Trabal, *Breve historial de la Liga de Mutilados e Inválidos de la Guerra de España* (Barcelona, 1986).

from 1938 onwards. They quickly organized help for the disabled, which included economic assistance to cover basic necessities, but also the provision or subsidy of any orthopaedic devices required. They likewise dealt with the design and/or opening of centres of functional and/or professional rehabilitation²³.

Meanwhile, among the foreign doctors who formed part of the International Brigades, mention should be made of the psychiatrist Max Hodann who, as well as carrying out a novel experiment in the field of psychiatric rehabilitation²⁴, offered an interesting programme for dealing with the problem of the rehabilitation of war disabled in 1938²⁵. This programme was based on the experience gained in the First World War and on the knowledge that Hodann had of the rehabilitation activity carried out in Spain before the Civil War. This background allowed Hodann to formulate his proposal along three basic lines: 1) the creation of “rehabilitation centres with workshops to rehabilitate the wounded in different professions, together with the possibility of providing surgical treatment”; 2) the preparation of a census of Army amputees and invalids; and 3) the application of the economic and rehabilitation benefits of the 1932 Law of Compulsory Insurance of Workplace Accidents to the disabled and invalids of the Civil War²⁶. In accordance with this plan, the cases of “partial permanent incapacity for normal profession” and those of “permanent and total incapacity for normal profession” should receive the benefits of professional rehabilitation, while cases of “temporary incapacity” and those of “permanent and absolute incapacity for any work” would be excluded. The latter would only have the right to medical assistance and pensions as established by law.

Hodann considered it essential that the Rehabilitation Centres which were set up should have the cooperation not only of surgeons, teachers and craftsmen, but also of representatives of the disabled and wounded. An essential part of these centres was the setting up of workshops for the manufacture of artificial limbs with craftsmen expert in the construction of orthopaedic apparatus adapted to wartime requirements. Hodann thus found it expedient to establish close links with the National League of War Disabled and Invalids, in order to gain access to

23 Archive of the Civil War of Salamanca, Liga de Mutilados, Inválidos y Viudas de la Guerra de España en Francia and Archive of the Civil War of Salamanca, Sección Santander, C.574, Exp.3

24 Cándido Polo Griñán, “La Psiquiatría en las Brigadas Internacionales”, in Ricardo Campos, Olga Villasante and Rafael Huertas, eds., *De la ‘Edad de Plata’ al exilio. Construcción y ‘reconstrucción’ de la Psiquiatría española* (Madrid, 2007), pp. 211–237.

25 Max Hodann, “El problema de la reeducación de los mutilados de guerra”, *La Voz de la Sanidad*, 6 (31-5-1938), 5–6; Max Hodann, “El problema de la reeducación de los mutilados de guerra”, *La Voz de la Sanidad*, 7 (18-7-1938), 9–10; Max Hodann, “Informe respecto al problema de la reeducación de los mutilados de guerra, Valencia”, *Alameda*, 15 (1938), p. III.

26 Max Hodann, “El problema de la reeducación de los mutilados de guerra”, *La Voz de la Sanidad*, 6 (31-5-1938), 5–6, p. 6; Max Hodann, “El problema de la reeducación de los mutilados de guerra”, *La Voz de la Sanidad*, 7 (18-7-1938), 9–10, p. 9.

orthopaedic craftsmen and specialised workshops. Another vital element was the acquisition of the necessary raw materials for the manufacture of these items.

Clearly, one of the possible ways to respond to the requests of the National League of War Disabled and Invalids, and to act in accordance with the ideas put forward by Hodann and other doctors, was to make use of the existing specialised centres such as the Orthopaedic Surgery and Rehabilitation Clinic of the Military Hospital of Carabanchel (Madrid), the INRI (National Institute for Rehabilitation of Invalids) or the Clínica del Trabajo (Work Clinic). All of these remained within the Republican zone until June 1937 when the Nationalist forces reached the southern outskirts of Madrid. However, their use as rehabilitation centres seems doubtful. In fact, the Clinic of the Military Hospital, being so close to the front line, was dismantled and transferred to the Palace Hotel in the centre of Madrid²⁷, the Work Clinic became a field hospital²⁸ and the surgical equipment of the INRI was transferred to field hospitals²⁹.

Without going much further into the matter, we may mention one of the main initiatives taken on the Republican side in response to the demands we have just seen. This was the initiative taken by the surgeon Bastos Ansart in the Swedish-Norwegian International Brigade Hospital in Alcoy from 27 August 1937³⁰. Upon his arrival in this hospital Manuel Bastos took it upon himself to organise a “Centre for Orthopaedic Surgery and War Wound Recovery” which, according to Beneito³¹, carried out the same functions as those of the Orthopaedic Surgery and Rehabilitation Clinic of the Military Hospital of Carabanchel (Madrid) of which this surgeon had been the director. This involved not only operating on the wounded, but also dealing with the adaptation of the appropriate artificial limbs and the rehabilitation of the disabled. Continual bombing forced the closure of the

27 Manuel Bastos Ansart, *De las guerras coloniales a la Guerra Civil. Memoria de un cirujano* (Barcelona, 1969); Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004); Ángel Beneito Lloris, “La ayuda escandinava y el hospital sueco-noruego de Alcoi”, in Manuel Requena Gallego and Rosa María Sepúlveda, coords., *La Sanidad en las Brigadas Internacionales* (Cuenca, 2006), pp. 131–160.

28 Antonio Oller, *Memoria de la Clínica del Trabajo del INP (1933–1934)* (Madrid, 1935); Antonio Oller, *Memoria de la Clínica del Trabajo del INP (1935)* (Madrid, 1936); Ángel Bachiller Baeza, *La Medicina Social en España* (El Instituto de Reeducción y la Clínica del Trabajo 1922–1937) (Valladolid, 1985), pp. 41–78.

29 General Military Archive of Avila, C2323, L.46, Cp21.

30 The Scandinavians asked Bastos to take on the management of the Swedish-Norwegian Hospital in Alcoy once his agreed collaboration with them had finished. Bastos refused the directorship, but did accept the directorship of the Hospital’s surgical team. Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004), pp. 70 and 115.

31 Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004), pp. 71, 116–117.

Alcoy Hospital in November 1938³². Bastos, together with some of his patients, moved to a small Convalescent Centre in Villa Joyosa (Alicante). The centre, enlarged and equipped with the material recovered from Alcoy, was used until the end of the War and the arrest of Bastos on 6 April 1939³³. This traumatic end signalled the harsh and sorry fate which awaited the war disabled of the Republican side after the establishment of Franco's regime at the end of the war, at which we shall look more closely later.

Rehabilitation initiatives of the Nationalist group during the war, and the design of a general plan for "Reorientation and professional placement of War Disabled", to be applied by the new regime

On the Nationalist side, the Decree of 23-1-1937 (BOE, 24-1-1937) set up the "General Directorate for War Invalids of the Fatherland" (Dirección General de Mutilados de Guerra por la Patria). Its aim was to organise the "Honourable Corps of War Disabled" (Honorable Cuerpo de Mutilados de Guerra), as well as the classification, rehabilitation, legal organisation, placement, and care of its members. Important elements for the achievement of these goals were "the creation and establishment of Offices of Professional Rehabilitation", where the War Disabled would be trained in new activities, as well as "proposing the positions which were to be reserved for the members of the Corps of War Disabled in State, Provincial and Municipal bodies"³⁴. This decree led to the progressive establishment of pensions and to the development of certain rehabilitation initiatives (initially very limited), but the process was not without its difficulties. Documents consulted in the General Military Archive of Avila show the problems presented in applying the Decree of 1937. It was quite difficult to carry out the medical examinations, establish the invalidity and its seriousness, deal quickly with invalidity reports and thus award pensions to help the disabled to survive³⁵.

Problems also arose in providing the functional and professional rehabilitation of the disabled and invalids. At an early stage, some groups put forward suggestions to help resolve these difficulties: for example, in April 1937, the National Health Headquarters of the Requetés (the Carlist National Council) proposed the creation

32 Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004).

33 Ángel Beneito Lloris, *El Hospital Sueco-Noruego de Alcoi durante la Guerra Civil española*. (Alcoi, 2004), pp. 73–74, 118–119.

34 Article 2 of Decree of 23-1-1937; Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), p. 47.

35 General Military Archive of Avila, C.2326, L.50.Cp88, and C2326, L.50, Cp.91.

of a National Institute of Orthopaedics and Rehabilitation of War Wounded³⁶. This was justified by the existence of some 26,750 invalids needing rehabilitation at that moment, and it was proposed that it should be installed in the Zaragoza Military Academy or in the Infantry Barracks of Astorga to keep costs down. This initiative was turned down on the basis that an institution of this kind, the INRI, already existed. It had just been liberated in June 1937, and it was necessary to carry out a census of the disabled in order to evaluate possible requirements. In fact, the INRI's proximity to the front line, its deteriorated condition and the confiscation of its surgical equipment meant that it was inoperative during the conflict.³⁷ On the other hand, it appears that early in January 1938 two rehabilitation centres for the disabled were set up for the natives in Tetuan and Melilla³⁸. In the same month the Istituto Rizzoli of Bologna, in Italy, offered twelve places for the rehabilitation of officers and leaders of the Nationalist group, although only two of them were taken up due to economic constraints³⁹. During 1938 rehabilitation centres were set up in Oza (La Coruña) and in certain military hospitals such as those of San Sebastian, Seville and Zaragoza.

The problem of the disabled acquired greater importance after 1938, and particularly in 1939: in January there was a Census of Disabled⁴⁰, on 2 February the Gran Patronato de Asistencia a Frentes y Hospitales (Grand Foundation for Assistance to Battle Fronts and Hospitals) was set up, and on 2 April the Statute of the Honourable Corps of War Disabled was enacted⁴¹. The latter included a comprehensive list of injuries for the classification of the disabled (fit, potential, permanent and absolute) and made definitive provision for their professional placement. One result of these two legislative initiatives of 1939 was the creation of the "Service of Recovery of War Disabled for [civilian] Work", and the establishment in the Military Hospital of San Sebastian of the first Vocational Guidance Office⁴². This office was created partly on the basis of the material and

36 General Military Archive of Avila, C.2323, L.46, Cp.21.

37 Julián Palacios Sánchez, "Evolución histórica", in Julián Palacios Sánchez (coord.), *Historia del C.P.E.E. de Reeducación de Inválidos. Antiguo INRI*, (Madrid, undated), pp. 51–59; Julián Palacios Sánchez, *La institución pionera de la Rehabilitación en España*, (Madrid, 1990).

38 General Military Archive of Avila, C.2380, L.158, Cp.25.

39 General Military Archive of Avila, C.2323, L.45, Cp.51.

40 General Military Archive of Avila, C2326, L.50, Cp.91.

41 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), pp. 46–57.

42 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), pp. 127–128; General Military Archive of Avila, C2344, L.86, Cp.29.

staff already employed in the State Office attached to the Apprentice School. Similar offices were located in the hospitals of Bilbao, Zaragoza and La Coruña⁴³.

The management of the Orthopaedic and Rehabilitation Services was in the hands of orthopaedic surgeons and traumatologists from the military or civilian health services, who had generally gained experience in the military field – in Bastos' Clinic in Carabanchel– or in the different institutions mentioned above [the Institute of Professional Rehabilitation for Workplace Invalids (IRPIT), the National Institute for Rehabilitation of Invalids (INRI) or the Work Clinic], with invalids from the workplace or elsewhere⁴⁴. One of these was Mario Oliveras Devesa⁴⁵, the Head of the Orthopaedic and Rehabilitation Service of the General Mola Military Hospital in San Sebastián⁴⁶. The limited data currently available makes it difficult for us to evaluate the role performed by these services during the war and their results.

What we do know for certain is that at the end of the war it was these same professionals who, either on their own initiative or on the occasion of the holding of the First Commission on the Recovery of War Disabled⁴⁷, pointed out the need to establish and/or maintain “Centres of Orthopaedic Surgery and Rehabilitation” in order to deal with “the problem of the treatment of all the residual wounds of the members, and the rehabilitation of the disabled”⁴⁸. They even drew up a general national organisation plan for the “Reorientation and Professional Placement of War Disabled”⁴⁹, which excluded those from the Republican side⁵⁰.

43 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), pp. 127–130 et seq.

44 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), pp. 153–157; Mario Oliveras Devesa, “La Reeducción funcional protésica en los amputados de brazo”, *Revista Española de Medicina y Cirugía de Guerra*, 2 (1938), 91–102, p. 92.

45 Mario Oliveras Devesa, *La recuperación de mutilados* (San Sebastián, 1939); Mario Oliveras Devesa, *Traumatismos e incapacidades de la mano* (Barcelona, 1948).

46 Mario Oliveras Devesa, *La recuperación de mutilados* (San Sebastián, 1939). The author refers to earlier (1924) works of his concerning his experience with workplace accident victims.

47 Primera Ponencia, *Recuperación quirúrgico-ortopédica de los mutilados de guerra*, (Madrid, 1941).

48 J. Pruneda, “Los Servicios de Cirugía Ortopédica y Reeducción”, *Revista Española de Medicina y Cirugía de Guerra*, 15 (1939), 372–376, p. 372. Pruneda's previous experience had been acquired in the Orthopaedic Surgery and Rehabilitation Clinic of the Military Hospital of Carabanchel in the six years prior to the war.

49 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939), pp. 29–37.

50 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976); Antonio Trabal, *Breve historial de la Liga de Mutilados e Inválidos de la Guerra de España* (Barcelona, 1986).

According to the project drawn up by Lieutenant Nogales Puertas (1939), Doctor of the Army Medical Corps and Medical Inspector of the National Workplace Accident Insurance, the National Plan for “Reorientation and Professional Placement of War Disabled” should be centred on five key elements: 1) Centres and Institutes for functional Rehabilitation and Prosthetics; 2) the Central and Provincial Offices of Vocational Guidance 3) the Central and Provincial Offices and premises dealing with Professional Rehabilitation; 4) the Central and Provincial Offices of Professional Placement; and 5) the establishment of a Board of Social and Professional Guardians of the War Disabled⁵¹.

As was to be expected under a regime such as that of Franco, these Offices, Commissions, and the Board itself included representatives of the ministries concerned in each case; of the Instituto Nacional de Previsión (INP) (National Social Security Institute); of the Army Medical Corps; of the Trades Union Delegations of the Falange Española Tradicionalista de las JONS (the only legally permitted political party), and of the Vertical Trade Unions; of the “Corps of Gentlemen Disabled in the Patriotic War”; of the Church and the religious orders involved in the plan; of the Private Banks, the Chambers of Commerce and of the Employers’ Federations, etc. The plan included the maintenance of the pensions which had been conceded since the end of 1937, and the application of the workplace accident law of 1932 to deal with some cases such as that of the disabled whose social rehabilitation consisted of self-employment, rather than obtaining work with a third party.

In addition to the clear political and religious connotations of this plan, it should be made clear that its practical realisation called for the use of all existing public resources, and the need to seek the aid of private enterprise (industrial, Private Banking, and private religious Professional Colleges) in order to deal exclusively with the problem of the disabled from the Nationalist side of the Spanish Civil War, at a time of great economic hardship as suffered in post-war Spain.

Vulnerability and Inequalities of the War Disabled after the Spanish Civil War

While not going too far into the degree of practical implementation of the reorientation and professional rehabilitation programme for the disabled veterans of the Nationalist side, we may point out that functional rehabilitation was based around four centres set up in Madrid, San Sebastian, Barcelona and Tetuan. Here they carried out reparative and orthopaedic operations, and provided the necessary

51 Benito Nogales Puertas, *La Reorientación y colocación profesional de mutilados de Guerra (Estudio de Organización Nacional)* (Santiago, 1939).

artificial limbs. Now, as certain doctors of the Army Medical Corps pointed out, this process was far from easy and required a greater quantity of resources and medical specialisation⁵². They likewise considered necessary a great deal of coordination in order to begin professional rehabilitation as soon as possible, and to achieve the return to the civil workforce of the re-educated veterans, which was not always the case.

In order to achieve this later objective, the Law of 25 August 1939 (Spanish Official Gazette 1 September) approved preferential access to public employment for the disabled, veterans and ex-prisoners of war, as well as for the families of war victims from the Nationalist side. Indeed, 80% of the vacancies in the lower levels of staff of the different administrative services were reserved for them, as well as a guaranteed number of positions of responsibility in the civil service for those who had taken entrance examinations, and 80% of the positions as doormen, janitors and receptionists in public buildings⁵³.

To the foregoing were added the pensions granted in each case, according to the Law of the Disabled of War for the Homeland and the regulations of the Corps of Military Invalids. In addition to the legal measures brought into force during the Civil War, two new laws –that of 12 December 1942 and that of 26 December 1958– regulated the economic assistance to be received by the wounded and disabled of the Nationalist Army⁵⁴. All this provided a solution to the situation of the war disabled and invalids of the Nationalist zone.

The fate suffered by the Republican disabled and invalids was very different⁵⁵. If those who remained in Spain had to subsist basically on charity, those who went into exile had no less difficulty. The “League of the Wounded and Disabled of the War in Spain”⁵⁶ was abolished at the end of the Civil War. In common with half a million Spaniards, the League went into exile in France, which gave it a cool reception until the end of the Second World War. Between 1939 and 1945 Republican disabled and invalids had to put up with extremely harsh conditions, and attempts made by some of the leaders of the League to mitigate their situation did not always meet with success. In fact, initially they received none of the economic support requested from the Republican Government in Exile in order to

52 Manuel Gómez-Durán, “Recuperación quirúrgico-ortopédica de los mutilados de guerra. Exposición general del problema”, in Primera Ponencia, *Recuperación quirúrgico-ortopédica de los mutilados de guerra*, (Madrid, 1941), pp. 7–26.

53 Manuel Valdés Larrañaga, *De la Falange al Movimiento* (1936–1952) (Madrid, 1994), p. 134.

54 Ángel Ruano Hernández, *Invalidez, desamparo e indefensión en seres humanos* (Madrid, 1993), p. 69.

55 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976); Antonio Trabal, *Breve historial de la Liga de Mutilados e Inválidos de la Guerra de España* (Barcelona, 1986); Pedro Vega, *Historia de la Liga de Mutilados* (Madrid, 1981).

56 In the National Congress held in Valencia in 1938 it was decided also to include the disabled of the Nationalist side.

set up residences for the Republican disabled and invalids in France. After long negotiations, the League finally succeeded in obtaining three residences in France, which were to be lost when the French army was defeated by Germany. It was not until after the liberation of Paris that the exiled Spanish disabled veterans were able to set up a “Committee for the Reorganisation of the League of the Wounded and Disabled of the War in Spain”. This committee asked for funds from Pablo Picasso and Pau Casals to prepare the National Congress of the Disabled of the War in Spain, which took place in Toulouse in 1945 and marked the relaunching of the activities of the League.

The steps taken by the League from that moment onwards permitted an improvement in the situation of the Republican disabled and invalids. One of the first successes was the application of the Cordonnier Law to Spanish double amputees. In addition, the French Government Decree of 7 May 1947 authorised Spanish doctors to give professional help to exiles of their own nationality, including disabled and invalids, through the Spanish Republican Red Cross (independent from that operating in Spain), which set up 90 dispensaries distributed throughout various major French cities. Each dispensary had a staff of specialists, and in Toulouse there was an orthopaedic workshop to produce artificial limbs⁵⁷. As well as this, there were the trade apprenticeship courses which the French government offered continuously to exiled Spanish disabled and invalids, in order to help their rehabilitation for work. The French government also helped to set up different co-operative societies (such as the Société Coopérative Sandalière of Bordeaux and its successor the Coopérative Ouvrière de la Chaussure), run by members of the League of the Wounded and Disabled, in which work and wages were provided to the exiled and disabled veterans from the Civil War⁵⁸.

The League of the Wounded and Disabled of the War in Spain sought to achieve the reinsertion of disabled and invalids into day-to-day French life, and between 1949 and 1977 provided regular subsidies to their neediest members, acquiring work for them by means of formulae such as the cooperatives mentioned above, loans and special grants, medical attention (the purchase of prosthetics and orthopaedic devices) and help in administrative tasks, such as the preparation of official and private documents⁵⁹.

57 Francisco Guerra, *La medicina en el exilio republicano* (Alcalá de Henares, 2003), pp. 203–208.

58 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976); Antonio Trabal, *Breve historial de la Liga de Mutilados e Inválidos de la Guerra de España* (Barcelona, 1986); Archive of the Civil War of Salamanca, Liga de Mutilados, Inválidos y viudas de la Guerra de España en Francia

59 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976); Antonio Trabal, *Breve historial de la Liga de Mutilados e Inválidos de la Guerra de España* (Barcelona, 1986); Archive of the Civil War of Salamanca, Liga de Mutilados, Inváli-

Both the Spanish Socialist Party (PSOE) and its trade union (UGT) came to the aid of the Republican war-disabled and invalids through their participation in the co-operative societies, and through the creation of the charitable institution 'Solidaridad Democrática Española'. From this organisation they tried by all legal means possible to ensure supplies of material and health assistance, and to give protection and legal advice to all Spanish citizens living in France, and to those still living in Spain.

Unsuccessful attempts were made right from the end of the Civil War until 1975 to rectify the situation of inequality which obtained between the rights and treatment granted to war disabled from the Nationalist zone and those from the Republican zone. In fact, conversations held between the League of the Wounded and Disabled and the Director-General of the Corps of Gentlemen Disabled in the Patriotic War broke down in 1939. A similar fate befell the demands made by the League from 1967 onwards to achieve "complete physical and moral rehabilitation for the disabled of the Republican Army", and the corresponding pensions⁶⁰.

It was not until 1975 that the first necessary legislative steps were taken to deal with the demands put forward by the Republican disabled and invalids. The first legislation came in 1976⁶¹ and in the early eighties⁶², but the situation was not finally settled until 1986⁶³. This implied, among other things, the concession of almost 50.000 pensions at a cost of almost 3,345 million euros between 1977 and 2005 inclusive.

Final Comments

Throughout these pages we have been able to see how the unfolding of the First World War gave rise to a vulnerable population: the disabled and invalids of that war. As the nations taking part in the strife faced up to this problem, there came

dos y viudas de la Guerra de España en Francia; Archive of the Civil War of Salamanca, Liga de Mutilados e Inválidos de la Guerra de España en Madrid

60 Antonio Bravo and Antonio Tellado, *Los mutilados del ejército de la República* (Madrid, 1976).

61 Decree 670/1976, of 5 March, by which pensions were granted to Spaniards who, having been wounded in the last War, were unable to become members of the Corps of Gentlemen Disabled in the Patriotic War; Royal Decree- Law 43/1978, of 21 December directed to war veterans irrespective of whether they belonged to one side or the other of the conflict.

62 Law 35/1980, of 26 June, concerning pensions to disabled veterans of the Republican Zone; Royal Decree 31/1982, of 12 February, integrating disabled veterans of the Republican zone into the Social Security system for purposes of medical attention and social services; Law 6/1982, of 29 March, concerning pensions to civilian war disabled.

63 Laws such as 37/1984, popularly known as the law "of Republican soldiers", or Law 18/1984.

about a general climate of opinion favourable to the functional and professional rehabilitation of the disabled in order to encourage their later reintegration into society. The medical community of each country played an important part, with the prevalence of the medical or individual model of disability.

This culture of professional rehabilitation of disabled and invalids also spread to Spain, where medical doctors applied it to the disabled from the War of Morocco and, above all, to the victims of workplace accidents. The Spanish Civil War produced another vulnerable population, to whom measures of functional and professional rehabilitation would be applied. Both sides took measures calling on the background and experience previously obtained in the field of professional rehabilitation. Of course, the characteristics of the war dictated certain differences in the availability of resources and the procedures applied on each of the two sides during the war: nevertheless, the real inequalities came about at the end of the hostilities. The disabled and invalids of the Nationalist zone received moral recognition, and benefited from a functional and professional re-education programme (albeit very limited), preferential access to jobs in public buildings and in the Spanish Administration, as well as a system of pensions. Those from the Republican zone, however, were excluded from this programme and the majority of them, as exiles, had to fight for almost 50 years to survive and to achieve parity with those of the other side. During this time the exiles in France depended on the work of the “League of the Wounded and Disabled of the War in Spain”, and aid provided by the French government, by international organisms such as the Spanish Republican Red Cross, by left wing political parties and trade unions and by artists such as Pablo Picasso and Pau Casals.

The case I have analysed here allows us to underline the important role played by cultural, economic, social and, most particularly, political factors in the construction of vulnerabilities and inequalities. We must take historical experience into account to apply it to our present-day life.

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