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Preface

Sam Willner

This volume of Hygiea Internationalis deals with legislative and institutional aspects of health and social welfare, as well as "real life" experiences of socioeconomic and health deprivation in different geographical contexts from the 14th to the 20th century. We look upon public health from a holistic perspective, also considering conditions of social and economic well-being.

Most articles are based on presentations made at different PhoenixTN-conferences (European Thematic Network on Health and Social Welfare Policy) during the last years.

Beginning with legislative aspects of health and social welfare, Anne Løkke presents the long-term trends in Danish health policy, starting with the first medical law of 1672 and ending in 1973, when the state took over the full responsibility of health insurance for every citizen. This policy, as an example of the Scandinavian welfare-state regime, could be characterised by the principles of *universalism* and *decommodification*, meaning that the whole population receives health services from the state, and that the services are not regulated by the market as commodities. According to Løkke, the roots of these principles can be traced back to experiences from nearly 200 years of absolutist, patriarchal biopolitics, including poor laws, publicly-paid midwives and district surgeons, *etc*. Fritz Dross discusses and critiques the German model of the welfare state, introduced in the late 19th century and based on compulsory health insurance, focusing on central legislation and the emergence of health and social welfare policy in pre-Bismarckian Prussia in the 19th century. Finally, Laurinda Abreu discusses the legislation against beggary and vagrancy in general and specifically the relevance of the legislation for the Romany population in Portugal during the 14th to 18th centuries. The laws conceptualized the "deserving poor", keeping other groups away from the institutionalized poor relief and health care, given by the hospitals.

Institutional aspects of health and social care are presented by Mariama Kaba, Petr Svobodny and Ronit Endevelt. Mariama Kaba´s paper deals with the institutional care of physically disabled people in 19th century Switzerland. The structure of medical and/or social care being a part of a process of integration or exclusion, according to whether the disabled person's state of health was likely to improve or not. Petr Svobodny presents the history of the Italian Hospital in

Prague from the late 16th to the late 18th century, with respect to the social care and health care of children. It developed from the provision of a refuge for the most helpless members of society (abandoned newborns and orphans) in the private houses of individual members of a lay religious congregation into professional social-health institutions (foundling and maternity hospitals) controlled by the authorities of the state and the Medical Faculty in Prague. Ronit Endevelt reviews the history of school lunch programs in Israel, from their creation in early 20th century Palestine to their abolishment in the early 1970s and the re-introduction on a trial basis in the early 21st century, justified by nutritional and educational goals.

Finally Victoria Nygren presents a study regarding health and wealth among socioeconomically depressed migrant men and their households in the town of Linköping in early 19th century Sweden, particularly discussing the role of material conditions and social integration.

A new, hopefully recurrent, section introduced in this issue is "New books", giving short reviews of books with relevance to the history of public health.

The next issue, dealing with cultural aspects of public health in a historical perspective will be released relatively soon, during summer 2007.

State and Insurance
The Long-Term Trends in Danish Health Policy from 1672 to 1973

Anne Løkke

Introduction

Although health policy is only one part of welfare policy, it is a very distinguishing component of the Danish welfare system, with its massive state involvement: the state provides tax-financed, free medical care, free treatment in hospitals and sickness benefits for all permanent residents. Nearly all hospitals in Denmark are owned and run by the public, leaving only a minimal market for private hospitals and other forms of private medical care paid for by individual patients. In short, Danish health policy is characterised, as Esping-Andersen has described the Scandinavian welfare-state regime as a whole, by *universalism* and *decommodification*[1]: the whole population receives services from the state, and the health services are not regulated by the market as commodities.

From abroad, this system is looked upon with dread or admiration, depending on political conviction, but also with wonder. How did it come into being and why do most Danes support it? And why is it not misused to a more serious degree?

What is not common knowledge is that this health system, which is seen by many, especially Americans, as "passive reliance on the state", was developed through enormous, voluntary civic engagement by non-profit health insurance societies (*sygekasser*). These associations were formed in the mid-nineteenth century and, starting in 1892, membership was encouraged by the state through substantial subsidies to those that accepted the advice, authorisation and auditing by the state. This policy succeeded, insuring an ever-increasing proportion of the population, such that by the mid-twentieth century almost the whole population was covered.

1 Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Oxford: Polity Press, 1990).

It was not until the 1970s that the public took over the responsibilities of these civic health insurance societies.

In this paper, I am going to argue that the Danish health policy of today can not be understood separately from its history. The principles of universalism and decommodification have both developed through the civic health insurance societies. But the roots go farther back to experiences from nearly 200 years of absolutist, patriarchal biopolitics, including poor laws, educated, authorised and publicly-paid midwives, publicly-paid district surgeons *etc*. This system was continued unchanged, even after Denmark became a democracy in 1849. The absolutist poor laws and medical laws remained a frame of reference for all new welfare organisations well into the modern Danish welfare state of the 1960s. They defined a minimum threshold of medical and social security basically accepted by all classes in the society.

In an international context, the most interesting questions are, however, why this system was not dismantled by liberalism in the nineteenth century, like the Elizabethan poor laws in England or the civic health insurance societies of the US[2], and how this continuity has influenced the health of the Danish population and the economic growth of the society. Thus, this article will discuss the long-term trends in Danish health policy, with the greatest focus on the second half of the nineteenth century, presenting the preceding developments as context.

Absolutist Health Policy

From 1660 to 1849, the Danish monarchy was an absolutist monarchy, a monarchy busily engaged in the competition between the emerging European states. This prompted huge biopolitical initiatives including medical laws, poor laws and school laws. The King's aim with the initiatives was surely to develop a great and healthy population able to provide taxes and soldiers. The aim was also to serve God by fulfilling the Royal duties of a good patriarchal master for the national household. Luckily for the Kings, the two aims were perfectly compatible, as care for the fatherless, poor and sick both pleased God and stimulated population growth. Just as learning to read and write did provide people with an instrument to improve their own economic situation, even though the purpose of education also was to prepare for the salvation of the soul.

The first medical law, of 1672, outlined the principles of an official health system for Denmark, which proved to be durable, lasting for more than 200 years. The law

2 Simon Szreter, Health, Economy, State and Society in Modern Britain: The Long-Run Perspective, *Hygiea Internationalis* vol 4:1 (2004), pp. 205–227. David Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services*, 1890–1967, North Carolina. 2000.

established a hierarchy with medical doctors on top, including barber surgeons, and authorised pharmacists and midwives as part of an official health care system.[3] Although the 1672 law was visionary, economic realism guided the pace of its implementation. During the eighteenth century, public medical expenses were kept under control, but the innovations of this century included the establishment of a group of partly state-paid district surgeons, a Royal Lying-in Hospital (free of charge for poor unmarried women), a school for midwives, a medical hospital with free treatment for the able-bodied working poor and academy training for surgeons.[4]

In the early nineteenth century, however, the health investments became massive. In 1803, the Royal Board of Health (*Det kongelige Sundhedscollegium*) was established as the supreme authority in public health administration.[5] The number of district surgeons was enlarged. They were not only to be doctors of the poor, but were to be distributed all over the country to provide the whole population with access to a doctor and provide the state administration with yearly reports of health issues and warnings in case of epidemics. Their basic salaries were tax financed; they earned the rest as practitioners.

In 1810, a detailed regulation on midwifery was introduced with the purpose of reducing mortality among infants and mothers by ensuring that best practice in birth attendance was applied to all births, whether the mother was rich or poor.[6] Every parish was required to appoint a district midwife who had been educated at the Royal School for Midwives and pay her a fixed, basic salary. In addition, her patients paid for each birth according to their income. The community paid for the poor.[7] The district midwife was obliged to present herself unhesitatingly to every parturient woman who requested her help, and she was forbidden to leave a woman once labour had begun. It was explicitly mentioned that a midwife would be fined

3 Forordning om Medicis og Apotekere. 4 Dec. 1672. Cited from C. P. N. Petersen, *Medicinallovgivning,* vol. 1, (København, 1833).

4 For a more detailed presentation of the Danish medical system in the eighteenth and nineteenth century, see Anne Løkke, "the 'antiseptic' Transformation of Danish Midwives, 1860–1920", in Hilary Marland and Anne Marie Rafferty (eds.), *Midwives, Society and Childbirth. Debates and Controversies in the modern Period (*Routledge: london, 1997) pp. 103–112.

5 'Royal Ordinance of 13 May 1803', Cited from C. P. N. Petersen, *Medicinallovgivning,* vol. 1, (København, 1833).

6 'Regulation of 21 Nov. 1810', Petersen, *Medicinallovgivning,* vol. 2:1 (1834). For a more specific analysis of this aspect, see Anne Løkke, "The 'antiseptic' Transformation of Danish Midwives, 1860–1920", in Hilary Marland and Anne Marie Rafferty eds., *Midwives, Society and Childbirth. Debates and controversies in the modern period* (Routledge: London, 1997) pp. 102–133.

7 Anne Løkke, "Did Midwives matter 1787–1845". *Pathways of the Past, Essays in Honour of Sølvi Sogner*, (University of Oslo, 2002), pp. 59–72.

severely if she left a poor patient to attend to a better off patient, because of the higher payment.[8]

The implementation of the law was remarkably quick. By around 1840, the public had completely adopted the system; every parish had an authorised, educated, relatively well-paid midwife and competition from unauthorised midwives had almost disappeared.[9] This was the birth attendance system Irvine Loudon has shown was among the most effective in the world until the 1940s, measured by its ability to keep mortality at a very low level for both mothers and infants.[10]

All the medical laws characteristically blurred the borders between the state and the private in several ways. The state provided the education, examination, authorisation, office structure and basic salary for doctors and midwives. In return they were expected to deliver services of the same high quality to all the King's subjects but only the very poor were to be served for free. The doctors and midwives were expected to charge their patients according to income, and in that way earn for themselves a decent living. Thereby the private interest of the doctor/midwife in a thriving practice and the interest of the state in an effective medical system were connected and the population grew used to the doctor or midwife being the same for all classes – doing their best in every case – and thereby separating quality from ability to pay.

Private practice outside the office structure of district medical officer/midwife was not prohibited, neither for doctors nor for midwives. On the contrary, it was encouraged, but outside Copenhagen, very few were able to make a living before 1850 as private practitioners without the basic wage for being district medical officers and midwives.

Absolutist Poor Policy and School Policy

Another huge investment of importance to health was the poor law from 1803. There had been ambitious poor laws in Denmark before, but they had depended on voluntary contributions and therefore very often faced shortages of means. The 1803 poor law secured the financial aspect by a principle mandating that local poor

8 Instructions of unknown date, but published in 1797. Continued in an almost identical 'Instruction of 3 May 1836'. F. A. Uldall, *Haandbog i den gjeldende civile Medicina-Lovgivning*, (Copenhagen, 1835), p. 43.

9 Det kongelige Sundhedscollegiums Forhandlinger for Aaret 1852, p. 258. J. Lehmann etc. eds. Hygiene and Demography, Denmark its medical Organization, presented to the seventh international congress of hygiene and demography London 1891, (Gjellerup, Copenhagen, 1891), p. 49.

10 Irvine Loudon, *Death in Childbirth* (Clarendon, Oxford, 1992).

councils had the right and duty to support the local poor through local taxation, linking local democracy to tax-paying and social responsibility.

The Danish poor law did not distinguish itself in other ways from European poor laws: it was designed to be deterrent and scant, so nobody would be tempted to ask for it out of laziness. But it was to provide everyone in need with the bare necessities of life and medical treatment if sick, so that no subjects of the King would die from hunger, cold or treatable illness. Moreover, this law was soon accepted by the population as a lower limit for hardship, although the better off complained about the expenses and the poor dreaded the humiliation connected with receiving support.

The absolutist school policy must be mentioned as well, because the school laws of 1814 ensured that the majority of the population became literate before 1850, and thereby indirectly was a precondition for the later civic and deliberate organisation of health insurance. Quite a few of the common people had learned to read already in the seventeenth century, and the eighteenth century saw the establishment of numerous different schools, including many for children of peasants, artisans and workers.[11] The 1814 school law, however, made it mandatory for children from seven to thirteen years of age to seek basal education in a school or in another way learn a specified minimum of religious knowledge, reading, writing, arithmetic, history and geography. The choice of school or teacher was the parents', but the local authorities were obliged to provide tax-financed schools, free of charge for every child whose parents did not prefer to or were not able to pay for schooling.[12]

The Health Legislation and the Young Democracy

When Denmark became a democracy in 1849, the medical laws, the poor law and the school laws had grown so familiar and legitimate that they were maintained almost unchanged. They constituted a known frame of reference defining a minimum threshold of medical, educational and economic security accepted by all classes in society. Additionally, the corps of civil servants of the state was kept by the new rule. Clergymen, jurists and doctors continued the biopolitic bureaucratic procedures of absolutism meant to preserve the life and health of individual subjects as a precondition for the prospering of the King and the country. Nobody thought of dismantling the tax-financed part of the support for educational and health personnel.

That does not mean, however, that there were no problems, discussions or political conflicts. On the contrary, the first 40 years of democracy was a period

11 Charlotte Appel, Læsning og bogmarked i 1600-tallets Danmark (Copenhagen, 2001).
12 Joakim Larsen, *Skolelovene af 1814* (Copenhagen, 1914).

with very fierce political discussions about these matters. However, removing or reducing the level of medical and economic security was not considered. What was discussed, however, was how the basic security could be conserved or even improved, without inviting misuse, laziness or resignation, without expenses growing wildly and without hampering economic growth.[13]

The fathers of the new constitution not only accepted the poor law, but included it as an inalienable right to be provided for by the public if one was unable to do so oneself. But at the same time loss of the franchise was added to the stigmatising consequences of receiving poor relief. And many parishes started to build workhouses, where poor relief receivers were forced to live as a precondition for help. Both procedures were meant to deter people who were not in the most desperate need from asking for poor relief. But nevertheless, the new democracy accepted the responsibility of taking care of the very poor in an economic situation in which most of the working population could only afford a very simple living and often less than that.[14]

The 1850s and 1860s were dominated by national-liberal politicians, the majority of whom trusted liberalism as the road to economic growth. However, what they understood as liberalism was not wild capitalism, but the removal of old privileges and monopolies that prevented competition in trade and production. When a freedom of trade law was passed in 1857, which dissolved the guild system, it was broadly believed that the economic growth that was expected as a result automatically would solve the problems of poverty for the working class. The obstacles preventing the workers from engaging in voluntary, independent self-help organisations to provide health insurance and old age pensions would be removed as well. In reality, a lot of organising of this kind took place.[15] Numerous private citizens engaged in local attempts to build workers' self-help organisations and many workers engaged in them too, but very few associations were able to deliver real, social security to the members in cases of sickness and old age.

The 1870s saw a shift in the agenda: the socialist labour movement, which was germinating in Copenhagen, claimed revolution to be the only solution to the misery of the workers. The strength of the movement, apparent from its ability to organise strikes, scared authorities and middle class citizens alike. This stimulated a sudden joint interest from liberals and conservatives to determine whether the workers really lived in unmerited misery, preventing them from organising their own insurance to guard them in cases of sickness and old age. Thus started a politi-

13 Anne Løkke, "Tryghed og risiko. Forsikring 1850–1950", In Ole Feldbæk ed., *Drømme om Tryghed*, Forthcoming (Gads Forlag: Copenhagen, 2007).

14 Jacob Christensen, De fattige 1814–1848 og Socialforvaltningen 1848–1901, in Tim Knudsen, *Dansk Forvaltningshistorie*, I, (Akademisk Forlag: Copenhagen, 2000).

15 Anne Løkke, "Tryghed og risiko. Forsikring 1850–1950", In Ole Feldbæk ed., *Drømme om tryghed*, forthcoming (Gads Forlag: Copenhagen, 2007).

cal and scientific process lasting twenty years, leading to the first social laws in the 1890s, carried through by a conservative government.[16]

The Economic and Health Consequences of the Poor Law in Nineteenth Century Denmark

According to censuses, the percentage of the population living permanently on poor relief was relatively stable at 2–3% in the years 1850–1880.[17] About twice as many got temporary relief every year, which is not reflected in the censuses. Neither did anybody in the past collect central data in other ways about this issue; only the local poor relief authorities knew how much was spent. In Copenhagen in 1878, for example, 4% of the inhabitants of Copenhagen succumbed to temporary poor relief because of sickness and 9% had expenses for medical care or hospitalisation paid for by the poor-law authorities during that year.[18]

The poor relief was given whatever the cause of need, but some groups were more at risk of becoming needy than were others. A study done in connection with the 1880-census revealed that, in the rural districts, children, women and old people made up the majority of the receivers. (Figure 1)

The number of children from birth to 5 years of age was not included in this study. If, however, their number is estimated to be the same as the number of children 5–10 years old, the distribution among the poor relief receivers was approximately: 35% children younger than 15 years of age, 2% young people (15–25 years of age), 21% adults (25– 55 years of age) and 41% elderly (older than 55 years of age). The majority of the adult women receiving poor relief were single mothers or widows with responsibility for children. This study showed that 8% of the elderly male population (older than 65 years of age) received permanent poor relief. Of the elderly female population it was 13%. Among elderly agricultural workers, more than a fourth were poor relief receivers after the age of 55 years.[19] A study of the poor relief receivers during most of the nineteenth century shows the same picture: orphaned children, single mothers, the sick and elderly, who could by no means provide for themselves in other ways and who lacked other social relations

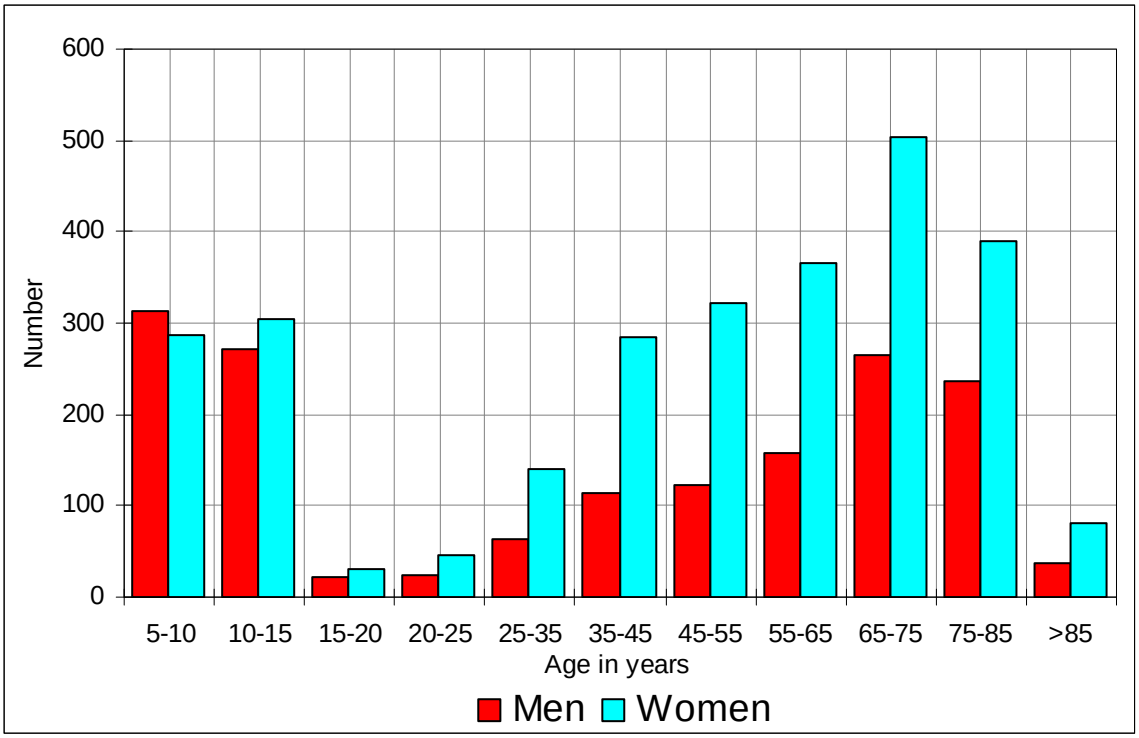
16 An analysis of this process can be found in Anne Løkke, "Creating the social question. Imagining society in statistics and political economy in late nineteenth century Denmark", *Histoire sociale/Social History*. vol. XXXV, no. 70 (2002), pp. 393–422.

17 Calculated from *Statitisk Tabelværk* A, V, Copenhagen 1905, table 39 and 120.

18 Calculated from *Tabelværk til Kjøbenhavns Statistik* Nr. 4, 1879, pp. 85, 129 and 132–133 and *Statistisk Tabelværk* 5 R. Lt. A, Nr. 5, 1905 table 9.

19 Marcus Rubin og Harald Westergaard, *Landbefolkningens Dødelighed i Fyens Stift*, (Copenhagen 1882), pp. 26–27.

Figure 1. Poor relief receivers in agricultural districts. Fyn 1880-census.



able to provide for them, were the ones who got the poor relief.[20] This distribution of the poor relief receivers suggests that the social security provided by the poor law, however scant, was of great importance for the life and health of the most vulnerable. These people would have succumbed to the elements and starvation if left to themselves.

During the nineteenth century, Denmark experienced very rapid population growth: from 1800 to 1900 the growth was 164%. That is among the highest in Europe. The rapid growth continued until the 1920s, when a decline in the growth rate began. In absolute numbers, the population increased from roughly one million in 1801 to two million in 1880 and four in 1940.[21] Infant mortality was amongst the lowest in Europe.[22]

Thus, Malthus may have been right in suspecting that poor laws stimulated population growth. Both the many children provided for and the old people escaping death from starvation must have contributed to this rapid growth. But instead of being a problem, the population growth in Denmark seems to support the argument proposed by Simon Szreter. He suggested that, far from being an obstacle to the industrial revolution and economic growth in Britain, the poor laws

20 Tabelværk til Kjøbenhavns Statistik Nr. 4, (Copenhagen, 1879).
21 *Statistisk Tabelværk* 5 R. Lt. A, Nr. 5 (Copenhagen, 1905).
22 Anne Løkke, *Døden i Barndommen*, (Gyldendal: Copenhagen 1998), p. 120.

were an important precondition for both.[23] In Denmark, the industrialisation took place slower and later than it did in Britain, and was a fairly continuous process. It is therefore not very meaningful to speak about an industrial revolution; no single period experienced a very rapid change of everything. Rather, a series of industrial growth periods took place starting in the late eighteenth century, when the first tiny textile industry was established. Small iron foundries popped up throughout the country from the 1840s and the early 1870s. The 1890s included periods of more rapid industrialization as well.[24] The industrial, manufacturing and construction proportion of the Gross National Product was 20% in the 1870s, 27% in the late 1890s and 39% in 1960.[25]

At the same time, agriculture was a very important sector in the economic growth. Starting in the late eighteenth century, waves of massive capital investments, new technology, new methods of cultivation and changes in products have taken place within agriculture, resulting in increasing productivity and economic growth inside the agricultural sector. This development in agriculture went hand in hand with increasing manufacturing, commerce and investments in the infrastructure. Together the result was considerable economic growth throughout the nineteenth and twentieth centuries.[26] The Gross Domestic Product at Factor Cost rose 2% p.a. (0.9% p.a. per capita) in the period 1822–1894. In the period 1894–1914, the rise increased to 3.5% p.a. (2.2% per capita p.a.).[27] The proportion of the population living in urban areas increased from 20% in 1801 to 38% in 1901, reaching 47% in 1960.[28]

My argument, following Szreter's, is that the Danish case indicates that the poor law and the more generous social laws of the 1890s did not prevent industrialisation and economic growth. On the contrary, it was a precondition for the economic growth that the population growth provided new hands ready for both agriculture and industry whenever the demand for labour increased.

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23 Simon Szreter, Health, Economy, State and Society in Modern Britain: The Long-Run Perspective., *Hygieja Internationalis* vol 4:1 (2004), pp. 205–227.

24 Ole Hyldtoft, *Københavns industrialisering 1840–1914*, (Summary in English), (Systime: Herning, 1884), pp. 418–428.

25 Svend Aage Hansen, *Økonomisk Vækst i Danmark*, vol 2, (Gads Forlag: Copenhagen, 1972), pp 209–220.

26 Svend Aage Hansen, *Økonomisk Vækst i Danmark*, vol 2, (Gads Forlag: Copenhagen, 1972).

27 Svend Aage Hansen, *Økonomisk Vækst i Danmark*, vol 2, (Gads Forlag: Copenhagen, 1972), p. 18.

28 *Statistisk Tabelværk* 5 R. Lt. A, Nr. 5, Copenhagen 1905, pp. 9–16; H. C. Johansen, *Dansk Økonomisk Statistik*, in Søren Mørch etc. (ed.), Danmarks Historie vol. 9 (Copenhagen, 1885), p. 22.

The Social Laws of the 1890s

The social era of Danish welfare policy started in the 1890s. The economic growth made it possible to increase expenses, and the new political strength of the workers' movement prompted a new attentiveness from the government and civil servants to the standard of living of the working population. Among the civil servants, the old perspective of the absolute monarchy trying to promote what was good for society as a whole was still alive. They argued for a policy that would avoid the type of disruptive situation seen in England under the most rapid industrialisation and urbanisation.

An old-age-pension law was passed in 1891, simply meant to exempt the working poor from the stigmatising aspects of poor relief in old age, if they had been able to care for themselves until the age of 60.[29]

The health insurance law of 1892 was more ambitious and built upon a more dynamic and structural understanding of poverty, than did both the poor law and the old-age-pension law. The health insurance law was meant to prevent the rise of poverty by curbing the negative spiral, which so often started with a provider falling ill in families with such small reserves that within a few days the choice was between hunger and poor relief. As even temporary poor help triggered the full stigmata of the poor law, many proud workers waited too long from a health point of view to ask for relief. The health insurance law was thought of as a way to keep up future economic growth by securing the future work capacity of individuals, by providing the best conditions for recovery. The means chosen was to give the honourable worker access to some compensation for lost wages and free medical care without the slightest doubt that it was a paid-for right and not poor relief. Therefore, it was given in the form of insurance with a member's fee. In fact, the organisation as insurance was used to mask a considerable amount of state subsidies.

The Danish health insurance law was designed in deliberate, proud opposition to what was called the *German coercion law*, which ordered mandatory health insurance for workers primarily in industry, partly paid for by the employer.[30] The Danish law was built on voluntary membership of local, self-organised societies. Since the 1860s, there had been an increasing interest in establishing such societies, alongside cattle insurance associations, personal property fire insurance associations, burial clubs and other voluntary, locally organised societies providing economic security on a mutual insurance basis. In 1885 there were 986 medical-aid societies, many of which, however, struggled severely to provide the help the members

29 Lov om alderdomsunderstøttelse til værdige Trængende udenfor Fattigvæsenet, 1891, *Lovtidende*.

30 *Betænkning afgiven af den af Indenrigsministeriet d. 4. Juli 1885 til Overvejelse af Spørgsmaalene om Sygekassernes ordning og om Arbejdernes Sikring imod Følgerne af Ulykkestilfælde under Arbejdet nedsatte Kommission* (Copenhagen, 1885) p. 23.

needed using the fees they were able to pay. The law opted to close that gap. It stated that if a society, which exclusively admitted members who did not earn more than a skilled worker, accepted being advised, authorized and getting its accounts audited by the state, it would receive state subsidies to supplement the members' fees. The society in return would provide a minimum sick benefit per day, free medical care and hospital treatment to the members.

To administrate the aid given to and the control of the societies, a new government office was created. A medically, statistically and politically experienced doctor, Th. Sørensen, was appointed its first chief. The choice of a medical doctor was not simply by chance. As in the US, many Danish doctors were against collective contracts with the health insurance societies. The Danish (conservative) government considered this resistance to be intolerable for the well-being of society as a whole; farmers party saw it as greedy urban arrogance and social democrats found it to be a threat against the health and lives of the workers. Political consensus was the background for choosing Th. Sørensen; he had the capacity to take care of the implementation of the law. In the first years it took all his skills in organising, explaining and negotiating to attract the old societies to the deal, to set up new societies where they were missing and to settle conflicts between doctors and societies. Backed by the authority of the state and the political system, he was able to end the doctors' resistance and propagate their understanding that the higher the percentage of the working population in insurance societies, the more these people would be able to seek medical treatment.[31] Time would show that he was right. The number of doctors increased from 676 in 1871 and 970 in 1890 to 1,918 in 1920 and 3,332 in 1940, corresponding to 1 doctor per 4,055 inhabitants in 1871 to 1 doctor per 1,153 inhabitants in 1940.[32]

The societies were able to keep the administration expenses at a very low level, because the members did the administration themselves as an un-paid, spare-time occupation or as part-time work paid the same wage per hour as the members normally got in their occupations. A precondition for this was that the school laws had given the worker population access to enough skills in writing and arithmetic to manage the accounts and the necessary bureaucracy. In that way, the health insurance societies – as with the hundreds of other self-organised insurance associations in nineteenth and early twentieth century Denmark – invested in the intelligent reserve of workers and farmers in the establishment of economic stability for the whole of the working population.

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31 Anne Løkke, "Tryghed og risiko. Forsikring 1850–1950", In Ole Feldbæk ed., *Drømme om Tryghed*, Forthcoming (Gads Forlag: Copenhagen, 2007).

32 Falbe-Hansen and Scharling, *Danmarks Statistik vol V* (Copenhagen, 1881), pp. 80–82, *Statistiske Undersøgelser* nr. 19 (Copenhagen, 1966) p. 165.

Further, fraud control was carried out inexpensively. As the members were neighbours or fellow workers or both, local informal social control mechanisms were effective concerning fraud control, without extra expenses.

Within a few years, the law succeeded in having a large proportion of the working population covered by health insurance. The target group (the people not earning more than a skilled worker) made up 75–80% of the population. Disabled people and people who for other reasons were unable to earn a living were not admitted. Thus, 62.6% (Table 1) of the population were members in 1930, which was very high coverage for a voluntary health insurance.

Table 1: Members of health insurance societies per 100 inhabitants more than 14 years of age, Denmark 1901–1950.

		1901	**1911**	**1921**	**1930**	**1940**	**1950**
Entitled to state subsidy	Men	-	38.1	61.5	61.5	73.6	73.4
	Women	-	37.5	63.6	63.6	75.9	76.5
	Total	20.0	37.8	57.4	62.6	74.8	75.0
Not entitled to state subsidy	Stand-by members		-	-	-	9.7	8.3
	Private health insured		-	-	-	-	9.9
Total health insured		-	-	-	-	-	93.2

Source: *Statistisk Aarbog* 1902, 1912, 1922, 1932, 1942 and 1952. Statistiske Undersøgelser nr. 19 (1966), pp. 26–27.

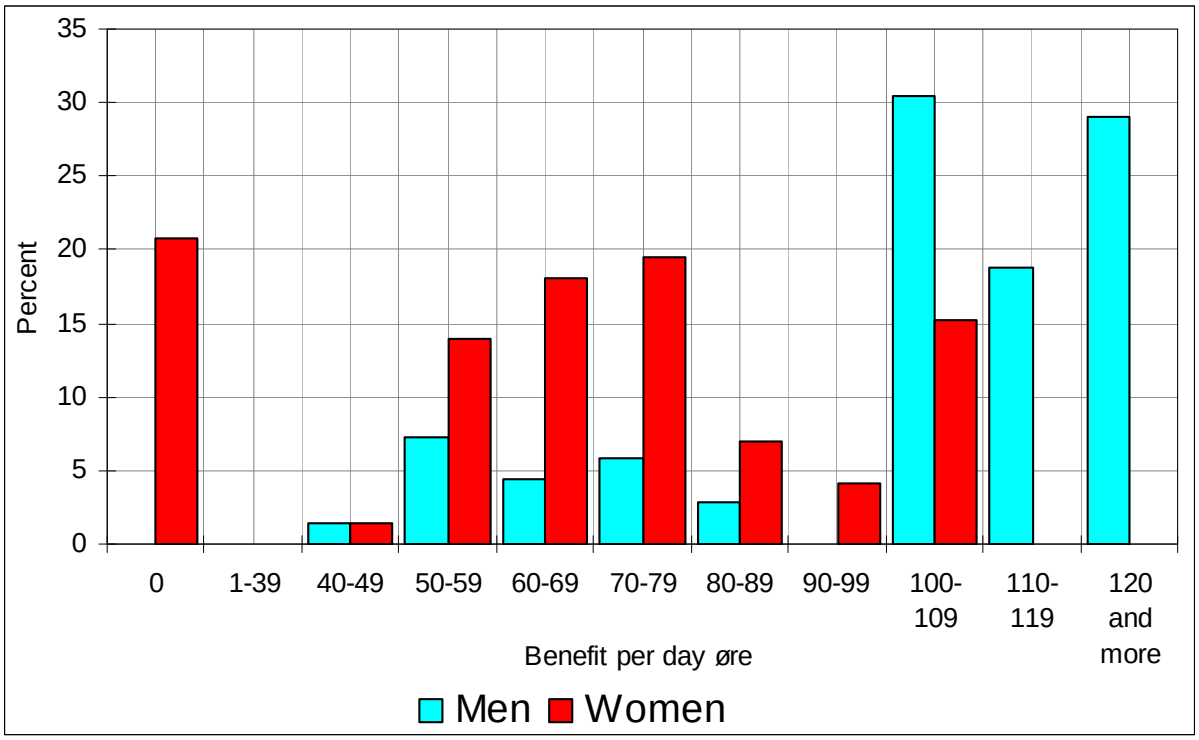
In 1933 the system was reformed; membership in a health insurance society became mandatory for every non-disabled citizen more than 21 years of age, regardless of income, but still the wealthier people did not receive state subsidy. They could choose to fulfil the insurance requirement with a very inexpensive Stand By membership by waiving the right to immediate coverage. The point was that a Stand By membership could easily be turned into an active membership after a deferred period. This prevented total social de route for middle class people facing unexpected hardship. Or they could choose membership in a health insurance society only taking members from among wealthier people. Commercial private health insurance had been offered during these years by different insurance companies, but they all gave up, as they tended to attract only customers who tried to avoid the close social control in the societies.[33]

33 J. Langkilde Larsen ed., *Håndbog i forsikring* vol 1, Copenhagen, pp. 388–389.

Individual Membership for Women

The most important reason for the high level of coverage in Denmark was that women were treated as individuals entitled to their own membership and the societies were free to design their insurance products so they suited various member groups including women and rural labourers (Figures 2, 3 and 4). The working poor, especially from the countryside, were attracted to societies providing the minimum coverage for a low fee. The male skilled workers in Copenhagen made themselves more covering, but also more expensive insurances. But the law prescribed that the difference was only in the size of the pay received per day under sick-leave. All societies had to pay for doctors, midwives, hospital stays and in some cases medicine.

Figure 2. Sickness benefit Copenhagen 1898. Health insurance associations with this per diem sickness benefit in percent of the total number of health insurance associations in Copenhagen.



Individual membership instead of family membership was a last minute decision before the law was passed, following the pattern of the existing Social Democratic health insurance societies. The commission preparing the law, as a matter of course, had proposed that a husband's membership should include his wife. The final law decreed instead that the societies should offer women individual membership at a discount price if they would only be receiving medical attendance and medicine and not a *per diem* sick benefit. Women were in no way denied the more expensive memberships with *per diem* benefits included, but many chose the cheapest

Figure 3. Sickness benefit per day from health insurance societies for men 1898. Health insurance associations with this *per diem* sickness benefit in percent of the total number of health insurance associations in this geographical setting.

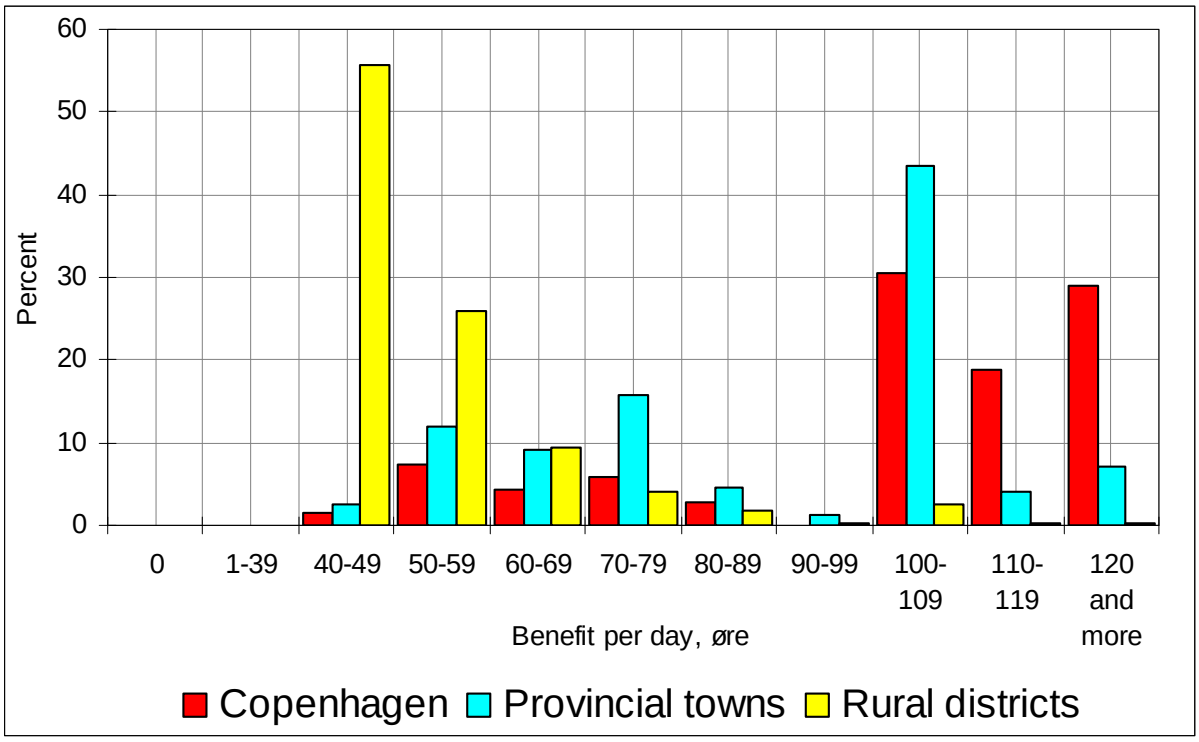
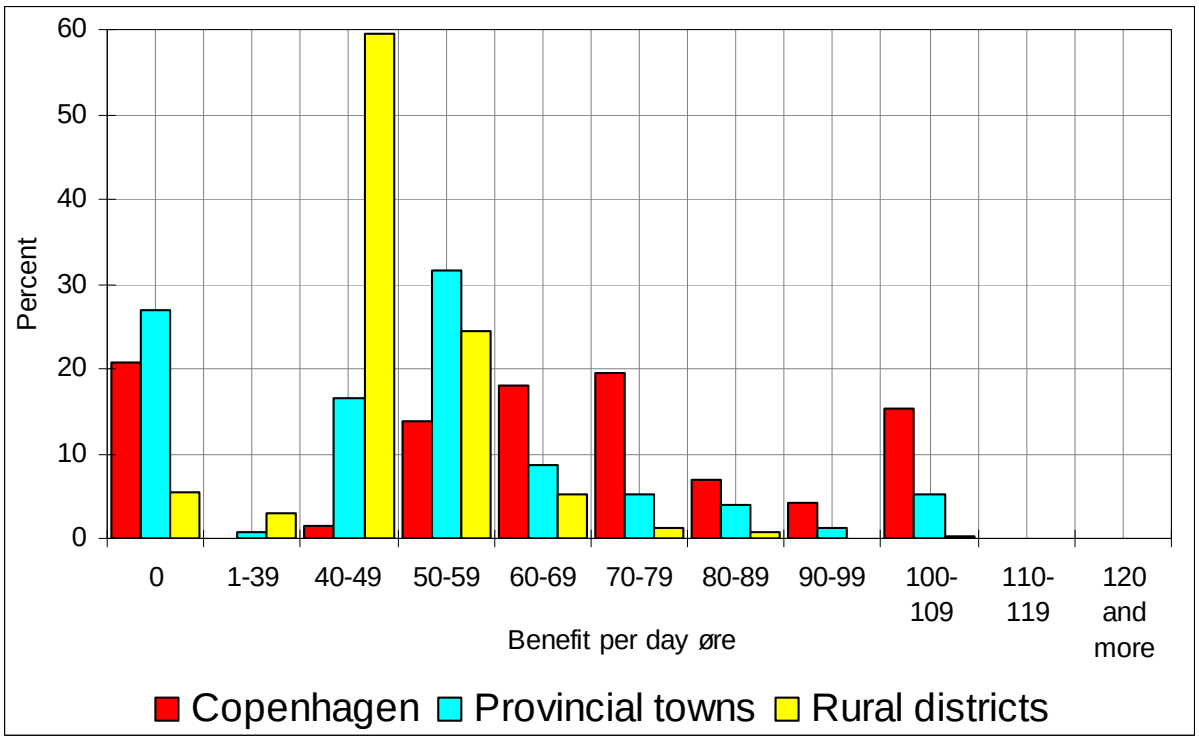


Figure 4. Sickness benefit per day from health insurance societies for women 1898. Health insurance associations with this *per diem* sickness benefit in percent of the total number of health insurance associations in this geographical setting.



solution. Of course this was reflecting as well the power hierarchies in the families, the often non-registered status of the occupation of married women and the huge gap in pay between the sexes. Generally, women earned approximately 40% of the pay men earned, making a full membership in a health insurance society unattainable. Although the law reflected the inequality of women, it nevertheless provided them with the possibility of having their own membership not dependent on their husbands' workplace, as in Germany, or on their marital status as first proposed in Denmark, which was a useful position in the long run.

Children were automatically covered both by the fathers' and the mothers' memberships.

The Small Step to Tax-Financed State Insurance

In 1973, the system with independent, state-subsidised health insurance societies was abandoned and their engagements taken over directly by the state. Every inhabitant in Denmark was now automatically health insured, financed by taxes and administrated by the public county and local administration. It was not a Social Democratic government that carried this reform out. On the contrary, it was a coalition government consisting of the three most rightist parties (the liberals, the conservatives and the radical liberals) – with a liberal Minister of Social Affairs. It was passed, however, in parliament with nearly complete consensus. Nobody voted against it – only 10 members (out of 179) abstained from voting.[34]

My argument is that the unanimous passing of a law that made it a responsibility of the state to provide every citizen from cradle to grave with high quality medical aid and economic security in case of sickness was possible only because it was experienced as a relatively small step, logically following the health policy maintained by changing democratic governments and the absolutist monarchy for several hundred years.

Discussion and Conclusions

When following the long-term trends in Danish health policy, the path dependency becomes very obvious. The decommodification and the universalism, so characteristic of Scandinavian Social Democratic welfare regimes, was not invented overnight and was not carried through by social democrats in fierce opposition to liberal and conservative parties. On the contrary, the laws taking the most decisive steps

34 H. C. Hansen, *Historien om Sygekasserne*, (Schølins bogtrykkeri: Aalborg ,1974), pp. 238–241.

towards these principles were all passed by conservative or liberal governments or by the absolutist King. Every crossroad offered several possibilities for solutions to the actual health policy problems, but no government dared to choose the road that provided a less efficient health policy for the population than the existing one. The barrier, among others things, being that there were civil servants, whose professional responsibility was to improve the long-term health of the whole population. The fierce body of tax-funded civil servants – clergymen, judges, doctors *et cetera* – were trained to take care of society as a whole, and did in fact make a fair match for the private interests of professional groups, like doctors, and business interests, like insurance companies.

Chance timing was also of importance here. There was a close connection between the central perspective of the absolute King and the central perspective of the social democrats once they settled on reform instead of revolution. The very few years that passed from the abolishment of the absolutist monarchy in 1848 to the emergence of the social democrats in the 1870s implies that the paternalistic sense of responsibility from the time of absolutism was alive among the conservative civil servants until the new ideology of social responsibility emerged among the social democrats.

The decommodification of medical aid reaches back to the laws of district surgeons and midwives from the years around 1800, which saw it as a goal to provide the whole population with the same high quality attendance for the price everyone was able to pay. In the case of birth attendance, this was implemented successfully as early as the 1840s. As regards service from doctors and hospitals, the health insurance act of 1892 meant that nobody should be inhibited from the medical treatment recommended at the time due to economic reasons. Although it can be argued with consistency that the wealthier still had (and have) the economical, social and cultural capital to obtain better than average treatment, it was (and is) very much against the national self-perception to declare that inequality in the access to medical aid is a natural consequence of economic inequality. The population has grown too used to the patriarchal biopolicy trying to distribute best practice to everyone to support any political party that would want to cancel that.

The universalism component of the Scandinavian welfare regime concerning health policy has taken a more meandering path, as it began as voluntary insurance. What distinguished it from the start in comparison with the liberal welfare state-regimes was that the population could be assigned to one of three categories, instead of two, in relation to state subsidies for medical treatment and sickness benefit: 1) The destitute receiving dishonourable poor relief, 2) the honourable working population, who entered a state subsidised health insurance society and 3) the well off, who could pay for themselves or enter a non-subsidised insurance society. The important thing was that the social laws distinguished the honourable workers from both the paupers and the well-to-do. In the early twentieth century,

75–80% of the population, according to these categories, belonged to the honourable workers entitled to be members of the subsidised health insurance societies, 20–23% were better off. A very small percentage, which decreased with every new social law, were paupers obliged to poor relief. The 1933 act included everyone in the same system, although the wealthier still paid for themselves. The step towards universalism thereby was only minor compared to states in which public medical aid and sick benefits still are handled as a kind of poor relief.

The history of the Danish welfare state can be explained with economic growth as an independent precondition. The absolutist Kings as well as the democratic fathers of the social laws of the 1890s, however, were very aware of the damage done by poor social security in cases of illness: the undesirable effects on the national economy of letting citizens become destitute was by no means hidden for them and historical analysis shows that organisations providing economic security and better medical treatment served more as accelerators of economic growth than as hindrances in the Danish case.

Of course there are weaknesses as well as strengths in the Danish tax-paid health system of today, as is the case with all health systems. One problem is how to tackle the freedom of individuals who choose health-threatening lifestyles when everybody else has to pay their medical bill through their taxes. Another problem is how to develop and distribute different high quality treatments meeting the needs of different people, when health services are not commodities in a market. An important strength is that over treatment of the rich and under treatment of the poor is not a problem.

Overall, however, the most important strength is that the very existence of more than one organisation of health systems provides the world with the opportunity to compare. Combined with reliable health statistics exposing the results of different systems, it provides an opportunity to learn from each other and thereby improving the performance in the different systems.

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The research for this paper is derived from a project I am engaged in, entitled "Safety and risk – the principle of insurance in Denmark". A book (in Danish) is under publication, expected spring 2007. The book examines all types of economic security organisation and risk management for individuals, where the principle of insurance has been used – whether it has been organised by the state, by associa-

tions or by companies. A previous version of this paper was presented at the PHOENIX network meeting at Catania 2005, and printed in a volume following the meeting. I want to thank the participants for comments and discussions. The English writing in this paper was corrected by Deborah Licht.

The Price of Unification
The Emergence of Health & Welfare Policy in Pre-Bismarckian Prussia

Fritz Dross

Introduction

Still the German model of a "welfare state" based on compulsory health insurance is seen as a main achievement in a wider European framework of health and welfare policies in the late 19th century. In fact, health insurance made medical help affordable for a steadily growing part of population as well as compulsory social insurance became the general model of welfare policy in 20th century Germany. Without doubt, the implementation of the three parts of social insurance as 1) health insurance in 1883; 2) accident insurance in 1884; and 3) invalidity and retirement insurance in 1889 could stand for a turning point not only in German but also in European history of health and welfare policies after the thesis of a German "Sonderweg" has been more and more abandoned.[1] On the other hand, recent discussion seems to indicate that this model of welfare policy has overexerted its capacity.[2] Economically it is based on insurance companies with compulsory membership. With the beginning of 2004 the unemployment insurance in Germany has drastically shortened its benefits and was substituted by social

1 Young-sun Hong, "Neither singular nor alternative: narratives of modernity and welfare in Germany, 1870–1945", *Social History* 30 (2005), pp. 133–153.

2 To quote just one actual statement: "Is it cynically to ask why the better chances of living of the well-off should not express themselves in higher chances of survival? If our society gets along with (social and economical) inequality it should accept (medical) inequality." H.-O. Wiesemann, "Editorial", in *Zeitschrift für Versicherungsmedizin* 57 (2005), p. 62 (translation by FD). For the broader discussion (in Germany) see e.g.: *Aus Politik und Zeitgeschichte* 8–9 (2006); *Aus Politik und Zeitgeschichte* 29–30 (2002); *Das Soziale neu denken. Für eine langfristig angelegte Reformpolitik*. Die deutschen Bischöfe. Kommission für gesellschaftliche und soziale Fragen. Bd. 28, 12. Dezember 2003.

welfare in wide areas of its former competence.[3] The actual discussions both on health and retirement insurance point to the same direction of redefining the border between social risks to be coped with by the individual on its own and those burdened by the general public in a strictly organised and mandatory manner. Thus, it might be helpful to take a look back to understand how these borders had developed in the process of an emerging Prussian "welfare state" in the course of the 19th century.[4]

In order to give a concise, but narrow, overview, the following paper is going to concentrate on the Prussian development as mirrored by Prussian legislation.[5] Doing so, one has to be aware of two crucial points, which have lead to essential misunderstandings: 1) By no means Prussia should be mistaken for "Germany" – whatever should be named by this term with respect to 19th century historical developments. 2) Even the kingdom of Prussia was far away from a uniform state in terms of territory or legislation, not to mention the socio-economical development, socio-cultural aspects or mentality. In the course of the 19th century Prussia comprised different territories with different state of industrialisation and even different laws while steadily growing by incorporating smaller territories:[6]

As consequences of the Silesian and the Seven Years' War (1740–1763), Prussia gained and consolidated Silesia; it appropriated West Prussia, South Prussia, New East Prussia, Ermland, the Netz district, as well as Danzig and Thorn following the Divisions of Poland (1772–1795). The suspension of the ecclesiastical principalities by the *Reichsdeputationshauptschluss* in 1803 bestowed the kingdom with significant territorial gains in central Germany (the dioceses of Hildesheim, Paderborn, as well as large parts of Münster and parts of Mainz (Thuringia); the imperial abbeys in Essen, Herford, Quedlinburg, Elten, Werden and Cappenberg; the free cities Mühlhausen, Nordhausen and Goslar). Having lost large parts of its territory in the Treaty of Tilsit (1807), Prussia emerged from the Congress of Vienna as one of the biggest winners in the political reorganisation of Europe in the post-Napoleonic era. After gaining the kingdom of Hanover as well as Schleswig-Holstein, Nassau, Hesse-Kassel and Frankfurt (1866–67), the Prussian monarchy comprised approximately two-thirds of the territory and three-fifths of the population of the Second Empire at its founding in 1871. Thus, Prussian unification was not only an

3 Cf. *Aus Politik und Zeitgeschichte* 16 (2005).

4 Cf. Florian Tennstedt, "Sozialwissenschaft – Sozialrecht – Sozialgeschichte. Kooperation und Konvergenz am Beispiel der Sozialpolitik", in G. Schulz et. al., eds., *Sozial- und Wirtschaftsgeschichte. Arbeitsgebiete – Problem – Perspektiven* (Stuttgart, 2004), pp. 551–575.

5 Cf. Fritz Dross, "Health Care Provision and Poor Relief" in *Enlightenment and 19th Century Prussia*, in O. P. Grell, A. Cunningham, R. Jütte, eds., *Health Care and Poor Relief in 18th and 19th Century Northern Europe* (Aldershot 2002), pp. 69–111.

6 Cf. Gerhard Köbler, *Historisches Lexikon der deutschen Länder. Die deutschen Territorien und reichsunmittelbaren Geschlechter vom Mittelalter bis zur Gegenwart*, (5th ed. Munich, 1995), pp. 477–480.

important prerequisite but set the pace for German unification until the foundation of the (Prussian-) German Empire in 1871.

From this perspective the following paper is going to analyse central legislation with respect to health and social welfare policy. Of course, this method is incapable to show the (historical) social reality of poverty and disease. But legislation could be seen as a central – if not the most important – mean of the politics of unification in 19th century Prussia, which had to counter the differing local and regional situations with a uniform reaction of the state. At the same time it becomes possible to take a look at legislation dedicated to several spheres of unification policy but carrying out diverse consequences in the field of unifying health and welfare conditions for the whole Prussian population.[7]

The role of health and welfare regulations in Prussian state-building

In Prussia poor relief became a general responsibility of the state in the framework of the General Prussian Code (*Allgemeines Landrecht*) of 1794.[8] In effect, the responsibilities of local communities, especially the municipalities, were laid down by the state. Central government did not in any way commit itself to the extension of benefits, but only provided the legal parameters of poor relief carried out by local communities. The communities, for their part, were explicitly not obliged to give welfare provision vis-à-vis the poor, but rather vis-à-vis the state. The *Allgemeines Landrecht* fundamentally followed a principle of poor relief by which the community of origin, usually the place of birth, determined the relief agency. To enable labour migration obviously demanded to reach a state of unification of poor relief provision and administration beyond that, which was one of the major aims in Prussian welfare policy for over three quarts of the 19th century.

Communalisation of the welfare system meant to locate the problem in the cities and communities. These were required by the Prussian state to solve the social problem arising from poverty. The Municipal Code (*Städteordnung*) of 1808[9]

7 The Sources are edited in a substantial and exemplary publication series: *Quellensammlung zur Geschichte der deutschen Sozialpolitik: 1867 bis 1914.* Im Auftrag der Historischen Kommission der Akademie der Wissenschaften und der Literatur, Mainz, begründet von Peter Rassow. Karl Erich Born et al. (eds.), Wiesbaden (Stuttgart, Darmstadt) 1966 et sqq.

8 *Allgemeines Landrecht für die Preußischen Staaten von 1794. Textausgabe*. Mit einer Einführung von Hans Hattenhauer und einer Bibliographie von Günther Bernert (Frankfurt/M., Berlin, 1970); Reinhart Koselleck, *Preußen zwischen Reform und Revolution.* Allgemeines Landrecht, Verwaltung und soziale Bewegung von 1791 bis 1848. (2. ed. Stuttgart, 1975), pp. 23–149.

9 *Ordnung für sämmtliche Städte der Preußischen Monarchie mit dazu gehöriger Instruktion, Behuf der Geschäftsführung der Stadtverordneten bei ihren ordnungsgemäßen*

compelled the municipalities to establish communal authorities on a uniform, corporate legal basis, while the state withdrew completely from the welfare system. The principles of late-absolutist administrative poor relief did, in fact, fundamentally contradict the new early industrial social order, just as the liberal economic policy contradicted the conservative domestic and welfare policy. Freedom of movement and contractual freedom as a foundation of commercial freedom were irreconcilable with the principle only to admit those to poor relief benefits, who were born at the place where they fell ill and got needy.

On 31st December of 1842, the law on the incorporation of newly arrived individuals theoretically superseded the "home principle of poor relief" (*Heimatprinzip*) in Prussia,[10] which had been an object of discussion already since 1824. It introduced more or less unlimited freedom of movement and commercial freedom of settlement for any individual not being dependent on public relief. Poor relief was adapted to these new conditions with the law on the obligation of poor relief of the same day, 31st December 1842.[11] If no other obligated parties, such as relatives, could be drawn upon, then the registered domicile was obliged to assist the poor person. But a paradigmatic shift in Prussian poor law, theoretically intended, did not come along with the new poor law. In fact it excluded those sections of the population who were most in need of it – servants, journeyman and factory workers. In questionable cases the legislature gave the municipal governments the option to treat every impoverished person as a beggar or a vagrant. A law on the punishment of vagrants, beggars and the slothful was passed on 6th January 1843,[12] one week after the two laws just mentioned.

The Municipal Code of 1853,[13] as well as the amendment of the poor law in 1855,[14] laid down that poor relief should begin only after one year in residence at a new location. Any benefits before then had to be extended at the cost of the

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Versammlungen. Vom 19ten November 1808; cf. Wolfgang R. Krabbe, *Die deutsche Stadt im 19. und 20. Jahrhundert* (Göttingen, 1989), pp. 10–14.

10 *Gesetz über die Aufnahme neu anziehender Personen*, 31. December 1842.

11 *Gesetz über die Verpflichtung zur Armenpflege*, 31. December 1842.

12 *Gesetz über die Bestrafung der Landstreicher, Bettler und Arbeitsscheuen*, 6. January 1843; W. G. von der Heyde, *Staats- und Orts- Angehörigkeits- und Armenverpflegungs-Verhältnisse, so wie polizeiliche Behandlung der Bettler, Landstreicher und Arbeitsscheuen.* Geordnet durch die Gesetzgebung der Jahre 1842 und 1843, die darauf bezüglichen Ministerial-Rescripte und die aus der ältern Gesetzgebung noch zur Anwendung kommenden Vorschriften, (Magdeburg, 1844); W. Dittmar, *Die Gesetze vom 31. Dezember 1842 und 56. Januar 1843 ... nebst den dieselben ergänzenden und erläuternden Gesetzen, Verordnungen, Ministerial-Reskripten und Judikaten des Ober-Tribunals und des Gerichtshofes zur Entscheidung der Kompetenz-Konflikte* ... (Magdeburg, 1862).

13 *Städte-Ordnung für die sechs östlichen Provinzen der Preußischen Monarchie*, 30. May 1853.

14 *Gesetz zur Ergänzung der Gesetze vom 31. Dezember 1842 über die Verpflichtung zur Armenpflege und die Aufnahme neu anziehender Personen*, 21. May 1855.

"community of origin", usually the place of birth. In case of incapacitating illness, the municipalities were definitely obligated to carry the costs of lost wages for at least three months. In those towns and cities where no wealthy, old foundations could be called upon, the share of the entire municipal budget expended on poor relief exceeded half of the cities' total expenditures and, at times, even comprised two-thirds.[15]

As a consequence, early forms of health insurance were less concerned with the risk of illness as such, but rather with the risk of impoverishment arising from the inability to work. Private and independent health insurance and burial funds became common in the 1840ies and 1850ies. These insurances and funds were private insurance associations based on reciprocity. In fact, workers and craftsmen were often forced to join these associations by labour contracts, factory rules and guild regulations.

In the Prussian case one has to take into account the extreme differences between the old Prussian territories in the east and the Rhenish and Westphalian industrial zones in the west. Even though the population density in entire Prussia nearly tripled between 1816 and 1910, it was lower than in the German Reich (after 1871). Only the provinces Silesia, Saxony, Westphalia and Rhenania exceeded the Prussian and the "German" average in every socio-economic parameter pointing to industrialisation and urbanisation.

For the first time the Prussian central legislation allowed for commercial support organisations at a local level in 1845. This was done in the Prussian Industrial Code *(Gewerbeordnung)*.[16] In a supplementary directive of February 1849 this was expanded to include factory workers in addition to journeymen and assistants.[17]

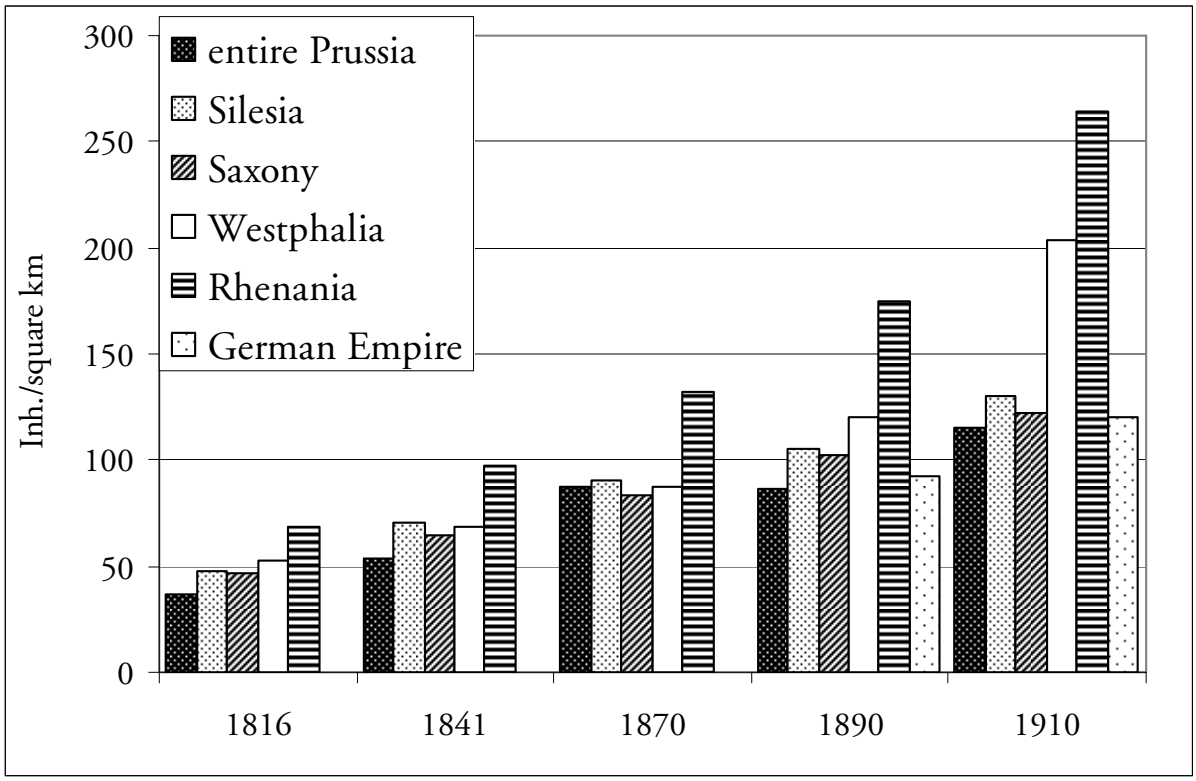
The municipalities were allowed to force the individuals in question to join an insurance organisation, as well as to demand contributions to these organisations from the factories, although this was seldom done in practice. A completely new perspective on the problem was opened by the commission concerned with the law on commercial support organisations (*Unterstützungskassen*) in 1854 by stating that a workers' income should nourish him not only in times of health, but also in times

15 Wolfgang R. Krabbe, *Die deutsche Stadt im 19. und 20. Jahrhundert* (Göttingen, 1989), 99–107; Jürgen Reulecke, *Geschichte der Urbanisierung in Deutschland* (Frankfurt/M., 1985), p. 212, tab. 9; Wolfram Fischer, Jochen Krengel, Jutta Wietog, eds., *Sozialgeschichtliches Arbeitsbuch.* Vol. 1: Materialien zur Statistik des Deutschen Bundes 1815–1870 (Munich, 1982), p. 212; F. J. Benzenberg, *Die Gemeinde-Ausgaben der Städte Düsseldorf, Elberfeld, Coblenz, Trier, Berlin und Paris*. (1833, 2nd ed. 1835); Alfred Emminghaus (ed.), *Das Armenwesen und die Armengesetzgebung in europäischen Staaten* (Berlin, 1870), p. 62.

16 *Allgemeine Gewerbeordnung*, 17. January 1845.

17 *Verordnung, betreffend die Errichtung von Gewerberäthen und verschiedene Abänderungen der allgemeinen Gewerbeordnung*, 9. Februar 1849.

Figure 1. Inhabitants per square kilometre in different Prussian regions.



Source: Jürgen Reulecke, *Geschichte der Urbanisierung in Deutschland* (Frankfurt/M., 1985), p. 201.

of illness.[18] Through this law the regional governments (*Bezirksregierungen*) were empowered to introduce mandatory membership when needed. It did not call for compulsory insurance in general, but rather for mandatory membership for certain professional groups. A comparison with the kingdom of Bavaria[19] shows that in Bavaria early forms of health insurance paying hospital treatment for artisans, journeymen and domestic servants have been proved for two dozen towns as early as 1811. The members had to pay an entrance fee and weekly contributions for the entitlement to free medical care, usually in local hospitals. In 1850 a Bavarian government ordinance obliged the communes to provide health care measures for a

18 *Gesetz, betreffend die gewerblichen Unterstützungskassen*, 3. April 1854; Ludwig Puppke, Sozialpolitik und soziale Anschauungen frühindustrieller Unternehmer in Rheinland-Westfalen (Köln, 1966); Ute Frevert, Krankheit als politisches Problem 1770–1880 (Göttingen, 1984), pp. 151–174; Margaret Asmuth, Gewerbliche Unterstützungskassen in Düsseldorf (Köln, 1984), p. 19.

19 Cf. Michael Stolberg, "Health care provision and poor relief in the Electorate and Kingdom of Bavaria", in O. P. Grell, A. Cunningham, R. Jütte, eds., *Health Care and Poor Relief in 18th and 19th Century Northern Europe* (Aldershot 2002), pp. 112–135; Eva Brinkschulte, "Die Institutionalisierung des modernen Krankenhauses im Rahmen aufgeklärter Sozialpolitik", in A. Labisch, R. Spree, eds., *"Einem jeden Kranken in einem Hospitale sein eigenes Bett"*. Zur Sozialgeschichte des Allgemeinen Krankenhauses in Deutschland im 19. Jahrhundert (Frankfurt/M., New York, 1996), pp. 187–207.

period of 90 days for servants, day labourers and factory workers who would not have been entitled to poor relief according to the *Heimatrecht*, which was effective in Bavaria until 1916.

Beneath industrial policy, however, sanitary police was an important field of legislation. The measures taken against epidemics were primarily concerned with the prevention of cholera. Although not the prevalent cause of death at all, cholera came to be seen as a 'scandalised illness' which contained various interpretations. The early 1830ies showed with dramatic clarity, that neither military cordons nor medicine could do much to counter the march of cholera. Hence, avoiding cholera meant protecting oneself from its potential carriers, the poor, who consequently were placed under tighter control and supervision.

Following the cholera epidemics the Prussian government introduced a number of new laws dealing with public health. The Prussian Hygiene Regulation (*Regulativ über die sanitäts-polizeilichen Vorschriften bei den am häufigsten vorkommenden ansteckenden Krankheiten*) of 1835 provided the framework for public preventive measures during future epidemics.[20] In the case of acute epidemics the aim was to quickly isolate a maximum number of affected individuals – respectively those suspected of being infected.

By the 1850ies many Prussian cities had introduced a decentralised and non-uniform system of municipal poor relief by relying on voluntary bourgeois activities. This system was based on the subdivision of the cities into as many welfare districts as possible. Towards the end of the century volunteer activity had shifted to the bourgeois' associations and clubs while the municipal administrations adopted welfare systems administered by full-time employees. These employees occasionally developed detailed concepts of a genuine communal social policy as a part of a general system of public services. These developments have been called the emergence of the "welfare city".[21] Furthermore, municipal servants, engineers and doctors developed a programme of urban sanitary reform. The practice of hygiene in urban public buildings and houses, in factories and commercial zones, the removal of garbage, burials, food inspection, water supply and waste-water

20 *Allerhöchste Kabinetsorder (8. August 1835), womit das Regulativ über die sanitäts-polizeilichen Vorschriften bei den am häufigsten vorkommenden ansteckenden Krankheiten bestätigt wird*; Sanitäts-polizeiliche Vorschriften bei den am häufigsten vorkommenden ansteckenden Krankheiten. Barbara Dettke, *Die asiatische Hydra*. Die Cholera von 1830/31 in Berlin und den preußischen Provinzen Posen, Preußen und Schlesien (Berlin, New York, 1995); Olaf Briese, *Angst in den Zeiten der Cholera* (4 vol.s, Berlin, 2003).

21 Cf. Jürgen Reulecke, ed., *Die Stadt als Dienstleistungszentrum*. Beiträge zur Geschichte der "Sozialstadt" in Deutschland im 19. und frühen 20. Jahrhundert (St. Katharinen, 1995); Jürgen Reulecke, *Geschichte der Urbanisierung in Deutschland* (Frankfurt/M., 1985), pp. 62–67, pp. 118–131; Wolfgang R. Krabbe, *Die deutsche Stadt im 19. und 20. Jahrhundert* (Göttingen, 1989), pp. 99–128.

management – all of these created the hygienic technological infrastructure of the (industrial) cities.[22]

The state of Prussia found itself increasingly unable to manage the challenge of poverty by means of an uniform legislation. In this respect the Prussian state was not unique. Spectacular accidents involving labourers caused public fear and awareness. Consequently the protection of workers became part of the agenda of state politics. However, Bismarck opposed the legislation on the protection of workers.[23] He thought that the personal freedom of workers to earn their living (e.g. by doing dangerous jobs) should not be limited by unnecessary legislation. A civil law compensation failed because the basic idea of the employers' general risk liability and that of presumptive guilt of the employer was incompatible with liberal economics and the personal legal comprehension of Chancellor Bismarck.

On another level, these considerations were connected with the so-called internal establishment of the new German Reich (*Innere Reichsgründung*).[24] Correspondingly, the Imperial Address of November 17th 1881, which publicly promised the three laws on accident, health, retirement and invalidity insurance, claimed:[25] "The healing of social damage will not be found exclusively in the repression of social democratic rioting, but rather steadily in the positive advancement of the workers well-being." At the same time, the protestant Prussian administration of course still judged the catholic movement as major enemy of the Reich. Protestantism and social policy are very closely linked in the Prussian case.[26]

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22 Cf. Jörg Vögele, *Urban mortality change in England and Germany, 1870–1913* (Liverpool, 1998), pp. 150–189; Jörg Vögele, Wolfgang Woelk eds., *Stadt, Krankheit und Tod*: Geschichte der städtischen Gesundheitsverhältnisse während der epidemiologischen Transition (vom 18. bis ins frühe 20. Jahrhundert) (Berlin, 2000).

23 Wolfgang Ayaß, "Bismarck und der Arbeiterschutz", in *Vierteljahrschrift für Sozial- und Wirtschaftsgeschichte* 89 (2002), pp. 400–426.

24 Hans-Peter Ullmann, *Das Deutsche Kaiserreich 1871–1914* (Frankfurt/M., 1995), pp. 14–31, pp. 173–181; Heinrich August Winkler, *Der lange Weg nach Westen*. Deutsche Geschichte 1806–1933 (Bonn, 2002), pp. 247–257; Wolfgang Reinhard, *Geschichte der Staatsgewalt*. Eine vergleichende Verfassungsgeschichte Europas von den Anfängen bis zur Gegenwart (Munich, 1999), pp. 458–479.

25 Florian Tennstedt, "Vorgeschichte und Entstehung der Kaiserlichen Botschaft vom 17. November 1881", in *Zeitschrift für Sozialreform* 27 (1981), pp. 663–710, quotation p. 732/33 (translation by FD); *Quellensammlung zur Geschichte der deutschen Sozialpolitik 1867 bis 1914. II. Abt.: Von der kaiserlichen Sozialbotschaft bis zu den Februarerlassen Wilhelms II. (1881–1890). Vol. 1: Grundfragen der Sozialpolitik. Die Diskussion der Arbeiterfrage auf Regierungsseite und in der Öffentlichkeit* (Darmstadt, 2003).

26 Jochen-Christoph Kaiser, Martin Greschat, eds., *Sozialer Protestantismus und Sozialstaat. Diakonie und Wohlfahrtspflege in Deutschland 1890 bis 1938* (Stuttgart, 1996); Heinz-Gerhard Haupt, Dieter Langewiesche, eds., *Nation und Religion in der deutschen Geschichte* (Frankfurt/M., 2001); Norbert Friedrich, Traugott Jähnichen, eds., Sozialer Protestantismus im Kaiserreich (Münster, 2005).

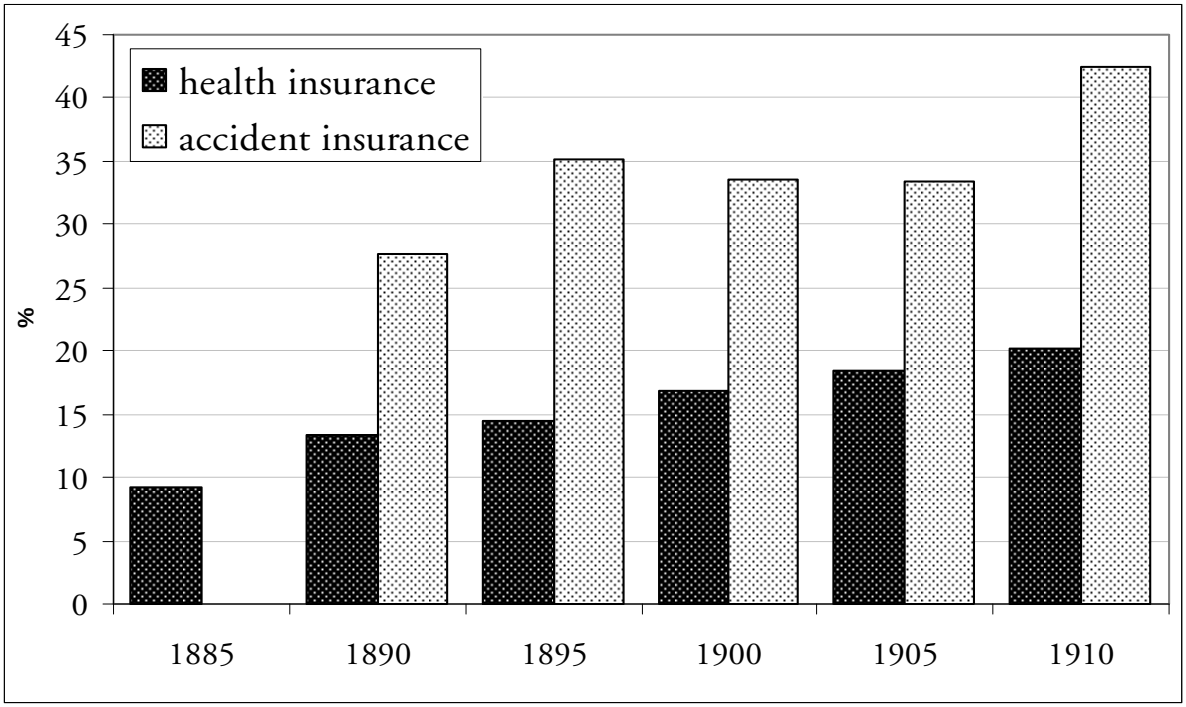
The Prussian-German introduction of social insurance was implemented by means of three laws in the 1880ies. The law on accident insurance enacted in 1884 represents the central piece of the legislation and consequently was the most controversial. The negotiations got more disimpassioned when the waiting period after an accident and before starting benefits to the injured was suddenly extended from 14 days to 13 weeks. This happened definitely against the instructions of Chancellor Bismarck. As a result, in 1883 health insurance was invented to bridge the time gap of 13 weeks. The main issue of German health insurance was to politically enable accident insurance and not to improve workers' – not to speak of "public" – health system. With the passage of the invalidity and the retirement insurance laws in 1889, the legislative part of the reform of social insurance was completed.[27]

Different political objectives of this legislation are to mention and health care did not feature prominently among them. It intended to keep the insured factory workers from abject impoverishment in case of accident, illness or old age, and to relieve the municipal poor relief burdens on a second level. The social democrats voted against this law as the health insurance pointed directly to the inclusion of their constituency. Initially, the focus was on compensation for the loss of earnings in case of illness after the fourth day of incapacity to the amount of half the average of a local wage for a day. Medical treatment, medication and, under certain circumstances, admission to a hospital, had been the secondary purpose. But until the First World War the health insurance developed into an institution primarily financing medical services for the insured, thus becoming detached from poor relief in terms both of organisation and intention.

The health insurance companies were financed by premiums paid two-thirds by the employees and one-third by the employers. With the health insurance companies a completely new actor appeared in the field of health care politics. Internally, they served to balance the interests of employees and employers which shared the independent insurance administrations according to a ratio of two-thirds by the employees and one-third by the employers; externally, they were powerful representatives of their members' vis-à-vis the state, the municipalities, and the suppliers of medical services, particularly doctors. This "German" model of health care provision by compulsory insurance refers to the conservative model of social pacification which seeks to establish an authoritarian, monarchist welfare state by

27 Florian Tennstedt, Heidi Winter, "'Der Staat hat wenig Liebe - activ wie passiv'. Die Anfänge des Sozialstaats im Deutschen Reich von 1871", in *Zeitschrift für Sozialreform* 39 (1993), pp. 362–392; Florian Tennstedt, Heidi Winter, "'Jeder Tag hat seine eigenen Sorgen, und es ist nicht weise, die Sorgen der Zukunft freiwillig auf die Gegenwart zu übernehmen.' Die Anfänge des Sozialstaates im Deutschen Reich von 1871", in *Zeitschrift für Sozialreform* 41 (1995), pp. 671–706.

Figure 2. Insurance members in percent of population.



Source: Gerd Hohorst, Jürgen Kocka, Gerhard A. Ritter, *Sozialgeschichtliches Arbeitsbuch.* Vol. 2: Materialien zur Statistik des Kaiserreichs 1870–1914. (2nd Ed. Munich, 1978), p. 22, p. 154/55 (All data relate to the German Reich, not to Prussia.).

supporting a way of balancing social antagonisms in self-administrated organisations under public law outside the parliamentary bodies of political representation.

The insured workers obtained rights to benefits which were uniformly laid down by law. As premium-paying members, workers participated in insurance administration. Thus, to receive benefits from the health insurance system was freed from the discriminating proceeding of public welfare by municipal poor relief, which until 1908 meant the loss of several civil rights, e.g. voting rights. Poor relief, which continued to be administered primarily on a communal level, did not become obsolete, not only as supplementary to the very low benefits of health and retirement insurance. Since the duration of health insurance payments was limited, illness remained the most common factor of poverty. A specific division of responsibilities developed between social insurance on the one hand and welfare care/poor relief on the other – which to overcome is one of the major aims of nowadays social policy in Germany.

Membership was systematically connected with having a regular job as a worker. Total membership grew relatively slowly, not only because the family members of the insured were excluded until 1911. Only one-fifth of the German population

participated in health insurance in 1910.[28] Membership grew faster after the "Reich Insurance Code" (*Reichsversicherungsordnung*) of 1911.[29] The laws on health insurance, accident insurance and retirement insurance were given an uniform legal frame and compulsory health insurance was extended to salaried employees (*Angestellte*) – finally to the waste majority of those employed and dependent on wages – as well as family members of the insured. Of course, to include the family members of the insured obviously meant to get the married women into health insurance, which was already anticipated in 1883 and 1892.[30]

Until 1892 supplementary local insurance funds were often favoured by the insured. These funds paid out three-quarters of the average local wages instead of medical treatment. Since an amendment of 1892 structural disadvantages developed vis-à-vis the state health insurance. Thus, the latter developed to a governmental and economical framework primarily financing medical services for the insured individuals in the last decade of the century.

As an immediate effect of health insurance great additional amounts of money were paid for medical treatment within two decades – even if the individual benefits were still low. This could be regarded as the starting point of a modern "medical market place" where prices were dealt between health insurance companies and doctors. Non-academical healing and "alternative" medicine did effectively not profite to an amount which represents its sympathies in the population;[31] from the 1880ies onwards the professionalised, academic medicine dominated the market of medical treatment more than ever before, even if medical treatment by doctors still legally was regarded as a trade like others, which to overcome was already one of the major aims of the early doctors' associations. At the same time, the benefits paid out to the insured were constantly increasing.

To give a rough overview, one could compare the benefits per member with the average income. Although the highly aggregated data does not allow a detailed analysis, it becomes clear, that health insurance benefits per member had nearly tripled until the First World War while the average annual income only doubled. Thus, even the insured individuals could have regarded the system as a successful one considering the rising amounts of benefits, and in consequence, the rising chances to obtain medical treatment in case of need.

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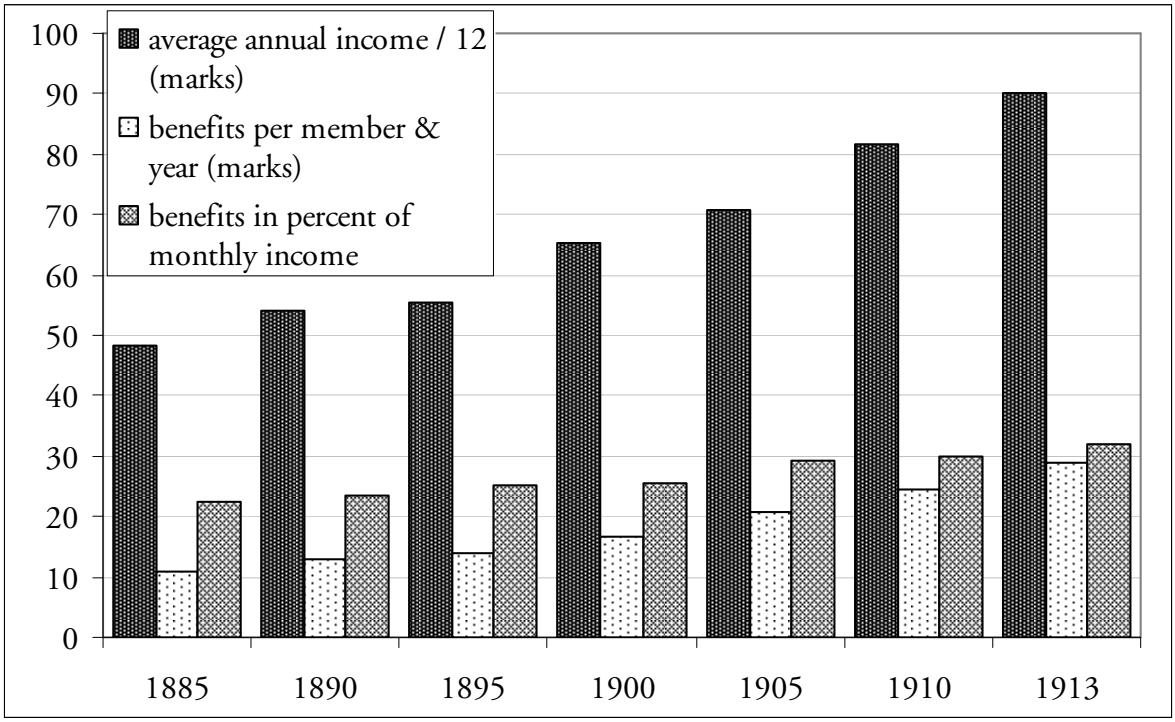
28 Gerd Hohorst, Jürgen Kocka, Gerhard A. Ritter, *Sozialgeschichtliches Arbeitsbuch*. Vol. 2: Materialien zur Statistik des Kaiserreichs 1870–1914 (2nd ed. Munich, 1978), p. 22, p. 154, p. 155.

29 *Reichs-Gesetzblatt 1911*, pp. 509–860; *Versicherungsgesetz für Angestellte*, 20. Dezember 1911, Reichs-Gesetzblatt 1911, pp. 976–985.

30 *Gesetz betreffend die Krankenversicherung für Arbeiter,* 15. Juni 1883, paragraph 21; *Gesetz über die Abänderung des Gesetzes betreffend die Krankenversicherung der Arbeiter*, 10. April 1892.

31 Martin Dinges, ed., *Medizinkritische Bewegungen im Deutschen Reich ca. 1870–1933* (Stuttgart, 1996).

Figure 3. Health insurance benefits per member and average income.



Source: Gerd Hohorst, Jürgen Kocka, Gerhard A. Ritter, *Sozialgeschichtliches Arbeitsbuch.* Vol. 2: Materialien zur Statistik des Kaiserreichs 1870–1914. (2nd Ed. Munich, 1978), p. 107, p. 154 (All data relate to the German Reich, not to Prussia.).

Finally, there is at least chronological evidence of some kind of connection between new strategies in public health policy and the process of epidemiologic transition.[32] Mortality was already decreasing in different regions of Germany during the late 18th and the early 19th centuries.[33] Although the actual crude death rates remained high, there were only a few years in many German regions in the late 18th century in which the number of deaths exceeded the number of births. Such mortality crises visibly disappeared, and the annual fluctuations of mortality were significantly; the average mortality rate declined in numerous parts of Germany. Around the middle of the 19th century, the long-term decline of mortality was interrupted, and between the 1830ies and the 1880ies, mortality rates remained relatively high. Since the late 1870ies, the long-term development of mortality was marked by a drastic downward trend. In this respect, the secular change of mortality in the German

32 Cf. Jörg Vögele, *Urban mortality change in England and Germany, 1870–1913* (Liverpool, 1998); Jörg Vögele, Wolfgang Woelk eds., *Stadt, Krankheit und Tod*: Geschichte der städtischen Gesundheitsverhältnisse während der epidemiologischen Transition (vom 18. bis ins frühe 20. Jahrhundert) (Berlin, 2000).

33 William R. Lee, "The Mechanism of Mortality Change in Germany, 1750–1850", in *Medizinhistorisches Journal* 15 (1980), pp. 244–288; Peter Marschalck, *Bevölkerungsgeschichte Deutschlands im 19. und 20. Jahrhundert* (Frankfurt/M., 1984); Arthur E. Imhof, *Lebenserwartungen in Deutschland vom 17. bis 19. Jahrhundert* (Weinheim, 1990).

"Kaiserreich" in a phase of accelerated industrialisation and urbanisation, was a major step in the epidemiologic transition towards the modern state of health.

Historical epidemiology approved that the decline of infant mortality could be named as one of the major factors of the transitory process, when the traditional mortality situation with the predominance of diseases and low life-expectation turned to the modern situation with high life-expectation and dominating degenerative causes of death. Furthermore it is possible to identify several determinants of the remarkable decline of infant mortality. But for sure there is no one-way dependency which would allow for weighing the significance in a statistically precise manner.

Trying to assess the impact of workers' social insurance one could wonder if there was any impact at all as social insurance of the Bismarck-era did not include the care for mothers and their (new-born) children. But already in the first decades until the First World War health insurance as well as accident insurance and retirement insurance had remarkable effects in disencumbering the municipal poor relief funds. In consequence, communal welfare was freed to broaden its activities, e.g. in the field of mother and child care.

By the end of the 19th century, however, the decrease of birth rates prompted the fear that Germany's future was endangered, from an economic and military point of view. In particular, the direct comparison with England and France provoked hectic activities in the realms of industry and politics. The supply of adequate milk was considered a central municipal responsibility, and infant welfare societies spread after the turn of the century.[34] Infant welfare centres were founded, particularly in larger towns, with the specific aim to increase breastfeeding rates. It is, however, apparent that infant mortality is decreasing with rising standard of living in general. In the highly industrialised regions of western Germany the differences in infant mortality rates between breast-fed and bottle-fed children steadily disappeared.[35]

34 Paul Weindling, *Health, Race and German Politics between National Unification and Nazism, 1870–1945* (Cambridge, 1989), pp. 206–209; Silke Fehlemann, *Armutsrisiko Mutterschaft: Mütter- und Säuglingsfürsorge im Deutschen Reich 1890–1924*, Phil. Diss. Düsseldorf 2004 (in print); Silke Fehlemann, Wolfgang Woelk, "Der 'Wiedergesundungsprozess des deutschen Menschen'. Zum Verhältnis von Gesundheit, Hygiene und Gesellschaft auf der Düsseldorfer Gesolei", in: Hans Körner, Angela Stercken, eds., *1926–2002 Kunst, Sport und Körper* (Düsseldorf / Ostfildern-Ruit 2002), pp. 186–192.

35 Jörg Vögele, *Urban mortality change in England and Germany, 1870–1913* (Liverpool, 1998), pp. 119–135; Jörg Vögele, Wolfgang Woelk, Silke Fehlemann, "Decline of the Urban Penalty: Milk Supply and Infant Welfare Centres in Germany, 1890s to 1920s", in: Helen Power, Sally Sheard, eds., *Body and City: Histories of Urban Public Health* (Aldershot 2002), pp. 194–213.

Summary

Based on the discourse on poverty of the Reformation era, the late absolutist Prussian state formulated the idea of an absolutist "welfare state" which cares for its poor subjects by obligating the communes and local authorities to concrete measures in fighting beggary and supporting the "deserving" poor. Within the process of industrialisation and urbanisation the local organisations of poor relief and health care for the poor became the longer the more incapable to manage the risk of impoverishment by miserable health conditions of a migrating labour population. At the same time a continuously growing number of legal regulations became in different ways attached to health care provision of the population: poor relief regulations, municipal codes, hygiene / sanitary regulations and the Industrial Code are to be named firstly.

Several early models of insurance, usually locally based and regionally differing came into existence: Hospital insurance funds were connected to a precise single hospital and allowed their members free hospital treatment for a regularly paid premium. As these, early mutual aid associations to support handicraftsmen organised outside or beneath the trade guilds like associative health insurance as well as burial funds were voluntary, completely based on (occasional) payments of their members, without any governmental regulation or support. In the middle of the century, some municipalities began to force migrating labourmen and factory workers to join local insurance funds before admitting their establishment in order to protect the municipal poor relief funds. At the same time the Prussian state began to set up a legal framework for these funds. The main goal of all of these, besides the hospital funds, was not medical treatment but to protect their volunteer members from impoverishment by illness causing incapability to work and avoiding unexpected expenditures of the municipal poor relief agencies respectively. In consequence, their benefits were intended to substitute the loss of earnings in the period of illness and not to pay doctors or medication.

Municipal as well as state poor relief and health care provision policy changed in the last third of the 19th century. The cities and towns by cooperation with bourgeois welfare associations developed into communal welfare agencies providing water supply, waste-water management, mother and child centres as well as tuberculosis consultation and municipal hospital services to name just the most important. The state developed social insurance by means of legislation and, secondly, financial support. The political objective has to be understood in the framework of labour and not least confessional politics intended to support the "internal foundation of the Reich". Introduction of health insurance in 1883 in the very first instance served to hit the Gordian knot of legal principles which obstructed a successful implementation of accident insurance. Within a decade the primordial goal to substitute the loss of earnings in case of illness transformed into

effective medical healing. Since the 1890ies health insurance changed into a powerful agency to finance medical services. Thus in the long run the balance of demand and supply of medical treatment was restructured in favour of doctors, hospitals and academic medicine. Medical help became affordable for a growing number of people, who would not have asked for a doctor otherwise. To obtain benefits was strictly detached from every form of poor relief because the legally fixed benefits of the insurance corresponded to legally fixed rights of the insured in case of need.

As an economical effect, the growing demand of medical services led to a growing supply, offering the longer the more specialised medical treatment. At the same time, on the communal level, municipal services could broaden and differentiate their offers with respect to diverse advisory activities, especially mother and child welfare care including milk supply, but also municipal hospital services which around the turn of the century became dominating in Germany. This was enabled by freeing the municipal poor relief funds from the older duties and responsibilities to a degree not to be underestimated.

Finally, one has to state that we actually know very little on the immediate consequences of social insurance at the countryside. The effects may be weak as the introduction of labourers' insurance changed social security parameters especially for the urban lower classes. But there should have been at least some indirect and collateral effects (e.g. on migration) which to know would be helpful to better understand the whole complex. Germany was a widely rural country in 1910, when still half of the population lived in communities with less than 5,000 inhabitants.

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Beggars, Vagrants and Romanies
Repression and Persecution in Portuguese Society (14th–18th Centuries)

Laurinda Abreu

The social exclusion and the fragility that the present economic situation bears is not a new phenomena in Europe. Forced by uncontrolled circumstances or as a result of individual or group choices, the non integration into society carries elements of disorder, insecurity and fear that go through all times and spaces. The trauma brought on by the Black Death, associated with the process of transformation of the dominant political model in Europe and to changes in the economic structures, made it easier to implement actions to discipline society and to reduce the violence. In the Europe that witnessed the construction of the Early Modern States, those who did not have an occupation, refused to work or search for a "master", were stigmatized, severely persecuted, marginalized and expelled from their communities.

What I propose here is to go back to the first regulations against vagrancy and idleness in Portugal. Created and developed in crucial moments of transformation of the economic and social structures, these policies help to understand the beginning of a historical process – of European dimension – which, in a certain way, is extended to some of the present social attitudes, at a global scale.

With no substantial differences to the other European States' diplomas promulgated at the same time[1], the Portuguese laws against the false beggars, the vagabonds and everyone refusing to work had two particularities: they represented the thought of a central government and were conceived to be applied at a national scale, which was at that time relatively exceptional.

A more precise analysis of these normative texts gives important indications on the way the concept of vagrancy was socially defined – "the idle, the lazy and the dangerous" – and the means developed to deal with such people. The inclusion of the Romanies in these texts at the beginning of the 16th century sheds some light on the subjacent criteria of the identification as a group, and on the reasons why

1 Cf. Robert Jütte, *Poverty and Deviance in Early Modern Europe*, (Cambridge, 1994), pp. 143–200.

they were marginalized and controlled. Going back to the beginning of the process of controlling beggars, vagrants and Romanies, offers new elements so as to make the whole process understandable.

And Those that "don't want to serve will be publicly beaten and expelled from our kingdoms"[2] the Medieval Definition of the Deserving Poor

The idea of the generosity of the medieval people, ready to share their daily bread that in many cases was not even enough for themselves, perpetuated by several authors, is strongly rooted in the European historiography emphasising the context of the Christian worldview that attributed specific roles to the rich and poor. Without denying this idea, it is justified to re-evaluate it in the light of the sources that support it: documents attesting good social practices towards the poor and the beggars, reports on the budgets of the monasteries and convents showing their charitable donations, religious literature, hagiographies and saints' lives. In general terms, the main purpose of this documental corpus was to teach and catechise society in the Christian values. And it is in that sense that it has to be taken into account.

This does not mean that the feelings of tolerance, benevolence and charity did not exist or were exceptional in Medieval Times. They existed but have to be analysed at different scales. A common situation for the majority of the population, poverty was a worrying target for some of the sectors of society, justifying charitable actions, that the Christian doctrine stimulated, whether in the form of single and more private donations, whether in more institutional and public projects. As Michel Mollat mentioned, one of the biggest social concerns of the time was to prevent the poor from going beyond the threshold that drove them to poverty and misery[3].

It was precisely to protect their more vulnerable members that the communities organized themselves creating structures of support that normally resolved the problems at a local level, through informal support – family or vicinal –, or through the institutions, either of individual foundation and management or confraternal or

2 A preliminary version of this paper was present as an introduction to the book *Monitoring health status and vulnerable groups in Europe: past and present*, Laurinda Abreu and Janos Sandor (ed.), Santiago de Compostela, 2006.

3 Cf. Michel Mollat, "Pauvres et assistes au Moyen Age", *A Pobreza e a Assistência aos Pobres na Península Ibérica durante a Idade Média. Actas das 1as Jornadas Luso-Espanholas de História Medieval, Lisboa 25–30 de Setembro de 1972* (Lisboa, 1973), vol. I, pp. 13–15.

even parochial[4], not forgetting the important role that the monastic orders played in this field[5]. The social definition of the deserving poor, which was shared earlier by the population is clear: the ill, the elderly and the poor in shame, but also the pilgrims, the widows, the orphans and the abandoned children, the poor prisoners and, surely enough, the captives captured by the Moorish, due to the religious risk they ran. Hospitals and brotherhoods were founded for them, food, clothes and money were regularly distributed and spiritual support was provided.

However, the urban development and the economic and social transformations initiated in the first half of the 14th century, and precipitated with the Black Plague, would make the discrepancy between the capacity to create poor relief resources and the real necessities of the populations very clear. In Portugal, as in the rest of Europe, the crises of the 14th century, even if of a different dimension and amplitude, would breach unstable balances, dragging "hoards" of destitute to the urban centres to look for work, alms or assistance. Thus, one of the first problems that the late-medieval generosity came across was of quantitative order or, better, on the difference of greatness. In fact, in spite of the generosity of the religious institutions, ecclesiastics, common people or royal houses and the poor integration in the "economy of the salvation", that multiplied all sorts of pious foundations in the benefit of donators, the offer of poor relief resources was far from that of the real necessities. To select the targets became, therefore, a practical question, of major importance. To know who, among the crowds, truly needed assistance or were impostors, became a priority as the disequilibrium between the offer/search was more prominent.

At the same moment there was a highly-precise reaction against those who cheated and deceived and these were, according to the social perceptions, the lazy, the vagrants, the false beggars and the foreigners whose source of income was unknown. To sum up, the wandering people, or, to quote the representatives of the citizens at the Courts of Lisbon in 1371, the ones "that wander around"[6]. The adjective used to identify them – "wandering" – elucidates the stigma that had been imposed on them and the social repercussion behind their profile: uprooted people without social duties, refusing to work, even though they had the capacity for it[7]. It was presumed, in these cases, that they lived "on misdeeds". That is to say, deceiv-

4 Cf. Maria Helena da Cruz Coelho, "As confrarias medievais portuguesas: espaços de solidariedade na vida e na morte", in *Cofradías, grémios, solidaridades en la Europa Medieval, Actas XIX Semana de Estudios Medievales, Estella 92*, 1992.

5 Cf. José Mattoso, "O ideal da pobreza e as ordens monásticas em Portugal durante os séculos XI–XIII", in *A Pobreza e a Assistência aos Pobres na Península Ibérica durante a Idade Média*, tome II, pp. 637–670.

6 Courts of Lisbon, of the 8th of August 1371, quoted in *Portugaliae Monumenta Misericordiarum*, (henceforth *PMM*) (Lisboa, 2003), vol. 2, doc. 62, p. 125.

7 *Ordenações Afonsinas* (Lisboa, 1984), vol. IV, pp. 141–142.

ing, stealing and begging just out of laziness. The feeling of the social injustice that is present among the "honest people" is made explicit by the violence of the words of the population: let them "be banished and expelled from our kingdom"[8].

The genealogy of the Portuguese medieval legislation against beggary and vagrancy[9] can be divided into two periods chronologically divided by the Law of the Sesmarias, of 1375. In the first, we can integrate the diploma of D. Afonso II, of 1211, that determined the expulsion of the idle ones; the 1349 law, that condemned the false beggars; the D. Fernando deliberation, taken in sequence of the 1371 protests, above mentioned, which delegated power to the local authorities to deal with the delinquents and vagabonds and, finally, the Law of the Sesmarias, this one ending the first period and starting a new phase in what concerns the control of the beggars. Especially studied as a source for the promotion and development of the country through the recovery of agriculture, abandoned and with lack of labour as a consequence of the Black Plague, the social clutters that it provoked, the epidemics that followed, and of the general demographic cut, the Law of the Sesmarias initiates, in fact, a new stage in social policy terms and this for two reasons: because it systemizes disperse measures previously taken, giving important orientations to the beggary phenomena, representing the first effectively structuralized and consistent political answer on the question[10], but, above all, because it will serve as a matrix to the 16th and 17th century laws against beggary and vagrancy.

Using the arguments that Juan Luis Vives would propose 150 years later, the law convokes the biblical texts to condemn idleness and to restrict begging. Considering, for instance, that not all physical handicaps should give direct access to beg, it should be limited to the very weak, very old or very ill. Mirroring previous social attitudes, the Law of the Sesmarias incorporated the difference between the true and the false poor, or rather, between those who had the right to beg and those who "scrounged around shamelessly"[11] and hence considered more exigent and more dangerous, ready to assume aggressive and criminal behaviour. As a matter of fact, this law, put forward by the central government and applicable to the whole country, already included most of the measures that would be considered the basis of Early Modern Period policies in what concerned the fight against beggary and vagrancy, even listing the ways of facing it. For instance, proposing an amazing, relatively elaborate information gathering system which, at the local level, would serve to find out the lifestyle of each inhabitant and to transmit it through a well-defined hierarchy that reached the higher agents of the king, responsible for

8 Courts of Lisbon of 1410, quoted in *PMM,* vol 2, doc. 64, p. 126. Also, Courts of Santarém, 1418, quoted in *PMM,* vol. 2, doc. 65, p. 126.

9 About the subject, see Humberto Baquero Moreno, *Marginalidade e Conflitos Sociais em Portugal nos Séculos XIV e XV* (Lisboa, 1985), especially footnote nr. 13 of p. 27.

10 *Ordenações Afonsinas*, book IV, Das Sesmarias, titile LXXXI, 1375, pp. 281–304.

11 Will of the 25th of January of 1349 (*PMM,* vol. II, p. 138).

authorising beggary and condemning those who did not abide by the rules – begging without a licence[12].

Generally speaking, registered in the Law of the Sesmarias, even if only as a draft, the main elements that were considered revolutionary in Vives' discourse[13]: the division of the beggars between those who were apt for work and those who were impotent; their control and inspection; the pressing question of the work; the special care to be taken with the ashamed poor[14]. In a long term analysis, the most significant alteration that was made to the Law of the Sesmarias occurred at the beginning of the following century and foresaw the possibility of the non-authorized beggars falling into slavery, having to serve almost for free whoever requested them, a measure that was not applied to the foreigners until 1427, when the law became general[15], precisely when the king was requested in courts, that, as was determined by D. Fernando, the municipal authorities should recuperate their authority in the attribution for beggary licenses[16], pretension, repeated again in the 1481–1482 courts[17], followed by the petition to arrest those who were found begging without authorization, as the Ordenações Afonsinas already determined, ratifying the decision that D. João I took in the Évora courts, probably, in 1408[18].

In conclusion, similarly to what happened in other parts of Europe, the limitation of the beggary, the repression of the one exerted illegitimately and the fight against vagrancy, have an old history in Portugal. And it was a determinant for the definition of the deserving poor and, in consequence, of the making of the concept of poverty, moulding the social perceptions and representations, that had an extraordinary longevity although it characterized a complex social reality, fluid in time and in the vocabulary that defined it.

Related to the previous point, another element that was important in the social representations and in the legal discourses that, supposedly, answer them, is the association between the practice of charity and assistance with the necessity of

12 *PMM*, 126, doc. 65, dated from 1418.

13 Except for the individualization of the foreigners, incorporated in the Portuguese law only later on.

14 Jean Luis Vives, "Del socorro de los pobres, o de las necesidades humanas", *Biblioteca de autores españoles*, vol. LXV (Madrid, 1953). A careful analysis can be found in Linda Martz, *Poverty and welfare in Habsburg Spain* (Cambridge, 1983), pp. 7–15.

15 Far from, however, the violence of the law promulgated by Toledo, in 1400, that foresaw cutting the ears and even the death of the vagabonds. Cf. Linda Martz, *op. cit,* p. 12. Armindo de Sousa, *As cortes medievais portuguesas (1385–1490)* (Porto, 1990), vol. II, p. 280.

16 Similar determination is taken after the Courts of Madrid, of 1435. Cf. Juan Torres Fontes, "El concepto concejil Murciano de Limosna en el siglo XV", in *A Pobreza e a Assistência aos Pobres na Península Ibérica durante a Idade Média*, vol. II, p. 845.

17 Maria José Pimenta Ferro well demonstated in *Pobreza e Morte em Portugal na Idade Média* (Lisboa, 1989), p. 39.

18 *Ordenações Afonsinas*, book IV, title. XXXIV, pp. 141–142.

workers for economic development. It is known that the circumstances of the moment propitiated such links but it is also true that these preoccupations would be made law in the following centuries; the moral aspects always accompanied by the economic ones: charity should fulfill the needs of the poor and not ferment laziness and all the vices that were associated to it, an especially important orientation when the lack of workers was almost dramatic. As king D. Duarte (1391–1438) said, «the life of men shall not be idle and the alms shall not be given to those who can work»[19].

The question of work was, in fact, a social matter of great importance and not only for economic reasons but also because of the organization and balance of society. The work was an obligation of the poor. It was their way of integrating the social order as it was drawn. The absence of work, forced by uncontrolled circumstances or by life option, led to social exclusion. This is the third point to bear in mind when we approach the poor relief and health care support and the legal documents that frame them.

The description of the beggar in permanent displacement as a stranger who tried to have access to community resources, without contributing to the local economy, and, in addition, as an agent of disorganization of the daily life, has an old history. Even if in the context of an economic crisis the authorities very often had the perception that the line between poverty and beggary was easily overcome and that it had to be taken into account. Socially unframed, parochial and family uprooted, the wage-earning worker was frequently at this borderline and the confraternities and the hospitals played, as it is well known, a relevant social role there.

Different, however, was the situation in the cases where the poor was a stranger to the community and showed its poverty through beggary. Except for the religious – a focus of permanent instability once the Franciscan and Dominican's clothes were used by the false poor to beg freely – the medieval communities did not peacefully accept outsiders. In the majority of situations they tended to be self-centred in what concerned charity, the reason why the shelters for pilgrims, which also lodged beggars and vagabonds, determined a stay usually no longer than three days.

The Early Modern Legislation

The demographic increase, the economic development and the social transformations registered, with prominence for the "urbanization" of the peasant, using

19 *Livro 2º dos Reis D. Duarte e D. Afonso V,* doc. nº8, fl. 8, in Humberto Baquero Moreno, *Exilados, Marginais e Contestatários na Sociedade Portuguesa Medieval (*Lisboa,1990), p. 57.

Geremek's words[20], in the open sense of the population movements from country to the city but also from the smallest centres to the bigger ones, would have to pull down the fragile "social balance" that was breached in each plague and famine outbreak, without forgetting the frequent wars. It was at this time that the interventions of the authorities tried to rationalize the poor relief, look for effectiveness in the way of work, thus, developing some specialization in terms of administrative rules and from then on, a growth in the punishment that also include the ones that were conniving with the vagabonds[21]. It is no surprise, therefore, to see them excluded from the hospitals, at the beginning of the 16th century, as ordered by D. Manuel I, on the 23rd of May of 1502, to the Évora municipality: the hospital was made for the sick and not for the beggars who could work[22]. The continuation of the regal politics to control beggary and, therefore, setting the universe of the deserving poor, would lead to the diploma of the 8th of July of 1500 that included the control of the beggars and the task of separating the true from the false poor in the competences of the new confraternities of the Misericórdia. The importance of this diploma does not come from the novelty of its content but from the fact that, for the first time, the crown gives to a charitable institution responsibilities that until then belonged to the political authorities, although the latter maintained the control of the roaming and the vagrancy that were linked to it. In 1521, at the end of D. Manuel I reign, times of epidemics, the king ordered a general inspection of the beggars that were invading Lisbon.

Among the various questions that he asked them before deciding on the begging licences, he identified, and made a compulsory register, of the beggars' geographic origin, civil state, economic situation and time of stay in the city[23]. The ones with curable illnesses were sent to the city general hospital, the Hospital de Todos-os-Santos and the handicapped were obliged to learn a trade according to their capacities. If they refused, they could be given to whomever wanted to teach them. For

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20 Bronislaw Geremek, "Mouvements hérétiques et déracinement social au bas Moyen Age», in *Annales. Économies. Sociétés. Civilisations*, 37e année –nº 1, Janvier-Février, Paris, 1982, p. 188.

21 For Portugal, Humberto Baquero Moreno, *Marginalidade e Conflitos Sociais em Portugal nos Séculos XIV e XV*, pp. 24–60. Also, Rui Abreu Torres, «Mendicidade» e «Vadiagem», in *Dicionário de História de Portugal* (Joel Serrão dir.), respectively, vol. IV, pp. 254–255; vol. VI, pp. 239–240. For France, Michel Mollat, "Les problèmes de la Pauvreté", in *Études sur l'Histoire de la Pauvreté*, Michel Mollat (ed), Paris, 1974.

22 Arquivo Distrital de Évora (henceforth ADE), *Livro I dos Originais*, nº 71, fl. 251. Cf. Humberto Baquero Moreno, *Exilados, Marginais e Contestatários na Sociedade Portuguesa Medieval* (Lisboa, 1990), pp. 59–60 and pp. 66–67.

23 The utopia of the questionnaire foresaw that his responsible tried to assure the truth of the poor statements by asking those who were from the same area.

the robust and the non-authorized beggars, the usual treatment was punishment by permanent expulsion from the city and whipping[24].

It is never too much, however, to detach that such a direct intervention of the Crown in the configuration of the concept of the deserving poor reflected and answered the fears of the populations, to its beliefs and suspicions, namely in relation to the foreigners, invaders of their daily lives. One of the particularities of these diplomas is the fact that they not only reflect the feelings and the attitudes of the dominant groups, but of the common people that make their voices heard in Courts and in this sense it is not an exaggeration to affirm that the legislation seems to reply to very specific social situations, not fiction, as many others, ideal realities that the legislator intended to implement. By doing so, they restricted, as it was seen, the access of some groups to the poor relief, at least to the institutionalized one. An element that would not suffer any alterations during the period analysed. If some changes occurred these were at the "ashamed poverty" level, whose social composition could vary according to the conjunctures. This means that when we analyze, in the long term perspective, the beneficiaries of the hospitals, conservatories or poor home relief, we do not find, except in very rare cases, any relevant social changes among the receptors. On the contrary, the conditions that allow, for example, those without work and the sick people to benefit from the home assistance, and, above all, the migrant workers, to the care of the hospitals, the young women and the widowers to profit from the subventions granted for the different institutions, remained. The decline of "the loose" charity in detriment of the direct donations for the institutions, reinforced after Trento, could have strengthened this trend without completely modifying it[25]. Although other identical interventions in order to forbid and delimit beggary are known for different parts of Europe at the same time[26], most of them came from the municipal authorities and were, therefore, circumscribed to specific geographical areas, although the English Statute of Labourers, from 1349, also had the aim of bonding labourers to the land.

By the beginning of the 16th century, when the Portuguese Crown created a nationwide network of brotherhoods, the so-called Misericórdias, aiming to harmonize the charitable and assistance practices, covering a large universe of poor, did not have any repercussions in the way the central power understood the concept of the "deserving poor". In other words, the widening of the "system" did not make it socially more inclusive. Beggars, vagabonds and the idle, not only continued, at least theoretically, excluded from the institutionalized poor relief organized by the Crown, as they also became a target of more repressive legislative measures.

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24 ADE, *Livro IV dos Originais*, nº 74, fls. 87–88v.

25 Ângela Barreto Xavier, "Amores e desamores pelos pobres", in *Lusitania Sacra,* 2ª série, 11, 1999, p. 63.

26 Such as Nuremberg and Ypres, for instance.

The panorama was common to the generality of Europe that, since 1520, went through an increase of repression and control exerted on the *delinquents* as well as a more active interference in the areas of the poor relief and health care. Related to the first case, the list traditionally presented – Nuremberg, 1522; Strasbourg and Leisning, 1523–24; Zurich, Mons and Ypres, 1525; Venice, 1527–28; Lyon, Rouen, Geneva, between 1531 and 1535; Paris, Madrid, Toledo and London, 1540, apart from the laws that emanated from the central power in the Netherlands, in 1531, England also in 1531 and in 1536; Brandenburg and Castile in 1540, France in 1536 and 1566 – was only incorrect by having omitted the Portuguese experience and it had, as was seen, deep roots in the medieval Law of the Sesmarias, even though touched by the Christian humanism of Erasmus and Juan Luis Vives. In fact, the charitable and social Portuguese politics defined in the first half of the 16th century equally congregates the three elements that Paul Slack, summarizing M. Todd[27], identifies as the base of the thought and the humanist attitudes in relation to the poor relief: the Christian charity, the moral reform and the protagonist character of the public authorities' intervention in these areas[28]. The first one, based on the principle of the obligation of the wealthy in relation to the poor – now with other purposes, not only the soul salvation or the moral and social advantage of the donators – was spread in the Regiment of the Misericórdias, confraternities which were more devoted to the "public service" rather than to the brothers' self-help. The moral reform, so important for this humanism, and with it the defence of the work as structuring value of the society, comes to the Portuguese 16th century through the Law of the Sesmarias, that continues in force, then developed in unrealizable plans of action that identify and enumerate occupations for the handicapped[29]. The leading of these politics by the public authorities, the last of the three elements mentioned by Todd, was, as demonstrated, an old characteristic of the whole process, reinforced then by the new capacities that the central powers had of carrying out their social politics. Enough reasons, although there were still any doubts, to place the reforms done in Portugal by the ones carried through in Germany, France and England[30].

The reasons for such an "intervention", in Portugal as everywhere, have to be found in the economic crisis that Europe was going through but also in the emergent political power expressions: the ones of the Early Modern State, trying to be more efficient and more present than ever. Vagrancy did not facilitate the control

27 M. Todd, *Christian Humanism and the Puritan Social Order*, Cambridge, 1987.

28 Paul Slack, *The English poor law,* pp. 6–7.

29 The emphasis on the handicapped is a substantial difference in relation to the English laws promulgated at that time. Cf. Paul Slack, *The English poor law, 1531–1782*, p. 9.

30 We claim for Portugal the same "statute" that Paul Slack demanded for England when he comparatively analysed the English case with the ones of France and Germany. Cf. Paul Slack, Paul Slack, *Poverty and Policy in Tudor rand Stuart England*, p. 23, p. 116, pp. 119–121.

neither of space nor of people and were a threat for cities and villages. With no fixed residence, there were no men to fight or to pay taxes. And the royal authority, which had already imposed the military and tributary measures with difficulty to the stable population, was more hindered by the wanderers.

After the letter of D. Manuel I of 1520, two diplomas emanating from D. João III government need to be highlighted: one from 1538 and another one from 1544. In both cases the effectiveness in the application of the laws, especially in relation to the city of Lisbon, was the central question. Continuing the Law of the Sesmarias, the law of 1538 severely penalizes idleness.

The decisions concerning beggars promulgated by D. João III in 1538 – the King who was responsible for the first general account of the Portuguese population (*Numeramento de 1527*) – were not so different from those listed in the Law of the Sesmarias, but they were more rigorous in order to make them more effective[31]. Thus, they were followed by an increase in the punitive powers of the royal police, especially in Lisbon[32], where a crowd of Portuguese and foreign vagrants remained, refusing to work and "becoming thieves and getting into other bad habits", even if the latter were forbidden to enter the kingdom[33].

The penalties assigned for the impostors were clear: if the beggar was a slave and begged with the consent of his owner, this one lost his right of property that would pass to whoever denounced the situation. If he acted without the proprietor's agreement, the beggar would be publicly beaten. In the case of a free man who dissimulated illness, he should serve the denouncer for five years, only having the right to be fed and clothed. Finally, his owner could negotiate the beggar as he pleased[34]. In short, a very violent law if compared with the 1547 English one, at least in terms of time once it imposed two years of slavery to the vagabonds. Not in terms of penalties as the English 30's laws already imposed measures of mutilation for those who offended for a second or third time[35].

Still more daring and complete – a probable evidence that the previous document would not have produced the desired effect – would be the law of the 4th

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31 Duarte Nunes do Lião, *Leis Extravagantes e Reportório das Ordenações* (Lisboa, 1987), pp. 154–155.

32 Idem, *ibidem,* p. 32. (Also, Eduardo Freire de Oliveira, *Elementos para a História do Município de Lisboa,* tome I (Lisboa, 1889), pp. 545–546).

33 Duarte Nunes do Lião, *op. cit.,* p. 155. The same law that gave foreigners 20 days in order to leave the place in which they had been caught and 30 days to leave the kingdom.

34 Less strict was the law for the sick owners, only forced to pay 5 000 reais to those who found them begging. Cf. Duarte Nunes do Lião, *op. cit.,* 4th part, title XIII, law 1, pp. 154v.–155.

35 In England the law was not efficient and probably the same occurred in Portugal. Cf. Paul Slack, *The English poor law, 1531–1782*, p. 10). A detailed analyses of this law can be found in C. S. L. Davies, "Slavery and protector Somerset; The Vagrancy Act of 1547", in *The Economic History Review,* New Series, vol. 19, nº 3 (1966), pp. 533–549.

November of 1544[36]. Four years after the cardinal Tavera, in Castile, had promulgated the law that recuperated the restrictive legislation of D. João I (1387), adapting it to the circumstances of the time, the Portuguese monarch congregated some disperse laws creating a sort of "Regiment of the Beggars", later identified by D. Sebastião as the "Law of the vagrants". It started being applied in the places where the King was but in 1558 it was extended to the whole country. Summarizing a very long document, its content can be organized in two great lines of intervention. The first one dedicated to the punishment and another one that identifies the parameters to be respected in the concession of begging licenses.

Punishment appears in a cumulative hierarchy and is described in a clear and simple way: when offenders were arrested for the first time, they should be imprisoned, publicly flogged and expelled from the place where they had been caught. The second time, they would be expelled from the kingdom. The third time, Brazil would be their destiny for a period of 10 years. The loss of personal belongings, if they had any, as well as imprisonment and flogging were inherent to each of those punishments.

A little more complex was the process leading to the issuing of authorisations to beg. The model was still the medieval one developing two rather old and interdependent topics: the restriction of the number of beggars, even in the case of the physically handicapped poor, and the incentive to the self-supportiveness by means of work.

Those who had any properties or a trade, even if ill or lame – including the blind – were automatically excluded from getting licenses. All the other cases should be analysed one by one. And the indications were clear: those who had problems with their feet would be taught the trade of goldsmith, shoemaker or the like. Those whose handicap affected their hands would have to try a way of life with religious institutions. The blind would have to be taught the trade of "smiths or blacksmiths, in order to work the bellows". Within this context of restrictions, the poor who had curable diseases – therefore temporarily handicapped – should be sent to hospital and not allowed to expose their disability. To sum up, the main objective was to seek for any compatible activity for every potential beggary, involving the authorities in charge of setting them on the right track. To fight against idleness and the evil it might cause, was a priority and the pedagogy of the work, already found in the Law of the Sesmarias, and afterwards defended by Jean Luis Vives and Cristóbal Herrera many years later, is clearly stated here, but the social awareness was also extended to the children. The beggars were now only allowed to move about accompanied by their own siblings (except in the case of the blind) but only until they were 9 years old. In the other situations, they had to hand over the children to

36 Duarte Nunes do Lião, *op. cit.,* law 3, pp. 155–157, (decree of the 4th of November of 1544).

the partner who did not have a license to beg (which presupposed that there were no couples among the beggars), under the threat of losing them. Finally, all licenses to beg lasted only a year, and after that period each situation was re-evaluated. To the restricted group of those authorized to beg, the license would only be granted after presenting a certificate guaranteeing that they had confessed. Not being familiar with the Our-Father and the Creed were conditions for the refusal of new licenses. The high degree of bureaucratization and control of the process still demanded the existence of a specific writing – already foreseen in the diploma of 1520 – that registered all the data that identified the beggar: name, age, dwelling, birthplace, disease or cause that could justify the license. It must be mentioned, however, that in no circumstance would it be possible to grant licenses to foreigners, even in the case of obvious necessity or "acceptable" justification. A usual procedure at the time, that Cordova, like other Castilian cities, had already been practising since the 1520s [37].

Really important was the fact that the diffusion of the information was made through the beggars – ten or twelve would be called making them responsible for spreading it – and the strong incentive to the population to denounce everybody that did not fulfill the rules established in the law. Nevertheless, not only restrictions were registered in the diploma of 1544: the brotherhood of the court, in charge of the implementation of these measures, would have to provide installations – illuminated and warm – where the authorized beggars could spend the night, if they so wished.

The search for the efficiency of the mentioned measures was followed by the reinforcement of the policy action of the regal officers, above all in relation to the capital, where to the Portuguese loafers joined the foreigners, including gypsies[38], except in the cases where they had a skill and wanted to make use of it[39]. Less than three months later, a new regal order obliged an inspection every six months to "the loafers without work" that were roaming in Lisbon, arresting and proceeding against them according to the Ordinances[40]. Once again, the monarch acted, as stated by the diploma, answering the request of the people, in this case the ones represented in the courts of Almeirim of 1544, that inclusively suggested an immediate banishment of the transgressors to Brazil[41].

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37 Linda Martz, *op. cit.,* pp. 14–15.

38 Duarte Nunes do Lião, *op. cit*, 4th part, title XIII, lei II, p. 155, (law 24 from the Courts of 1538).

39 In 1563, the 14th of August decree defined foreigners: anyone who looked like, dressed and spoke like an Armenian, Greek, Arabian, Persian or any other nation under Turkey. (Idem, *Ibidem,* law V, p. 158v).

40 Idem, *Ibidem,* 1st part, title X, law III, p. 32, (decree of the 1st of February of 1545).

41 Eduardo Freire de Oliveira, *op. cit.*, tome I, p. 546, note 1.

Whether through regal initiative or through the pressure of the populations, it was certain that more and more was demanded of the judicial officials, whose repressive competencies were gradually widened[42]. In 1544 the central government recuperated the Law of the Sesmarias' idea that foresaw the existence of a net of employees and informers who (now) had to watch the quarters, each of the beggars and all the places that could receive vagrants and foreigners[43].

The social pressure that the big cities, and specifically Lisbon, suffered with the migratory waves that arrived in crisis conjunctures justified, in part, the aggravation of the overwhelming measures against "the beggars and the vagabonds". According to the regal letter of the 30th of March of 1546, the young men from Beira and Alentejo flocked to the capital, refusing to work, wandering meaningless, ending up, very often in jail, burdening the confraternity of Misericórdia with feeding and release expenses[44].

So, as the Law of the Sesmarias had been the source for the social politics developed in the following two hundred years, this "Beggars' Law" would be the guide for the future. Neither the philosophy nor the principles would be changed. In fact, from the late Medieval Ages until the end of the 18th century the discourse of the laws only introduced a few alterations accompanying the social and economic evolution. In the 14th century as in the 18th century, beggary, vagrancy and crime were synonyms, both for political powers and for society in general. It can be said that the repetition of the same laws, year after year, proves its inefficiency, but it also testifies the permanency of the values considered to be the basis for the good functioning of society, such as work, for instance. When we analyse the 1544 law and the tasks proposed for the handicapped, this is quite obvious. The main question was to maintain people occupied with a job and to assure that everybody had an "honest" way of earning his/her life.

The same happened with the condemnation of the nomadic life. Since the old Law of the Sesmarias the monarchy dreamt of a system to gather the information in order to promptly act in the case of those who refused to work, opting for begging and vagrancy. In the Early Modern Period this control was based on a network of officers and informers that, in the different districts, watched people and the houses that might shelter the wanderers, the prostitutes and the non working foreigners, the latter, more and more controlled by the authorities[45]. If the defence of public health and public order was the main argument used, the persecution of the vagrants was the way found to deal with the problem. Neighbourhood dilation,

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42 Idem, *Ibidem,* pp. 545–546, (30th of Março of 1546). (Also Duarte Nunes do Lião, *op. cit.,* 4th part, title XIII, law IV, p. 157–158v, (letter of the 6th of November of 1558).

43 Eduardo Freire de Oliveira, *op. cit.*, tome III, pp. 69–70.

44 Idem, *ibidem*, tome I, pp. 545–546.

45 Idem, *ibidem*, tome III, pp. 69–70. See also the law of the 9th of March of 1641 in *Collecção chronológica da legislação portugueza*, 1845–1859, p. 76.

urban militias and the rise of the salaries of the people involved in the execution of these laws – such as the prison guards – became the strategic factors of the whole system.

The Romany Question

It was in this specific social-economic context that the crown politics related with the Roma were developed. It is not possible to ascertain the exact date of the arrival of the gypsies in Western Europe, but it is more than probable that it might have taken place early in the 15th century, spreading all over Europe since 1417[46]. From the beginning of the following century, there was an increase in the number of laws exiling and condemning them to the galleys. These documents have provided grounds for the thesis that they were subjected to ethnic oppression as soon as they stepped on European soil. The long tradition of social marginalization against the Jews and the Moorish justifies the studies that viewed the persecution of gypsies as the result of a new movement of intolerance. However, these studies have forgotten to take the context into account, namely, its historical framework: in this case the one of a Europe involved in violent fights against the nomadic life that the official discourses named as vagabondage and vagrancy. Portugal, like Spain, France or England, only to refer some examples[47], was legislating since the 14th century against the false beggars, people who refused to work even if they could, preferring idleness and the absence of social obligations. Living as vagrants, the gypsies were punished as such. The social stigmatization against the lifestyle that characterized them was already constructed when they arrived in Europe. What happened then was, therefore, a process of aggregation and not of construction of a new concept[48].

In the case of Portugal, what is relevant is the briskness of how the political discourse considered first gypsies as a new group of vagrants and then as a sort of reference of a specific lifestyle and as a specific cultural feature. The absence of specific punishments promulgated for the gypsies should be highlighted. In fact, the same ones imposed on false beggars and idle people were applied to them. The sentence

46 According to Bernard Leblon, "Les Gitans dans la Péninsule Ibérique", IN *Études Tsiganes. Bulletin de l'Assiciation des Etudes Tsiganes*, 10e annee, nºs 1 et 2, Mars-Juin, 1964, pp. 1–24 e nº 3, Octobre, 1964, pp. 1–28. See also, Angus Fraser, 1992. Quoted by Karina Bates, "A brief history of the Roma", SCA Home Page.

47 H. T. Crofton, "Early Annals of the Gypsies in England", in *Journal of the Gypsy Lore Society*, 1, 1888/89 and F. de Vaux de Foletier, *Les Tsiganes dans l'ancienne France,* 1961.

48 Take out the laws from their context, or extract from a general law against beggars and vagabonds only the orientations related to the gypsies and refer those laws as if they were specific of the gypsies, as suggested Bernard Leblon (Idem, *Ibidem*, nºs 1 et 2), creates another reality that doesn't exactly correspond to the historic reality.

used in the laws enlarging the population of vagrants to "those who live like gypsies", shows that they are seen as the archetypal unacceptable lifestyle. It was assumed that the vagrants' way of life was as an intrinsic characteristic of the gypsies and it signifies the rejection of the principles that the society had identified as essential elements for its functioning: a settling place for the family in the countryside or in a city. The radicalization of the official discourse – not of the severity of the punishment – would occur when the authorities understood that the gypsies' way of life was not a transitory state of foreign newcomers but a long lasting one. From then on the exiles were justified with the purpose of the group extinction.

What is the more detailed analysis of this history? Having probably entered Portugal during the last decades of the 15th century, the first literary[49] and legislative references of gypsies appeared in the 1520s. During the early modern period, the relationship between the Portuguese society and authorities with this group of newcomers can be divided in three different periods.

The first one coincides, roughly, with the reign of João III (1521–1557). It was the beginning of the process and it is quiet obvious that the question of the gypsies did not detach itself from the problem of false beggars and vagrants. The first decree known, from the 13th of March 1526[50], forbidding the entrance of gypsies into the kingdom and ordering those who already lived there to leave, is justified by the monarch's need to guarantee public order. This is the same argument used in the laws that were promulgated against idle people and foreigners in general. Of the population complaints against gypsies, only the reference to "so many spells that they pretend to know, which cause people so much loss and trouble"[51] stands out from those received by the King against the vagrants since the 14th century. The proceeding law, issued in 1538, which preceded and laid the grounds for the aforementioned "Beggars Law", didn't alter the root of the question in spite of the specification that it concerned both false beggars and gypsies, and also for "other people from any other nation wandering about or living like gypsies"[52]. But, although in a subtle way, it shows that the legislator had recognised nomadic life as the typical way of life of the gypsies, and to this, the common people had long ago associated an ensemble of activities that they considered perverted the order of their everyday life. From that moment on, all the mandates condemning wandering and idleness would equally have as a target "those that lived like gypsies".

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49 Gil Vicente, *Farsa das Ciganas*, 1521 or 1525.

50 The non identification of the sources where Bernard Leblon gathered the information does not allow us to confirm several of the laws referred. For example, when he mentions that «A la suite d'une intervention des Cortés, Jean III décrète l'expulsion des Gitans» (*op. cit.*, p. 15), it is probable that he is implying only to a discussion occurred in the Courts and not to a law that is from the following year.

51 Joel Serrão, *op. cit.,* vol. II, p. 69.

52 Duarte Nunes do Lião, *op. cit.,* p. 155.

During the second phase – which basically extends throughout the second half of the 16th century – it is the religious side of the question that stands out, though the aforementioned assumptions do not change. The main point was then the expansion of the Ottoman Empire, trying to conquer Europe under the orders of Suleiman, the Magnificent. Around the Pope, the Holy League intended to combat the "unfaithful" and Spain became the protagonist in the fight against Islam. In 1571, the Battle of Lepante, was considered the most important victory of Christianity ever since the conquest of Granada, back in 1492.

Thus, it is easy to understand why the law issued on the 14th of August 1563, condemning false beggary and idleness, specified that anyone coming from Armenia, Greece, Arabia, Persia "or other nations under Turkish rule" would not be authorised to enter the kingdom[53]. To these, the one from 1604 would include "the Moorish from Granada". A detail that can reflect the Spanish kings' apprehension (by that time also kings of Portugal) before the possibility of a Moorish insurrection synchronized with a Turkish invasion, in the sequence of the rebellion against the Christians of Granada (1565).

In both diplomas, 1563 and 1604, the gypsies were present. Besides this, Pope Pius V, in his bull of 1568, had banned them from the lands of the Catholic Church. Coming from the lands under Turkish rule, gypsies were now considered a potential religious problem. The deportation of gypsies to the colonies ordered by Spain, France and Portugal at that time must be situated in the context of the crusade against Islam that threatened the Mediterranean. Yet, the religious situation did not overshadow the social question: the reference to the *Portuguese* beggars that lived like gypsies in the above documents shows that roving and the associated lifestyle continued to be a central concern. Further, because the situation of economic depression, increased by successive outbreaks of the plague since 1570, raised the fear of the population, who felt more and more fragile. In this sense, the 28th of August 1592 law, that gives the gypsies four months to leave Portugal or settle down in one place, banning them from living in groups or clans, under penalty of death, is already the prelude of the last phase previously referred to. Even though the religious reasons did not lose importance, they were not suggested any more after that. In the future, the law, as well as the population, would be divided into periods of violent repression against gypsies and of their social integration. The scene was of the hardening of the laws against the vagrants and beggars, when the settlement of people became almost a legislative obsession. One after the other, the diplomas repeated that those who wandered about without work, gypsies or not, could not do it for more than twenty days and even beggars with licences were only authorized to beg in their places of origin or areas of residence, not exceeding twenty leagues. Wanting to leave, they would have to be submitted to the

53 Idem, *ibidem*, p. 158v.

municipal inspection. The identification of the companions of the blind or crippled continued to be obligatory, the law determining that that function could only be done by people of the same sex, opening an exception for the women, authorized to have the company of their children, as long as they were not older than fourteen.

It was not only the restriction to the beggary that became more pressed but also the penalties became more deterrent: those who were caught infringing the law for the first time would be beaten and banished for one year from the place where they were begging. The second time, apart from being whipped, they would be banished for one year to Africa. The third time they were banished to Brazil for 5 years. In the case of the foreigners, they had 20 days since the publication of the regal diploma to abandon the place where they were captured, and should leave the kingdom within 30 days. If they were caught again they would suffer the penalties foreseen for the natives, except if they had a profession and wanted to exercise it – a common determination in this type of legislation.

Meanwhile the measures of policing the spaces and the populations multiplied somewhat all over the country. The justices were ordered to inspect the inns and hospitals every fortnight, checking if the above mentioned people were lodged there. If so, their arrest could be done only based on oral testimonies certifying that they were begging or roaming[54]. The objective was, obviously, the simplification of administrative and judicial procedures so that the processes could run quicker.

New data to consider in this context is the intervention of the local powers, precisely since the conjuncture of crisis of the end of the 16th century, trying to find some balance between the general guidelines emanated from the crown and the need to face specific social situations. It does not mean that the local authorities were more sensible and tolerant with beggars and vagabonds. But it is quiet clear that the perceptions of the acute crises could push people to beggary that otherwise would not be there and it was in this direction that some authorities acted while the crown strengthened its repressive politics, as it occurred, for example, in the 1604 diploma.

Entitled *On the poor that are begging* (*Sobre os pobres que ande pedir* [55]), the text starts as almost all those that had preceded it: although the Ordinances determine the procedures to follow against those who begged without the respective licenses, their number was increasing without any control[56]. The conjuncture imposed even more efficient and restrictive measures. The total prohibition of the beggary without license was reaffirmed but its control was taken from the local authorities. The

54 Duarte Nunes do Lião, *op. cit.,* 4th part, title XIII, law IV, pp. 157–158v, (letter of the 6th of November of 1558).

55 Biblioteca Pública de Évora, cod. CXIX/1–13, fls.64–65v.

56 For Portugal there isn't a list organized for the English 16th century as the one presented by A. L. Beier in "Vagrants and the Social Order in Elizabethan England", in *Past and Present,* nr. 64 (Aug. 1974), pp. 3–29.

central government officials, or the landlord ones, would be responsible for the examination of the candidates for a beggary license. The poor should previously be informed of the day and place for the public exam. Only the blind, the crippled and the old, unable to work, could receive permission to beg, but restricted to six months and only to be used in the places where they were granted. After this time, the certificate could be renewed, after an evaluation of each case. Whoever did not have the license eight days after the announcement of the public examination and continued begging would be imprisoned. The punishment, based on a short proceeding, followed all the common procedures, but for the first time severe punishments were foreseen for the authorities that did not correctly abide with their professional obligations.

Summarizing, at the beginning of the 17th century the Crown took on the competency to control beggary and the licences attribution again, as it was foreseen in the Law of the Sesmarias; the licences' validity time was reduced from one year to six months and, finally, the non efficient justice officers were penalized. Once again the chronological coincidence between the English law of 1598 and the Portuguese one from 1604 must be highlighted. Neither religion nor the distance caused any difference in terms of objectives and procedures. Only the option for the coordination of the processes, in Portugal under the control of the central power, introduced a dissonant note[57].

Abreast with these alterations, the ongoing justice reform redistributed, in Lisbon, the monitoring of the quarters for a better control of undesirables, among them, beggars. Point 13 of the new regulation specified that judges should be aware of who begged in their area of control, proceeding against them if they did not have a license respecting the orientations of the diploma of the 9th of January of 1604[58]. They should also inspect the ones that begged for the Church, certifying if they had the necessary authorizations, but also their way of life, if they had a skill and did not use it because they preferred to beg, and if they used the alms collected for their own benefit. But also not neglecting the control and visits to "gambling houses and other parts where vagrants used to be", arresting the transgressors and banishing them to India[59].

Reinforcement of policing and control, obviously, also reached the gypsies. However, when analyzed in detail, the diplomas that in this conjuncture had been promulgated do not differ substantially from the ones that the Regiment of the Beggars stipulates, in 1544, for those who insisted on begging without a license. What makes the two social situations different now (beggars and idle people "who

57 Paul Slack, *The English poor law, 1531–1782,* pp. 52–53.

58 *Collecção Chronologica de Leis Extravagantes posteriores á nova compilação do reino das Ordenações do Reino, publicadas em 1603*, tome I (Coimbra, 1819), pp. 87–100.

59 Except if they were skilled mechanics, once they should stay in the kingdom. Cf. José Justino de Andrade e Silva, *op. cit*, 1640–1647, p. 76.

lived like gypsies" and the gypsies themselves) – is the fact that the authorities assumed that the latter had very tight solidarities, able to protect them and, consequently, that they should be more controlled. Control that had to be extended to some royal officials, who used to provide them with false residence permits, allowing them to stay in the country even though they lacked a stable address[60].

Recognizing that the previous punishments had been insufficient to make them leave Portugal or to change their way of life, the law issued in 1606 wanted to make the expulsion effective immediately after the first imprisonment, increasing the number of years they should be kept out of Portugal on an increasing basis after each detention: from three years for the first time to six years if the person was arrested for the second time, and ten years the third time. The monarch appealed for the quick intervention of justice because, as he wrote, it was necessary "for the welfare and tranquillity of my vassals and my kingdom". Yet, only approximately eight years later, did he order the cancellation of residence permits for gypsies.

This was, in fact, a rather controversial situation that the monarchy seemed to manage without following a specific line of conduct, or, at least, seeming it wanted to integrate the gypsies, whereas they systematically rejected it as they did not accept the constraints it imposed on their mobility and actions. In this regard, we should bear in mind that the aforementioned law of 1594 that condemned them to death also gave them four months to settle down in a stable residence. A threat that did not seem to obtain any results, as attested in a royal letter dated the 28th of March 1618 that orders the authorities to take a census of the gypsies who moved about the kingdom "in different attire and speaking differently from nationals". Once again, the gypsies proved to have been strong enough to face the authorities, and it would not be the last time.

Another proof that the question of gypsies was far from being reduced to an ethnic matter can be found in the last Spanish mandate, when the reigning princess claims that "being a gypsy does not consist in the birth, but in living like one". The convicted that filled the galleys that were anchored in the river Tagus in 1639, after a fast court trial in order to facilitate their shipment, were in fact gypsies but also those who lived like them[61]. The uncontrolled mobility and the refusal to work were still the greatest hindrances to social integration and the main complaints presented by the communities.

It is not possible to know how many people were sent to exile in 1639 and how many of them were gypsies[62]. Documents of 1647 refer to the relatively-recent general persecution of "vagrants called gypsies that move about in clans, living off rob-

60 *Collecção Chronologica de Leis Extravagantes posteriores á nova compilação do reino das Ordenações, cit*, tome I, pp. 62–64, entitled *Alvará em que se accrescentarão as penas contra os ciganos que forem achados neste reino*.

61 *Collecção chronológica da legislação portugueza*, p. 193.

62 Idem, *ibidem*, pp. 332–333.

bery, deceit and lies". Although this document mentions, for the first time, that the objective was to do away with "idle people, who did not have a stable residence, a house of their own or a job", it equally informs that ten gypsy families were kept in one of the Lisbon prisons because their chiefs were considered to be too "old and unable" to make such long travels. The conditions that were imposed on them in order to allow their stay were not different from those imposed on other minorities before, and had already been repeated manifold: settling down in a place, in this case, in the centre of the country[63]; find a job and abandon the features that identified their ethnic background – language, attire, sorcery, animal commerce and, as documents added, "their manners and lies". The innovation of the 1647 law was related to gypsy children who had to be handed over to the institutions in charge of the upbringing of the abandoned children at the age of 9. That is to say, the *Misericórdias* and the orphan colleges: institutions that prepared – or should prepare – the children for the working market, instilling the basic values of Christianity in them. For the first time in the case of the gypsies the law assumed pedagogy as a form of repression and integration[64]. Thus, once more, they were considered at the same level as the beggars that dragged their children about with them illegally, contravening the specifications of the law issued in 1544[65].

The social and even the political aims that such measures intended to bring about are easy to understand. Especially, if we take into account the context where they were placed: a country that was going through a crisis after the restoration of its independence, under an atmosphere of social distress as a result of economic difficulties, worsened by the increase of taxes – so criticised during the Spanish rule and that explains, for example, the decisions taken in Court, in 1654, when people complained about gypsies "and other mobs of nationals that used to hang around with them", impelling the King to allow house raids in order to identify those who lacked residence permits. This time, as before, the plaintiffs received an affirmative answer from the political power: "because what they propose is provided for by the general law, being utterly fair and convenient"[66]. Some of the gypsies caught during these actions were expelled to Cabo Verde, S. Tomé, Cabinda, Quicombo, Mossamedes and Maranhão, in 1686[67], or to Baía, in 1718[68].

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63 *Collecção chronológica da legislação portugueza*, diploma from the 21st of October of 1647.

64 From this diploma on, this determination would be repeated in all the following ones.

65 *Collecção chronológica da legislação portugueza*, p. 11.

66 According to a report handed over to the people of Pombal (*Collecção chronológica da legislação portugueza*, pp. 219–222).

67 *Collecção Chronologica de Leis Extravagantes posteriores á nova compilação do reino das Ordenações do Reino, publicadas em 1603*, tome II (Coimbra, 1819), pp. 364–366, 10th of November of 1708.

68 Like Spain and France did more or less at the same time.

The restlessness that Portugal was facing generated a growth in violence of state officials. Reformed in the first decades of the 17th century, the judicial system multiplied the number of police agents and increased their power. The recurrent references to the saturation of prisons and the need to accelerate judgements to facilitate the expulsion of the criminals are, among others, good indicators of the *efficiency* of the measures taken.

Social "normalization" was, in this context, a priority for the authorities. Those who wanted to be part of society but without losing their autonomy had, obviously, very little room, but this did not mean that the State did not use the minorities, in this case the gypsies, guaranteeing them protection whenever convenient for its interests. The evidences of this behaviour are multiple. For example, "more than two hundred and fifty gypsies", that were "defending", according to the documents, the borders with Spain after 1640[69]. They were probably more like informants rather than soldiers, but still serving the King. The same reason, presumably, that justified the order sent by the monarch to the Évora municipality, in 1699, forcing it to accept several gypsy families that were moving from Lisbon – due to the high cost of living, as they complained. Acting in this way, not only did the monarch contradict the decisions of the local power – forbidding gypsies in the city – as he advised the authorities that the gypsies should not be molested, instead, the rights that he, the King, "used to bestow on them"[70], had to be respected. Not far from Évora, in Elvas – a Portuguese city at the Spanish border – the population complained that every time there was a new repressive wave in Spain it was invaded by hoards of gypsies[71].

To sum up, when analysed in a long term perspective, the relationship of the Portuguese society and the political powers with the gypsies ran under this contradiction and apparent conflict of interest. The latter, territorializing, momentarily, the places they went through, reproducing and perpetuating their lifestyle, showing that their social memory was deeply rooted being able to resist the values that were not theirs. For instance, values concerning work and sedentary habits that the authorities and the main part of society considered to be structural elements of public tranquillity and social stability[72]. The authorities proclaiming the conditions for the social assimilation of gypsies: "they should not use their attire and their language; not occupy more than two houses in each street; not walk together in the streets; not camp next to the roads or in the fields; not sell, buy or exchange ani-

69 *Collecção Chronologica de Leis Extravagantes posteriores á nova compilação do reino das Ordenações do Reino, publicadas em 1603*, tome I, I, pp. 524–526.

70 Arquivo Distrital de Évora, letter from the 30th of July of 1699.

71 Bernard Leblon mentions several riots of the populations and an intensive municipal legislative activity against the gypsies that were arriving in the city.

72 *Collecção chronológica da legislação portugueza*, 1845–1859, pp. 26–27.

mals; instead they should assimilate the customs of the country and leave aside their own customs".

All the historical evidence presented here prove that the gypsy question is, also, a cultural question, the reason why we second Daniel Chirot's opinion[73] : the States did not create the category of "gypsy". On the contrary, the gypsies appeared in Europe when the political authorities were developing strict measures against wandering and vagrancy. Living like idle people, they were punished as such. Expecting society to accept the difference, differentiating between born nationals who refused to obey the rules and live according to the established values, and the newcomers whose lifestyle consisted of permanent wandering, is an anachronistic exercise of little historical rigour. In a society where false beggars were flogged and expelled to the colonies, taking away their children; where robbers' hands were cut off; where prisoners were branded in order to identify them as criminals more easily, to defend that the violence against gypsies was, from the beginning, a result of ethnic persecution does not have historical support. The victimization discourse should not be applied for the period under analysis. Statements such as the one by C. R. Boxer, blaming king João V (1700–1750) for his "obsessive hatred" against gypsies[74], or that "it was in this particular respect that the trans-Atlantic shipment of the Africans differed from that of the gypsies: the former were transported for economic reasons; the latter, for reasons of hate[75]", imply a rather misunderstanding of the Early Modern period.

Final Considerations

What is surprising in the analysis of the legislation against beggary and vagrancy, Romany or not, is the almost silence of the 18th century. Only interrupted in the context of the 1755 Earthquake, by the diploma of the 4th of November, that restrained and condemned the vagabonds and beggars who could work, and later, by the General Intendancy of the Policy, created on the 25th of June of 1760, with competencies for the repression of the same groups and for the concession of begging licenses. However, neither in one case nor the other are there novelties to be

73 Presented in the review of the book of Chirot, Daniel "Gypsies and Other Itinerant Groups: A Socio-Historical Approach", in *Journal of Interdisciplinary History* – Volume 30, Number 2, 1999, pp. 306–308.

74 C. R. Boxer, *O império colonial português (1415–1825)* (Lisboa, 1981), p. 299.

75 Cf. Ian F. Hancock, The Pariah Syndrome: An account of Gypsy slavery and persecution, Download the full text of the web version of *The Pariah Syndrome*, cap. VII. Treatment Elsewhere in Europe: Spain, Portugal and France http://www.geocities.com/Paris/5121/pariah-ch7.htm.

registered[76]. How do we explain this situation? More tolerance from the authorities, precisely when in countries like France more repressive mechanisms of control were created[77]? More condescension of the populations, conscientious, also, of their own vulnerability?

When the crown opted to control the whole legislative process of repression of beggary and vagrancy, excluding these groups from the institutional support, it revealed, probably, too confident in its capacities, the officials that could spread and execute its orders were scarce. On the other hand, when it tried to uniform the charity and the assistance practices, the crown forgot the local specificities and priorities, namely in terms of the management of the available resources. It does not mean, however, that the laws were unknown or that they did not produce any effect. The (few) existing lists of poor that benefited from the Misericórdias' support do not include beggars, vagrants or gypsies and these are rarely found in the most open and less selective institutions of charity and assistance that existed in Portugal in the Early Modern Period: the hospitals. Could the hospitalized people defraud the authorities presenting false identities? No doubt about it. The most probable hypothesis is that a considerable number of beggars and vagabonds presented in the hospitals as workers, benefiting, thus, from the resources of institutions that should not shelter them, or, in other words, the social uses of the "system" and the permeability that characterized it cannot be forgotten. But vigilance existed and this explains, for example, the creation of alternative institutions to receive the poor that were not sick; in one way or another, the measures of social control had been spreading and had practical repercussions in terms of the people assisted in the institutions under the crown tutelage.

The silence of the Church in this process should also be highlighted, at least when compared with other European examples where identical measures created a climate of animosity and serious public discussions. The net of Misericórdias spread all over the country exerted, in fact, a charity based on the Christian principles but it was far from being a socially inclusive charity. Their prisoners, their poor, their sick, their ashamed poor, were, at least theoretically, citizens selected according to their moral positions, their work capacities and their real necessities. It is true that beggary was not completely forbidden but, in the laws, it was limited and subjected to a bureaucratic process of some complexity and one should be reminded that those laws were responsible for the raids that, in the 17th century, took place in the whole country, arresting and banishing the transgressors to the colonies. In contrast to what happened in Ypres and Castile in the 30s of the 16th century (and again in

76 Once again Bernard Leblon presents the laws that makes the gypsies work in the public works as if they were only made for them.

77 Olwen Hufton, Begging, vagrancy, vagabondage and the law: na aspect of the problem of poverty in Eighteenth century France», *European Studies Review*, 2, 1972, and from the same author, *The Poor of Eighteenth-Century France. 1750–1789* (Oxford, 1974), pp. 219–244.

Castile after 1565), Portugal did not register legislative retreats in this area. The principles that guided the practices of charity and of institutionalized assistance were the ones of Jean Luis Vives, Inácio de Loiola and, inclusively, of Lutero and other protestant reformers severely criticized by the Catholic Church and even if some theologians defended poverty and the compulsoriness of the alms, the ones that also defended a positive discrimination, according to age, work capacity and moral behaviour were in greater number. If the information concerning how the local authorities reacted to the central power orientations is scarce, it is not presumable that they have contested them: there is too much evidence showing them trying to escape from the expenses with the prisoners, foundlings and poor in general. Believing in the petitions presented in courts, the people's representatives had also not modified their attitudes towards the beggars. On the contrary, they were frequently requesting an aggravation of their criminal punishment. Before the law and the will of the citizens, the capacity of maneuver of the false poor did not seem to be too much. The reality could have, obviously, been different but not the one that appealed to the institutionalized charity. In fact, it is the perception of the limited quantitative expression that this type of assistance had that obliges a re-evaluation of the informal mechanisms of support, namely, the casual alms determined in the wills or the ones given at the entrances of the religious institutions, still of less documentary memories. *To give* continued to be one of the most important moral virtues, independently of how it was done and its social repercussions cannot be underestimated. As should also not be the competencies and the capacities of the Early Modern monarchs in terms of social discipline, poor relief, health and welfare politics. Even taking the social and political specificities where they were exerted into consideration.

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Social and Health Care Access for the Physically Disabled in 19th Century French-Speaking Switzerland: A Double Process of Exclusion and Integration

Mariama Kaba

During the 19th century, an unprecedented process of medicalisation and institutionalisation unfolded in Europe. At the beginning and at the end of the century, respectively, the medical upheavals of anatomoclinic and microbiology had a major influence on the organisation of hospitals and medical studies. Cantonal hospitals, rapidly linked to medical faculties, were created in Switzerland in the second half of the century, and by 1874, the first federal medical exams took place, implying a standardisation of requirements at a national level. The parallel development of urbanised and industrialised areas furthered the densification of a network of care institutions such as infirmaries and dispensaries, whilst medical tourism was developed among the upper classes stimulating the founding of new private clinics.

During that time, a more institutional kind of care structure for people with disabilities also emerged. This medical and/or social care structure was part of a process of integration or exclusion, according to whether the disabled person's state of health was likely to improve or, to the contrary, to become permanent. According to contemporary medical classification, there were numerous kinds of disability, ranging from the mechanical (amputees and cripples; those with fractures; the deformed, hump-backed, lame, ankylosed or paralyzed) to the sensorial (the blind, the deaf-and-dumb) and to curable or incurable diseases (scrofula, epilepsy, cancer). This paper will essentially focus on physically disabled persons, *i.e.* disabled workers, elderly invalids, the chronically or congenitally sick – all of whom were vaguely referred to as invalids or the "incurable" (in French: invalides, infirmes, incurables) in 19th century institutional documents. Being mainly interested in French-speaking Switzerland, I will present the access to social and health care in the cantons of Geneva, Vaud and Neuchâtel.

Poverty as a Factor in the Social Care of the Disabled

Looking at the history of the social and medical care of the disabled in the 19th century, one notices that this concerns first and foremost the history of the poorest social class. Rather, a disability only became visible in so far as it drove the person concerned to a state of such indigence that outside help became necessary. In addition to those without means, a large number of the physically disabled who became socially dependant belonged to the class just above the poverty-line. This mainly meant small-scale farmers, farm-workers, and artisans who, because they only just made a living from their work, were the most vulnerable in the event of an unforeseen accident. As of the second half of the century, this class was to grow to include urban workers and servants, as the process of urbanisation and industrialisation became a major factor in the emergence of new cases of disability among an ever-increasing population. Yet being handicapped did not automatically entitle anyone to aid: support was determined according to each person's circumstances. Not until late in the century did disability as such attract the attention already given to poverty by private philanthropy or public welfare.

In Geneva (legally) organized aid was provided by the General Hospital (or the Hospice). Set up in the 16th century by the city authorities, it was responsible for the administration of almost all charity for the sick and the poor. In the beginning of 19th century, when Geneva became a Swiss canton, the communes were also supposed to assist their poor but most of these did not receive enough and resorted to the General Hospital as well. Now this was more a welfare institution than a place for nursing the sick. For the disabled who applied there – along with the elderly or young orphans – the usual practice was “farming out”, that is to say, placing them as subsidized lodgers in some country household, while the General Hospital provided the necessary clothing and medical aid, and made official visits[1]. In the canton of Vaud, in 1850, the authorities founded the Cantonal Institution for elderly invalids and the “incurable”; the main activity of the institution was to place such people in private homes or care for them at home[2]. At the same time, there were around 500 sick poor in the canton of Neuchâtel, most of them with chronic diseases or mental deficiencies. Two-thirds of these were cared for by their own families and nearly 200 “farmed out” to live in miserable conditions[3]. In the town of Neuchâtel, a Committee for the Incurable financed the placing of such unfortunates in families as of 1854. One can see here how willing the authorities

1 Pierre Bertrand, "Les hôpitaux de Genève à travers les siècles", Centième anniversaire de l’Hôpital cantonal de Genève 1856–1956 (Genève, 1956), pp. 17–38; Rapports annuels et comptes rendus sur l’Hôpital, 1840–1850’s.

2 Victor Segond, La bienfaisance dans le canton de Vaud (Nyon, 1895), pp. 125–126.

3 Charles Thomann, *L’art de guérir au XIXe siècle en pays neuchâtelois* (La Chaux-de-Fonds, 1995), pp. 114–115.

were to remove the "unproductive" from urban centres already overcrowded with workers[4].

There is no doubt that in the first half of the 19th century such "farming out" was deemed preferable to building specialized institutions. This system saved the authorities the expense of building such facilities. Furthermore, contemporary society was against aid being made too easy, on account of the moral prejudice to both private charity and the family: the two mainstays of such health care in the 19th century. According to a then dominant liberal ideology, public responsibility for the disabled should not extend beyond the working-class poor, namely those who generally had no property or goods to bequeath and ought not to be left to themselves for fear that they might turn to begging or vagrancy, and become a real "public problem"[5]. It should however be noted that most of those who resorted to assistance were locals (droit de bourgeoisie) and thus entitled to aid. In the case of other, less stable populations (vagrants not belonging to any commune – "foreigners"), access to aid was always problematic and any financial help they did receive was usually next to nothing[4].

(Self-)Exclusion from Health Care Structures

As far as any medical care required by the disabled was concerned, this was in part delivered to in their own homes and, in the case of the most destitute, free of charge. They had, however, to be within reach of a doctor, which usually meant not far from a town. It was also in town that a large number of chronically sick or the "incurable" poor spent considerable time in health care institutions. However, during the first half of the 19th century, such care meant setting up the kind of infrastructures which rural areas – ill-equipped and with little centralized power – could not afford. In the canton of Vaud, for example, there were hardly any hospitals or hospices outside of the main town Lausanne until the 1850s[5]. Transporting a sick person was a serious problem in itself. In the 1830s local insurance companies sometimes required trade masters to have their sick workers nursed at home[6]. How-

4 This removal of the disabled poor was also justified by the feelings of repulsion and disgust aroused in the general public. It is indeed difficult to speak of disability in the 19th century without recalling the "monster" legacy (teratology) from the previous century. However, the vast subject of socio-cultural attitudes to physical handicap cannot be discussed here.

5 Nicolas Nussbaum, "Les asiles de vieillards genevois au XIXe siècle", *Bulletin du département d'histoire économique*, 19 (1988–1989), pp. 41–54.

4 Anne-Lise Head, "Au dossier de la pauvreté: Réflexions sur la politique d''encadrement' des pauvres dans les villes et les campagnes suisses (XVIe–XIXe siècles)", *Bulletin du département d'histoire économique*, 19 (1988–1989), pp. 31–39.

5 This date coincides with the creation of the modern Federal State (1848). This, together with industrialisation, probably accounts for the increase in the number of health care facilities from then on.

6 Françoise Nicod, "Le souci de l'utilité publique dans le canton de Vaud dans la première moitié du XIXe siècle", *Revue historique vaudoise*, 90 (1982), pp. 81–147.

ever, small farmers or self-employed artisans – which, in the first half of the 19th century meant most of the population – had no choice but to seek care in town. Moreover there is the question of the risk involved in clinical treatment. As far as many people were concerned, this not only aroused fear and mistrust but also often involved financial hardship. Workers were reluctant to stop earning their living for treatment which was often required to be lengthy to have any effect. The victim of an accident may have had trouble understanding why a particular treatment worked so well in some cases and was taking so long in others. However, even a minor fracture if not properly healed could lead to complications such as paralysis of the limb involved. Injuries sustained by field or other workers, mostly on the legs, soon became ulcerous in the absence of proper treatment; this could happen all the more easily in situations of poor diet and difficult working conditions. In the city of Geneva, at the Dispensary for the Poor founded by four doctors in 1820, more than 60% of the patients left before being discharged, in some cases after only one visit[7]. This situation was to change as of the middle of the century. Industrialisation began to have a direct impact on public health and medical practice. With so many workers in one place, mechanisation of the means of production and the implementation of major infrastructures, the number of sick and injured rose out of all proportion compared with that of traditional, rural populations. In Switzerland the first statistics, not gathered before 1876, show that during the last third of the century men had 3–4 times more accidents, fatal or not, of all kinds, than women (injuries sustained in accidents caused by vehicles, horses or machinery, falls, landslides, firearms, etc.)[8]. Among Swiss workers the most frequent injuries were to hands or feet: 72% of the total number of injuries recorded[9]. Taking their cue mainly from philanthropy, with foresight as their watch-word, mutual aid societies (insurances) came into being. This movement accompanied the development of medical infrastructures and wider access to health care.

Likewise, with the ever-increasing number of lines being laid, and railway companies having to take responsibility for the loss of human life or limb, not only did existing health care facilities develop accordingly but new local infirmaries were opened to deal with the growing number of accidents[10]. At the very end of the century, new surgical techniques appeared in hospitals, along with radiology. These new techniques were for critical cases where treatment required first-class medical performance but limited bed occupation, with the patient being cured and dis-

7 Rapports du Dispensaire de Genève, 1830's.

8 Hansjörg Siegenthaler (dir.), Heiner Ritzmann-Blickenstorfer (éd.), *Statistique historique de la Suisse* (Zurich, 1996), p. 344. At the end of the 20th century, among the causes of invalidity accidents still represented the greatest difference between the sexes: 6% in the case of women against 13% men. (Walter Weiss (dir.), *La santé en Suisse* (Lausanne, 1993), p. 87).

9 "Statistique des lésions corporelles et des morts violentes survenues chez les membres de caisses suisses de secours mutuels de 1886–1888, incl. Publication du secrétariat ouvrier Suisse" (Winterthour, 1891); cited in the bibliography of the Revue médicale de la Suisse romande, 7 (1891), pp. 434–435.

10 Pierre-Yves Donzé, "L'impact de la construction des chemins de fer sur la médecine hospitalière en Suisse romande, 1850–1914", *Cahiers de l'AEHMO*, 20 (2004), pp. 34–46.

charged as quickly as possible. For that reason, the incurable elderly, the chronically sick, the disabled, *etc*. – who up until then had been looked after in hospitals and infirmaries – were in need of new accommodation. "In such cases", noted a Genevese philanthropist of the time, "it is not a question of finding the means to cure them but to make it easier for them to lead a life dependant on public or private charity in the most suitable and economical way."[11]

The situation of the disabled from the wealthy classes was quite different. Most were cared for privately at the family's expense. As a few examples show, the well-off could be treated in their own homes and, depending on the family environment, remain socially integrated. One noteworthy case is that of Aimée Rapin (1868–1956), an artist born without arms into a wealthy family of Payerne (Vaud), who was to paint, using her feet, the portrait of several famous Europeans[12]. In any event, until late in the century the rich refused to have their sick treated in institutions primarily intended for the poor. They considered having to resort to such places, where people were shut in with no privacy, as shameful or socially demeaning. Towards the end of the century, the growing number of private clinics meant that the rich could be cared for in these new institutions, depending on the nature of the treatment required, more easily than in their own homes.

Institutionalisation of Care for the Disabled

In the last third of the 19th century, after the limits of the "farming out" of disabled persons had been recognized and the practice gradually given up in Switzerland (although it remained in use until the mid 20th century for abandoned children and those taken away from their parents), a process of institutionalisation of aid ensued on an unprecedented scale. In 1875, in the canton of Vaud, the first hospice for incurable women was opened. It also took in a few children as of 1890, while the asylum for the incurable elderly of the village of Château-d'Oex was already receiving patients in 1880[13]. Not until 1891, however, did the canton of Neuchâtel decide to found a cantonal hospice for the incurable, which was to be opened six years later in Perreux, a little town in the Jura region of Neuchâtel[14]. Once again, one can gather from the geographical location of such institutions that the idea was to send the disabled away from the towns.

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11 "Rapport sur les travaux de la Société pendant l'année 1869, lu par G. Moynier", Société genevoise d'utilité publique (1869), p. 96.

12 See Simone Rapin, *A propos d'Aimée Rapin, peintre sans bras* (Payerne, 1996). See also the reality-based fiction on a young disabled aristocrat living in Neuchâtel at the end of the century, analyzed in Mariama Kaba, "'6 mai 1868. J'essaie d'écrire'. Aventures et énigmes autour du journal intime d'un jeune handicapé", in Mauro Cerutti, Jean-François Fayet, Michel Porret (dir.), Penser l'archive: histoires d'archives – archives d'histoire (Lausanne 2006), pp. 131–145.

13 Victor Segond, *La bienfaisance dans le canton de Vaud*, pp. 130–131.

14 Charles Thomann, *L'art de guérir au XIXe siècle en pays neuchâtelois*, pp. 114–115.

This was also the case in Geneva. The Cantonal Hospital, built in 1856 in the middle of the canton and very close to the town, took in mainly medical and surgical cases and gradually came to refuse the chronically or mentally ill. It was in order to make more beds available at the Hospital that the authorities created, at the end of the century, the Asylum of Loëx, for the chronically or incurably ill, as well as the Mental Asylum. These two institutions were located in the Genevese countryside. The care offered by them consisted of no more than providing healthy conditions and proper food, for the inmates to live as best they could. That is why the Asylum of Loëx – already planned in 1876 but not opened until 1899 – had only a limited medical staff (one doctor and two nurses) to carry out check-ups and provide basic treatment. In its first year, however, the Asylum took in around thirty patients, the majority of which were hemiplegics, as well as cases of chronic alcoholism, disability, rheumatism, chronic bronchitis, poor sight, heart complaints and ulcers[15]. The cantonal authorities arranged for outpatient medical aid to be provided in the urban area by the University's polyclinic and, in the communes and elsewhere in the canton, by local doctors. The disabled stayed at home or were interned, with priority always being given to the needy.

The end of the 19th century saw a great increase in the number of institutions for the physically disabled, subsidized mainly by the public authorities. This was however a mixed blessing: the disabled did indeed benefit from a system of care specially adapted to their needs but, shut in behind institutional walls and kept out of sight of the able-bodied, they were completely cut off from society. Such exclusion through isolation or institutionalisation was society's response to fear of crime and begging traditionally associated with all social misfits – including the disabled. This also had to do with a new ideology which arose in the 1880s and at the end of the century had become widespread among European states, including Switzerland: fear of "degeneration of the race", which in turn originated in social Darwinism and eugenics. A bodily malformation was no longer considered to occur by accident but was attributed to a general weakening of the human species. The latter had therefore to be regenerated according to health principles laid down by doctors who, as part of the public establishment, were to be the guardians of public health for future generations. That is why, along with social exclusion of the less fortunate, preventive measures began to emerge, and be put in practice through intermediary of that modern institution, the state school.

Exclusion from School and Medical Initiative for Disabled Children

Indeed, from the middle of the 19th century onwards, European nations were opening state schools for the education of all social classes. State control over the

15 Armand Brulhart, *Loëx. L'Asile, la Maison, l'Hôpital dans la presqu'île* (Genève, 2000), pp. 34–43.

behaviour and development of future "citizens" was thus obtained through the intermediary of the teaching profession and school visits by medical staff becoming obligatory at the end of the century. With the State anxious to have the established order respected, which from then on was to be maintained by keeping a close watch on bodies[16], doctors developed systems of classification which led to the most seriously disabled being branded as deviant and expelled from the school system. Until the end of the century, when the question of special classes was raised for the first time (which in any case were only to cater for children considered to be the least mentally retarded), pupils who were physically or intellectually incapable of attending lessons were exempted from compulsory education. In the canton of Geneva, for example, according to the General Primary School Regulation of 1888 (of which the one of 1848 was the precursor) no children classified as idiots, deaf-and-dumb, blind or affected by any contagious or repulsive disease were allowed to attend school: they could be taken care of in specialized institutions[17].

Children physically disabled from a very early age were the object of particularly close medical attention. It was in fact in Orbe, a little village in the canton of Vaud, that the very first orthopaedic institution for children with malformations was founded in 1780 by Jean-André Venel. He advocated non-surgical methods and was particularly renowned for treating club feet with the aid of a special shoe which was named after him (*sabot de Venel*). He also improved traction beds for spinal deviations. Generations of doctors then succeeded one another at the head of this family institution until the opening in 1876 of the French-speaking Switzerland Orthopaedic Hospital. It was founded in Lausanne by the Genevese doctor Henry Martin and, upon a background of Protestant philanthropy, financed from private sources in the cantons of Vaud and Geneva. From then on, a network of doctors dedicated to the treatment of disabled children – free of charge for the poorest – was developed. Thus the doctor Edward Martin, cousin of Henry Martin, was also taking in young cripples at the Plainpalais Home for Sick Children in Geneva which he had been in charge of since 1886; in 1899 he founded the orthopaedic clinic of Pinchat for children with congenitally acquired malformations (club foot, dislocations, rickets, infantile paralysis) and bone-and-joint TB (Pott's disease, hip disease, white knee tumour)[18].

Orthopaedics is a typical example of the 19th century medicalisation process, in relation to physical disability. In the canton of Vaud, where the Orthopaedics Hospice for French-speaking Switzerland was located, a specific orthopaedic exam

16 See Michel Foucault, *Surveiller et punir: naissance de la prison* (Paris, 1975); Mariama Kaba, "La scoliose entre maladie scolaire et pathologie féminine: un débat opposant hygiénistes et orthopédistes au sujet du corps des filles et des garçons (fin XIXe–début XXe siècles)", *Le Détour*, 5 (2005).

17 Martine Ruchat, *Inventer les arriérés pour créer l'intelligence. L'arriéré scolaire et la classe spéciale. Histoire d'un concept et d'une innovation psychopédagogique*. 1874–1914 (Bern, 2003), p. 23.

18 Edouard Martin, Alfred Machard, Asile de Pinchat 1899–1924, [Genève, 1925].

organized by the Health Council of Lausanne had existed since 1850. It had to do with various medical and technical issues: anatomy and physiology of locomotion organs, orthopaedic means – mechanical or not – used for the limbs and the straightening of the spine, shoulders and pelvis, and hygienic means for their use. However, it was only after 1896 that a university teaching of orthopaedics was set up, because of the lukewarm interest of doctors for a profession considered as a less prestigious annex to surgery[19]. The professional recognition of the field is probably rooted in the concern for future generations which emerged at the end of the century in western countries, as well as in the search for a less invasive form of medicine to treat the physical disabilities of children. Moreover, as the medical market was becoming ever more attractive, orthopaedics also offered a new outlet for doctors interested in drawing in a new, or at least up to then neglected, clientele.

Thus, thanks to initiatives taken by influential, individual doctors, physically disabled children were no longer systematically considered "incurables" but could aspire to be full-fledged citizens and able-bodied workers. From then on they benefited from the latest surgical and orthopaedic methods along with heliotherapy, exposure to pure air and healthy living conditions. These treatments, at first particularly aimed to cure infantile pathologies, soon came to be adapted to adults as well. However, by their very nature such treatments often meant that growing children had to stay in hospital for several months, years even, in order to benefit fully from the therapy[20]. There still remained, therefore, the question of the future social integration of these children, who had had no formal education – a need which was not to be met until the next century.

Conclusion

Recognition for the disabled came in conjunction with two phenomena reaching their culmination at the end of the 19th century: the medicalisation of society and the gradual adoption of social policies by European states. More and more categories of physical disability were to be defined as the number of institutions and specialisations grew. This was accompanied by the growth of State intervention in all social fields, with private institutions, including those for the disabled, subsidized by the Swiss authorities, and the provision of legal protection for workers (the Factory Law of 1877 and the Illness & Accident Insurance in 1889).

Nevertheless, throughout the 19th century, social and health care access for the physically disabled remained dependent of private and sporadic public initiatives, which varied rather widely from canton to canton. The main beneficiaries of such care, generally from the most disfavoured classes of society, had no decisional power

19 Michel Gross, Placide Nicod. *Un pionnier de l'orthopédie moderne* (Yens-sur-Morges 1993), pp. 31–33.

20 Asile de Pinchat: Registre des enfants malades (1899–1922) and Registre des pensionnaires (1899–1943), Archives d'Etat de Genève, AP 39.1, 39.2.

over their fate, and could but endure situations of exclusion such as "farming out" and institutionalisation at the periphery of social life. In parallel, the expansion of care practices, such as orthopaedics, meant to further the insertion of disabled children, as well as that of adults in the workplace, answered the new social and economic requirements of a society on the path of industrialisation; thus proving, if need be, that the perception of disability is not only determined by the physical or psychical limitations of the individual, but rests in great part on the way society addresses the question of alterity.

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Social and Health Care of Children in Central Europe
The Italian Hospital in Prague in the 17th–18th Century

Petr Svobodný

Introduction

Particularly in the Romance lands of Europe (Italy, France and Spain),[1] care of orphans and abandoned children was an important part of care of children from the Earlier Middle Ages. It is therefore not surprising that the first institution to take a major interest in the care of children in Prague (Bohemia – today in the Czech Republic) was founded by members of the Italian colony in what was then an imperial, but later only the provincial capital. At the beginning the Italian Congregation and its hospital provided lodging and aid for all, regardless of nationality, religion, age or sex. At the turn of the 17th/18th century, as a result of fruitful competition with other traditional hospitals and newly founded specialised hospitals, the Italian Hospital started to focus primarily on care of children – orphans and foundlings – and later also pregnant women and new mothers.[2] The hospital was also distinctive for not having been set up by a religious order or other church organisation nor by the city authorities like other similar facilities, but by a special religious congregation of laymen, formed mainly (if not exclusively) for the purpose. In this context the Italian Congregation in Prague differed from all other religious congregations/brotherhoods in Bohemia. There is no other "hospital"

1 *Enfance abandonée et société en Europe XIVe–XXe siecle*, Collection de l'École Francaise de Rome 140 (Rome, 1991).

2 Petr Svobodný, "L'Ospedale italiano come struttura socio-sanitaria (1602–1789)", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), pp. 26–38; J. Rigetti and J. C. Panich, *Historische Nachricht sowohl von der Errichtung der Wellschen Congregation unter dem Titel Mariae Himmelfahrt als auch des dazu gehörigen Hospitals B. V. Mariae ad S. Carolum Borromeum* (Prag, 1773); Joseph Anton Riegger, *Materialien zur alten und neuen Statistik von Böhmen*, VIII (Lipsia – Praga, 1788), pp. 153–186; O. Romanese, *Riasunto storico sulla fondazione della Congregazione e sula erezione della Capella italiana* (Praga, 1898).

congregation to be found in Bohemia at that time, in contrast to the situation in other European countries.[3]

Medieval and early modern hospitals are rightly regarded as the forerunners of the modern hospital, even though originally the sick formed only a small proportion of their charges. The care provided for these charges was first and foremost care for their souls, and second provision for basic survival (food, clothing, a roof over their heads, ordinary care for the infirm); and only in last place were they provided with at least basic healthcare from the hands of the nursing attendants, wound-healers or even physicians.[4] Although the history of the care provided by the Italian Congregation to needy persons dates from its establishment in 1573, we can only speak of a hospital from 1602, when the congregation purchased a house in the Lesser Town of Prague belonging to one of its members, Domenico de Bossi. For practically the entire 17th century the Italian Hospital did not differ much from the other Prague hospitals in its orientation: it took care of all people in need – the poor, the abandoned and the infirm – without regard to age or sex. The presence of sick people among its charges is indicated as early as 1608 in an imperial decree of that year. During the first half of the 18th century the Italian Hospital, as a specialised social-health institution, ranked in significance at the side of the two real Prague hospitals: the Hospital of the Brothers of Mercy in the Old Town of Prague at Na Františku (founded in 1620) and the Hospital of the Sisters of St. Elizabeth in the New Town of Prague at Na Slupi (founded in 1722). By this time it was already caring principally for children and pregnant women, and not only their social welfare needs, but their health needs as well. It thus became the direct predecessor of several modern health institutions (the provincial maternity hospital and foundling hospital), set up by the Enlightened reforms in the 1780s, as well one of the first clinical facilities of the Medical Faculty, and to a certain extent it was also the indirect predecessor of the later children's hospitals.[5]

3 Jiří Mikulec, *Barokní náboženská bratrstva v Čechách [Baroque Religious Congregations in Bohemia]* (Praha, 2000), pp. 101–102.

4 Basic information on the history of Prague hospitals and health care in this period in Petr Svobodný, "L'Ospedale italiano come struttura socio-sanitaria (1602–1789)", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), pp. 27–31; more detailed information about history of hospitals in Prague: Petr Svobodný and Ludmila Hlaváčková, *Pražské špitály a nemocnice [Prague Infirmaries and Hospitals]* (Praha, 1999). More general information in Petr Svobodný and Ludmila Hlaváčková, *Dějiny medicíny v českých zemích [A History of Medicine in the Czech Lands]* (Praha, 2004).

5 This paper is based on my original works cited in following footnotes. More detailed information about archival and other original sources ibidem.

The Institutional Development, Administration and Funding of the Italian Hospital

The initial phase of the functioning of the hospital up to the end of the 17th century is in many respects (and especially from the point of view of care for charges) shrouded in obscurity because of a lack of sources. For the 18th century, especially its latter half when the hospital was at the height of its fame, the situation is much better. As an institution the Italian Hospital developed over the last third of the 16th century out of a religious and charitable initiative taken by the Italian colony that had gradually settled in Prague during the 15th and 16th centuries. The colony's Catholicism in a religiously divided Prague and its distinctive ethnic identity prompted first the organisation of special Italian masses in the Jesuit Church of St. Clement's, then in 1569 the building of a special Chapel of the Assumption of Our Lady for the community in the Clementinum College complex in the Old Town of Prague, and finally in 1573 the establishment of a congregation of the same name.[6] As the motto of the congregation, *Pro Deo et paupere* shows, apart from religious obligations it set itself the goal of providing care of the poor and infirm. Initially it provided help for the needy in the private houses of individual members of the association. At the beginning of the century (1601) the number of needy persons in the house of the assistant of the congregation Domenico de Bossi in the Lesser Town of Prague alone had reached sixty, and so the following year de Bossi sold the house to the congregation. This meant that the congregation now had its own building, in which needy persons could be provided for on a long-term basis at an institutional level. The crucial official approval for the hospital institution was obtained in the form of an Imperial Decree from Rudolf II on the 24th of April 1608. By this decree the emperor at the request of leaders of the congregation freed the hospital from taxes and impositions, and granted it permission to purchase other properties necessary to expand the hospital and to accept gifts and legacies. One interesting aspect of the decree from the medical point of view is a prohibition on accepting infected persons in time of plague. The Lesser Town Corporation was named as the guarantee of the tax privileges. The text of the decree speaks only of the poor and sick as the recipients of the hospital's charity, and at no point specifically mentions children, who later predominated among the hospital's charges.

6 Anna Bartolozzi, "La Congregatione della Beata Virgine Maria Assunta in Cielo. Religione e carita nella migrazione degli italiani a Praga in eta moderna", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), pp. 11–25. More detailed information on administrative and finances of the hospital in Petr Svobodný, "Vlašský špitál na Malé Straně a jeho místo v péči o matku a dítě josefinských reforem (1602–1789)" ["The Italian Hospital in Prague and its Place in the Care of Children"], *Documenta Pragensia*, 7 (1987), pp. 113–134; Petr Svobodný, "Das welsche Spital an der Kleinseite und seine Stellung in der Mutter- und Kindfürsorge vor den Josephinischen Reformen (1602–1789)", *Historia Hospitalium*, Heft 18 (1989–1992), pp. 79–91.

Until its dissolution the legally and materially secured hospital was to remain housed in a majestic Baroque complex built at the very beginning of the 17th century. Its core was the house of the member of the congregation already mentioned, the architect de Bossi, in Vlašská [Italian] Street. Reconstruction of this house started even before the Battle of the White Mountain (1620), and the Hospital Church of Our Lady and St. Charles Borromeo was completed under the direction of the architects de Bossi and Pietro della Pasquino in 1617, but we lack documentary evidence on the construction of the hospital buildings. During the Thirty Years War (1618–1648) the hospital complex was twice plundered. The appearance of the church today was created by construction during 1643–44. The hospital acquired its basic square disposition around a beautiful courtyard with arcades in 1654 and was expanded in 1675. Just as in the Hospital of the Brothers of Mercy and the Sisters of St. Elizabeth, the internal arrangement of the Italian Hospital was highly practical for its time. It included separate rooms for women, men and children, and rooms for the management of the hospital and essential service areas.[7]

The latter half of the 17th century and first half of the 18th century brought no major legal or architectural changes; the emperor repeatedly confirmed the hospital's existing privileges and several small modifications were made to the buildings. Substantial change came only in the 1770s as part of the reform programmes of Marie Theresa and her co-regent Joseph II. By an Imperial Decree of the 20th of January 1776 the New Town Foundling Hospital with the Mary Magdalena Maternity Hospital in Soukenická Street, which had been in operation since 1765 and financially supported by the Italian Congregation since 1774, was brought directly under the hospital itself. By another decree of the 29th of March 1777 the French Hospital of St. Louis in the New Town was also affiliated to the Italian Hospital for financial reasons. Shortly afterwards (1st of May 1777), the hospital purchased the Sporck House, adjacent to the hospital, in which a well equipped and properly run maternity hospital was then installed.

Radical official changes to the status of the Italian Hospital then came with the Josephinian Reforms to care for the sick and poor in the 1780s, and these eventually led to its closure. The rules of the Bohemian Provincial Government of 1784 for the reorganisation of institutes for the sick and paupers in Prague precisely defined categories of social-health institutions and their charges. Under these, the Italian Hospital, which was willing to submit to the supervision of the Prague Municipal Corporation and the supreme supervision of the Bohemian Provincial Government (*gubernium*), retained the character of an orphanage and foundling hospital with

7 More information on architecture of the hospital in Johana Kofroňová, "L'Ospedale italiano di Praga: genesi e storia dell'edificio", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), pp. 43–56.

maternity hospital.[8] It was not to survive for long, however. On the basis of a court decree of the 31st of December 1784 adult and child inmates were investigated for their property, health and moral status and then gradually moved to the appropriate newly established facilities (general hospital, lunatic asylum, poor hospital, poor house, maternity hospital, foundling hospital). Although most Prague older hospitals were dissolved in this year and their charges moved to the new institutions, the Italian Hospital actually continued to exist until the 17th of August 1789, when the last children and mothers were moved to the newly opened maternity hospital and foundling hospital of St. Apollinaire

The funding of the charitable activity of the hospital was at first covered by gifts and legacies, and later by the income from well-administered property. A statistical overview published by J. A. Riegger in 1788 offers a picture of the extent and composition of the hospital's property towards the end of its life, and one that indicates its gradual growth.[9] The property was divided into the hospital's own immoveable property and endowment funds that were specially administered, with special separate accounts, by the management of the hospital. At the head of the clerks and other employees of the hospital there was an administrator who oversaw the economic running of the institute and submitted regular reports on it to the congregation authorities.

With just a few exceptions we have no precise documentary evidence of the number of attendants, male and female, who directly provided care for the charges and together with their superiors also conducted regular checks on the welfare of the children placed with wet-nurses and foster-parents. Nor do we have precise evidence on the number of wet-nurses. According to data from the end of the 1780s more than ten attendants, mainly women, cared for charges directly in the hospital (one each for the men and women, 2 for the smaller children, 1 for smaller boys, 2 for older boys, 4 for girls, 1 for the sick). There was also originally one, and later two secular teachers, a hospital priest and his three assistants, a female needlework teacher and a military trainer. The health of the inmates was entrusted to external colleagues: a physician and a wound-healer (surgeon). As a rule these were Lesser Town official physicians and surgeons; we can name at least the professors of the Prague Medical Faculty Med. Dr. J. A. Cassinis (1645–1716) and Med. Dr. J. J. Bauer (1719–1802) or the surgeon Chir. Dr. J. Köller. The midwife Rosalie Sander assisted at births, and had an assistant who lived inside the maternity hospital.

8 Ludmila Hlaváčková, "200 Jahre seit der Gründung des Allgemeinen Krankenhauses in Prag", *Historia Hospitalium*, Heft 18 (1989–1992), pp. 61–78.

9 Joseph Anton Riegger, *Materialien zur alten und neuen Statistik von Böhmen*, VIII (Lipsia – Praga, 1788), pp. 153–186.

The Italian Hospital as a Foundling Hospital and Orphanage

Although the Italian Hospital did not admit children only, care of children became its main activity. We do not have solid evidence for the preponderance of child inmates over adults until the middle of the 18th century, but the proportion of the former rose strikingly especially in the latter half of the century. Care of adults remained as a relic of earlier even when the Italian Hospital had started to specialise in children and mothers. The other Pre-Josephinian hospitals also often took on the role of orphanages or foundling hospitals, but there were very few children among their charges.

When the Italian Congregation was formed in Prague at the end of the 16th century, Bohemian provincial and municipal laws refused illegitimate children property and other rights. Conditions in Italy, where special institutions for abandoned children had been founded early in the Middle Ages, were undoubtedly well known to the Prague Italians and this knowledge must certainly have been one of the reasons why it was their congregation, in particular, that should have made care for helpless children one of the purposes of its charitable work. According to the rules on the admission, care and upbringing of children in the Italian Hospital, published in 1788 by J. Riegger, the institution accepted legitimate and illegitimate children, newborns and older children, children born in Prague and "*children bereft of all human help*" of both sexes and without regard to religious faith. Despite the restrictions of rights suffered by illegitimate children in Bohemia in the 16th and 17th centuries, the hospital children were not made serfs to any private authority but remained free persons. By a supreme imperial regulation the illegitimate children at the hospital obtained all the rights of legitimate children and were permitted to enter any profession, for example, and go on to higher education.

It is extremely hard to determine the numbers of children within the overall numbers of charges of the Italian Hospital on the basis of the scattered data in archival and printed sources. Nor is it always clear how many children lived directly in the hospital complex and how many with wet nurses, foster parents, in apprenticeships or in service. 90 charges are mentioned for the year 1723 but the proportion of children is not given (and this is also the case in the oldest data, for the year 1601), although in 1746 children evidently predominated among the 194 charges (the precise number of children is not stated). In 1757 the hospital was caring for 66 children, 25 men and 61 women. According to what is already more precise data for the 1770s and 1780s, the hospital was caring for 1000 persons on a regular basis, mainly children. The data for different years is hard to compare: sometimes it relates to a particular date but at other times gives the aggregate of the number of people cared for in a particular year. Sometimes it distinguishes between child and adult charges (in some years it even gives numbers of employees), and

very rarely gives numbers of children according to age categories, or how long they had lived directly in the hospital or outside it. Of the overall number of roughly 700–900 children only around 1/6 lived directly in the hospital, while the others, at the cost of the hospital, were placed in the town and country with wet nurses, foster parents, in apprenticeships or in service. The ratio between girls and boys was essentially even. In 1773 the hospital was providing for 1,180 people including staff. In 1775, apart from an unknown number of adults, the hospital was maintaining 268 children younger than six years old, 159 children between 6 and 15, 30 boys in apprenticeships and 46 girls in service. In 1779, out of a total of 1131 charges cared for by 56 staff, there were 786 children younger than 15 years old and 139 boys and girls between 15 and 20 years of age. In June 1787, there were 221 foundling boys and 242 foundling girls, 294 orphan boys and 226 orphan girls younger than 20 years of age and a mere 39 adults. At the time when the hospital was dissolved it was caring for 786 children and young people (up to 20 years), 75 adult men and 124 adult women (including pregnant women and new mothers).).[10]

Table 1. Numbers of Persons in the Wards of the Italian Hospital 1723–1789.

	Children			Adults			
Period	**0-6**	**6-15**	**15-20**	**M**	**F**	**Total**	**Note**
1723						90	
1746						194	Mainly Children
1757		66		15	61	152	
1773						1180	Incl. Staff and children at foster parents
1775	268	159	76*				*30 boys in apprenticeship, 46 girl in service
1776 Dec. 31						793	
1776						996	
1777						1277	
1778 Jan. 1						889	
1778						1215	
1779		786	139		262	1187	Incl. Staff (56 persons)
1780 Jan. 1						857	
1783						1005	
1786 Dec. 31						961	
1787 June		983*		17	22	1022	*Orphans: 294 boys, 226 girls; foundlings 221 boys, 242 girls
1787						1435	
1788 Jan. 1						950	
1789 August		786		75	124	985	

Sources: Joseph Anton Riegger, *Materialien zur alten und neuen Statistik von Böhmen*, VIII (Lipsia – Praga, 1788), pp. 157, 169, 185. Ignaz Cornova, „Das Waiseninstitut der Italiener in Prag“, *Hyllos* (1819), p. 19. O. Romanese, *Riasuntostorico sulla fondazione della Congregazione e sula erezione della Capella italiana* (Praga, 1898), p. 24.

10 More detailed information on numbers and their sources in Petr Svobodný, *Child Mortality in the Italian Hospital in Prague (1719–1789)*, Journal of Family History 19:2 (1994), pp. 117–129.

Detailed reports have survived for the second half of the 18th century on the pattern of care specifically for children from their admission to the care of the hospital to their departure into independent life. The newly admitted children were first christened by the spiritual administrator of the hospital and then enrolled in the institution register by the administrator. Sucklings were placed with wet nurses in the city, who were paid a contribution of 30 kreutzers a week and were given linen and clothes for the children. After being weaned, the children stayed with foster parents, and were fully materially and financially secured by the hospital. Attendants and superiors from the hospital would regularly check on the responsible conduct of wet nurses and foster parents, and in cases of neglect, the children would be taken away from one foster parents and given to others. Once a year on the Sunday after the Feast of St. Mary Magdalene, all the children would be brought to the hospital by their wet nurses and foster parents to be inspected by the hospital superiors. When the children had reached the age when they could look after themselves (at 6–7 years old) they were taken back into the hospital, where they would be given all the necessary care.

In the hospital, the children would be accommodated in communal bedrooms.[11] Each bed had a straw mattress and horsehair mattress, two blankets, a pillow and sheets. Various kinds of under-linen, clothes and shoes (including indoor slippers) in various different sizes are listed with accountant's precision in the inventory made when the hospital was dissolved in 1789.[12] Meals were taken in a communal refectory, equipped with tables covered with tablecloths, and with simple benches; the children ate with complete sets of cutlery, not just spoons. The food was adjusted to the different ages and physical constitutions of the children, and for the sick on the basis of the recommendations of a doctor. Food was different for meat days, fasting days and festivals. On ordinary days lunch regularly included soup, and then usually beef and vegetables, while on Sundays and holy days there would be a 1/4 pint of beer as well. For supper there would only be soup.

Apart from caring for the bodily needs, the hospital also took care of the spiritual and moral development of the children. Every day, apart from attending two

11 Very interesting iconographical sources related to the history of the Italian Hospital in Prague describe hospital interiors equipped with beds with curtains. Compare drawings and pictures by Karel Škréta made for the hospital church in 1647, depicting St. Charles Borromeo visiting a plague hospital in Milano. More details on iconography in the Italian Hospital in Prague in Jan Royt, "La decorazione pittorica della capella della Vergine Maria e di S. Carlo Borromeo nell'Ospedale italiano", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), 57–64; Tomáš Berger, "I dipinti recentemento scoperti sulla volta della cappella della Vergine Maria e di S. Carlo Borromeo, nell'Ospedale italiano: restauro e datazione", *ibid*, 65–70; Anna Bortolozzi, "San Carlo Borromeo, patrono dell'Ospedale italiano", *ibid*., 71–77.

12 Compare its edition in Petr Svobodný, "Inventář vlašského špitálu na Malé Straně z roku 1789" ["An Inventory of the Italian Hospital in Prague of 1789"], *Documenta Pragensia*, 8 (1988), 35–57. Original in the Archiv hlavního města Prahy [Prague Municipal Archives], G 16/141.

obligatory masses and several prayers in the hospital church, the children would study in their own two-class school, equipped with school benches, blackboards and pictorial teaching aids. The curriculum was composed of religion, reading, writing and arithmetic. In addition the girls would learn needlework, knitting, spinning and laundering, while the boys had preliminary military exercises. To discourage sloth and idleness there was a spinning room and knitting school, which apart from the educational effects had economic benefits for the hospital as well.

On reaching 14–15 the boys were sent into apprenticeships of their own choice. For the duration of their apprenticeship (5–6 years), the hospital would also then supply them with clothes and cover their teaching expenses. On completing their apprenticeships they would then get new clothes and money for their journeyman travels, and this would be the last support that they obtained before embarking on independent life. Their free status in the Italian Hospital meant that specially gifted boys could go on to higher studies. At the age of 14–15 girls would be placed in service in Prague or in the countryside, during which time they would be supported in the same way as the boys. Their last contribution from the hospital property was a dowry of 30 guldens. Every year a special foundation gave a dowry of 20 guldens to another four girls outside the hospital who had to show official proof of marriage.

In case of sickness the hospital not only provided special care for children with foster parents and in the hospital, which was regularly visited by a physician and surgeon, but also ensured health care for its charges in apprenticeships and in service. The sick were isolated in their own hospital room. In cases where a boy or girl suffered long-term effects of ill health and could not continue to earn a livelihood, they were provided for by the hospital for life. Even the last needs of its charges were organisationally and financially secured by the Italian hospital, since like most of the older hospitals it had its own cemetery.

Although the registers of births and deaths kept by the Italian Hospital for the years 1719–1789 have survived,[13] they were kept in a peculiar way that makes them hard to compare with the data kept by ordinary parishes. Nonetheless, demographically analysed they allow us to gain a more precise picture, however relative, of the running of the hotel and especially its degree of success in caring for children. For newborns, sucklings and children up to six years old, the hospital was only a relative protection from the usual cruel fate of orphans and foundlings, since despite all the care provided these children died more often than their contemporaries in their own families. It was only in children of school age that the advantages of enforced life in the hospital, including regular meals and healthcare, could become apparent. Hospital children who survived to the age of 15–20 even

13 Archiv hlavního města Prahy [Prague Municipal Archives], Birth and Death Register 1719–1771, sig. N1 Z1, Birth and Death Register 1771–1789, sig. N3 Z2.

had an incomparably greater chance of successfully entering adult life (school, apprenticeship, dowry etc.) than most of their contemporaries.[14]

The Maternity Hospital at the Italian Hospital

The Italian Hospital also differed from the other hospitals of its time by providing care for the pregnant and new mothers, although it took on this role relatively late. Its exceptionalism in this respect was underlined when it was chosen as the place for clinical teaching of obstetrics at the Prague Medical Faculty. On the 30th of June 1776, 177 children and eight "fallen" women were moved from the foundling hospital and maternity hospital of Mary Magdalena to the Italian Hospital. From that time on, therefore, a properly run maternity hospital existed at the Italian Hospital. Here poor women could find a refuge and expert help in case of emergency or extreme need (it was normal to give birth at home). Their – mainly unwanted – children would then usually became charges of the foundling hospital with better starting conditions than those that had been left on its doorstep. According to the proposals for the directive rules of 1785,[15] the place was envisaged as primarily a place where "fallen" women could give birth, and the service was free of charge for those who could produce a confirmation of poverty from a priest. These new mothers were then obliged to wet-nurse hospital sucklings without charge (a similar practice was to be prescribed at the new St. Apollinaire Hospital). Mothers with new-borns were placed in the former Sporck House adjacent to the original hospital building. The inventory of 1789 mentioned above provides a picture of the premises and equipment of the maternity hospital, which in rough outline suggests the way that it functioned. One of the rooms at that time served as a treatment room, in the next there were two special birth beds, one ordinary bed and a mangle, and in the third there was an ordinary birth bed, 20 beds for lying-in mothers separated by curtains, a tin basin, a child's bath and other small pieces of furniture.

Similar practices, and the midwife herself, Rosalie Sander, characterised the last years of the maternity hospital at the Italian Hospital and the first years of the new Land Maternity Hospital at St. Apollinaire. At St. Apollinaire the midwife was assisted by three attendants, while in the case of the Italian Hospital we have evidence of only one. A surgeon would assist in more difficult births.

According to the proposals of the directive rules, poor women giving birth free of charge also had to submit to demonstrations during the teaching of practical obstetrics to students of medicine and midwives. For the academic years 1784/85 and 1785/86 these obstetrical demonstrations were announced by a lector at the

14 More detailed information in Petr Svobodný, "Child Mortality in the Italian Hospital in Prague (1719–1789)", *Journal of Family History* 19:2 (1994), pp. 117–129.

15 National Archives in Prague, Bohemian Government – Publice 1784–1785, D III/49/100, 113, box nr. 965, the proposals for the directive rules, 1785.

Medical Faculty, Hynek Ruth (1731–1797). The demonstrations were advertised as twice weekly and designed for both medical and surgical studies. For the years 1786–1789 no practical teaching is recorded, or else the lecture lists are missing, and even for the years 1784 to 1786 we have no evidence of whether the clinical teaching actually took place.

The transfer of the last children and mothers from the dissolved Italian Hospital to the new foundling hospital and maternity hospital at St. Apollinaire thus started a new phase in the development of care for abandoned children and pregnant women and for the clinical teaching of obstetrics in Prague. The activity of the Italian Hospital in the last two decades of its existence was an important organisational and material precondition for this new phase.

The short period of existence of a maternity hospital at the Italian Hospital in Prague is actually an important chapter in the history of obstetrics and gynaecology in the Enlightenment era in the Bohemian lands. The beginning of the process of professionalisation and masculinisation of the field under the supervision of authority (here the Prague Medical Faculty) is, however, only one element of the problem in the context of research on gender identity and bio-power. [16]

The Italian Hospital and Anatomical Autopsies at the Medical Faculty

Even before it obtained a maternity hospital, however, the hospital had been serving university medical teaching needs.[17] From the 1760s (like the Hospital of the Merciful Brethren) it was obliged to supply the Medical Faculty with the bodies of dead charges for demonstration autopsies. Prague university physicians and students originally conducted their explorations of human anatomy actually inside the Hospital of the Brothers of Mercy Na Františku. The first recorded autopsy since 1600 (the famous anatomy class of Johannes Jessenius) was conducted here in 1685 by Professor S. K. Zeidler (1620–1689). Later autopsies were moved to the medical lecture hall in the Carolinum College, where in 1723 the anatomy theatre was reconstructed at the instigation of Professor J. I. Mayer (1693–1757). The supply of bodies from the Hospital of the Brothers of Mercy was erratic and also limited to the bodies of adult men. Practical anatomy teaching was therefore greatly improved by the personal initiative of Professor J. T. Klinkosch (1734–1778), who

16 Compare Daniela Tinková, "V zájmu 'přirozenosti věcí'. Genderové identity, 'bio-moc' a osvícenská věda" [In the Name of ‚Nature of Things': Gender Identities, ‚Bio-power' and Enlightened Science], in *Práce z dějin vědy*, VI (Praha, 2003), 571–615; Daniela Tinková, *Déicide, suicide, infanticide. Crime, péche, folie; la transformation de la conception du "crime" et le process de decriminalization a l'epoque des Lumieres en France et dans la monarchie des Habsbourg; étude compare*, Dissertation, EHESS (Paris, 2002).

17 On the Medical Faculty in Prague: Ludmila Hlaváčková and Petr Svobodný, "The Medical Faculty", in Ivana Čornejová, Michal Svatoš and Petr Svobodný, eds., *A History of Charles University I, 1348–1802* (Prague, 2001), pp. 405–438.

requested permission to dissect children's bodies, to be supplied by what was at the time the only hospital specialising in care of children. In May 1763 the Medical Faculty was informed of the decision of the Royal University Commission, to the effect that the Italian Hospital as well as the Hospital of the Merciful Brethren would now be obliged to supply dead bodies for dissection.

The first documented removal of a child's corpse from the Italian Hospital to the Carolinum for dissection is recorded in the death register as early as the 10th of June of the same year, and from October the practice became routine. The bodies of the dead children would be supplied for dissections in the winter and spring months (November to April), which naturally corresponded to the term of lectures and demonstrations announced by Klinkosch in the winter semester. In the registers this practice is precisely documented up to 1771, when the volume of the older register ends.[18] It was undoubtedly continued in the following period, but in the new register there was no special section to record it. One body a week was best for teaching purposes, but of course the number of children's bodies supplied by the hospital to the Carolinum dissection room depended among other things on the number of deaths in the hospital. Nonetheless, from 1763 the conveyance of "anatomical material" was much more regular than at any time before and in the 1770s allowed for the drawing up of a precise advance timetable for autopsy demonstrations. Overall roughly every second child to die at the hospital was taken for dissection, the bodies of infants of up to one year being the majority. Prof. Klinkosch invited attendance at his anatomical demonstrations not only with regular notices for students, but also in the titles of some of his publications, for example of 1764 and 1767. The most valuable of his monographs is a publication on the anatomy of the stomach and localisation of hernia of 1764 (with an invitation to demonstrations in the following year), which in addition to information taken from the extensive cited literature is also based on his own rich experience acquired during dissections.[19]

The anatomical dissections of children's bodies brought from the Italian Hospital therefore contributed to the teaching of new doctors and to the scientific work of the professor himself. The findings not only enriched anatomy, but contributed to the understanding of the specific features of children's health and disease that were later to become the subject of a separate field - paediatrics.

18 Compare the footnote 13.

19 More detailes in Petr Svobodný, "Vlašský špitál a anatomické pitvy na pražské lékařské fakultě v 60. a 70. letech 18. století" [The Italian Hospital in Prague and Anatomical Dissections at the Medical Faculty in 1760s–1770s], *Časopis lékařů českých* 131 (1992), pp. 152–153.

Conclusions

In 1773 the Italian Congregation in Prague and its hospital celebrated the 200th anniversary of its founding.[20] The many-sided vocation of the hospital was illustrated by allegorical pictures painted in the Italian Chapel (the main shrine of the Prague Italians in the Clementinum College in the Old Town), and by the inscription:

> Quos spernit genitrix, hos per sua munera servat,
> enutrit miseros, quodque necesse docet,
> Respirantque senes, aegris medicina paratur,
> Postremo tumulu moriuntur habent.

("Of its office it makes provision for those rejected by their mother, supports the poor, teaches what is necessary, the old find relief here, and in the end the dying find a grave here.") Although the traditional, essentially still medieval hospital was making efforts by the time of the anniversary celebrations and also later in the time of the revolutionary Enlightenment reforms of social welfare and healthcare to make modernising reforms, its already anachronistic universality and undoubtedly also its wealth, which was to become an important part of the newly established hospital fund, ultimately proved its undoing. It was dissolved as a charitable institution in 1789 by Joseph II, but many of the principles of its care, some of its charges (mothers and foundlings) and some members of its staff (the midwife) moved to the newly founded health institutes in the New Town (maternity hospital, foundling hospital).[21]

The history of the Italian Hospital in Prague from the end of the 16th to the end of the 18th century is a notable example of the formalisation, professionalisation and medicalisation of care for children: from the provision of a refuge for the most helpless members of society (abandoned newborns and orphans) who were completely bereft of the protection of the family, to progressively organisationally and professionally improving care offered by a lay religious congregation, to the ever more stringent supervision and finally the complete transfer of the social-health institution created in this way (a foundling hospital and maternity hospital) into a sphere entirely controlled by the authorities of the "State" (Bohemian provincial health institutions) and the "Academy" (the Medical Faculty in Prague).

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20 Petr Svobodný, "I festeggiamenti per il giubileo della Congregazione e dell'Ospedale degli italiani nel 1773", in Anna Bortolozzi, ed., *La Congregazione italiana di Praga* (Praga, 2003), pp. 89–92.

21 Franz A. Stelzig, *Versuch einer medizinischen Topographie von Prag*, II (Prag, 1824), p. 289 ff.; Julius V. Krombholz, *Topographisches Taschenbuch von Prag* (Prag, 1837), 454 ff.

The "birth of the clinic"[22] in the Italian Hospital in Prague in the last quarter century of its existence sets the development of this particular institution, unusual in the Bohemian environment, firmly within the wider (Western) European context: „*The mechanisms of power, which are said to have pervaded Western society since the end of the 18th century, are used as a method of explaining the emergence of various facets of modern medical practice, particularly the hospital, post-mortem, and clinical examination.*"[23]

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22 Michel Foucault, *The Birth of the Clinic. An Archaeology of Medical Perception* (New York, 1975).

23 W. F. Bynum and Roy Porter, eds., *Companion Encyclopedia of the History of Medicine* (London: New York 2001), Vol. 2, p. 1658.

School Lunch Programs in Israel, Past and Present

Ronit Endevelt

Introduction

Over the last two centuries, the transition from a rural, agricultural society to an urban, industrial society has caused a shortage in many foods that had once been available in the villages, leading to deficiencies in essential nutrients. Nations worldwide have since faced the need to establish programs in order to feed those who no longer have ready access to the fruits of the land, in particular children.

Part of this need has been met by lunch programs. Many countries throughout the industrialized West have created programs of various sorts. Some aim only at feeding the children, while others also seek to teach nutrition. Such efforts have also been undertaken in Israel, beginning in the era of the British Mandate, but were ended in the 1970s as rising prosperity led the Israeli government to conclude that a rich country had no need for a program to feed the poor. The decision was not without its costs, including a widening gap between the various levels of society and a shorter school day that forced many mothers to work just part time. However, in 2005, the Knesset (the Israeli parliament) approved a trial lunch program in response to a survey that revealed a significant need for enhanced nutrition among the poorer students in Israel's schools. An understanding of earlier lunch programs should contribute to successful implementation of this trial.

The Beginning

Concerns for the nutrition of the Jewish population of Palestine came to the fore at the beginning of the 20th century. They first found expression at the end of 1913, when a Swiss visitor, Theresa Dreyfus, with the aid of the "Dutch Clark Organization," founded two soup kitchens in Jerusalem. The Joint Council on Accreditation of Healthcare Organizations also contributed to the enterprise. At the same time, an American pioneer, Nathan Strauss, founded another group of soup kitchens in Jerusalem. Both programs served soup and bread as part of their outreach to the

poor. Children and pregnant women could also get a glass of milk. A small fee was charged for the meal, but those who could not pay received it for free. The soup kitchens remained in operation until April 1933,[1] [2] when they were forced to close because of financial difficulties.

After the First World War, a few kindergarten teachers in Jerusalem came to the realization that their pupils could not concentrate and learn effectively because they were constantly hungry. These teachers started cooking lunches for the children. Financial assistance came from the children's parents and from the orphans' fund. The American Zionist Henrietta Szold helped to collect money for this lunch program.[3] These efforts formed the foundation for the lunch program in schools that started a few years later.

The School Lunch Program in Palestine and Israel, 1921–1970

In December 1921, the manager of one of the girls' schools in eastern Jerusalem initiated a school lunch program with the aid of Henrietta Szold. This was followed in 1923 by the Penny Lunch Program in Jerusalem, which was funded largely by pennies that Jewish children in America gave from their Hanukah money, though parents also helped. At a later stage, other donors contributed, including the Hadassah Women's Organization, but the name "Penny Lunches" remained. The program, like the other school lunch programs that had preceded it, was based on the understanding that children cannot study without proper nutrition. As Henrietta Szold told her friends in the Zionist organization: "In the lunch program, one could see girls for whom it was the first time to sit on a chair in front of a table with a fork and a knife and eat."[4]

These small initiatives spread throughout Palestine, and soon school lunches were being organized on a nationwide basis. Henrietta Szold established a management team and nominated a brilliant dietitian, named Sara Bavly, as the head of the program. Together they established rules for the program, found economic resources, and built core knowledge in nutrition among teachers in the schools.

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1 Bavly, Sara, "Report on the Hadassah/Vaad Leumi school luncheons project during the period October 1st 1944–September 30th 1945", The Zionist Archive, Z"A J/1/7741.

2 Bavly, Sara, Letter to Dr. Catzenelson on parents' guldens in the school kitchen, The Zionist Archive, A"Z 1946/3/25 J/1/7741.

3 Young Hadassah was an organization of young Jewish women that was founded in November 1920. Its goals were to help in the development of Israel through donations and to encourage young Jewish men and women to understand the importance of building a Jewish nation in Palestine. Henrietta Szold wrote in a letter to the members of Young Hadassah: "Let's accept our young women as teachers and mothers through feeding the young generation in our way." Hed Hadassah Sivan Tamuz TS"Z (1936), pp. 1–2.

4 Rubin Shchory Zipora, "Hadassah Educational Institute in the Mandate Times," Ph.D. dissertation, Ben-Gurion University (1998), pp. 178–212.

Eventually, a third of the schools in Israel joined in the effort[5]. At that time, the importance of the food calorie resources (protein, carbohydrates, and fat) was already known, and during the 1930s–1940s interest in vitamins grew as well. Thus, the lunch programs could be used as a means for providing valuable nutrition skills for the children and families in addition to feeding the poor children.[6] This was a revolutionary idea of implementing a central feeding program through a lunch program and was based on a new understanding of the importance of nutrition and social responsibility. Such programs adopted by other Western and developing countries have encouraged school enrolment and attendance and improved school performance and cognitive development.[7] [8] Other means to equalize the population especially the children and infants were laws for free education that were established later on. In 1949, as in many other modern countries, Public education was generally available to all. In most countries, it was compulsory for children to attend school up to a certain age.[9] Another social mean that was used in Israel as in other countries at-that time was, subsidizing some of the foods, and creating a food basket for all, and fortifying some of the foods with nutritional vitamins. Those fortifications were based on research that was done in the 30s and 40s in Israel.[10] [11]

Photo 1. Lunch program in a boys' school in Jerusalem in 1936 (private archive of Sara Bavly).

5 Szold, Henrietta, A letter that was sent to the Hadassah in New York about the welfare organizations in Palestine, 9/6/1924, The Zionist Archive, Z"A/A/125/638.

6 Rosenfeld, Louis, "Vitamine–vitamin. The early years of discovery" *Clinical Chemistry,* (1997) 43:4, 680–685.

7 Feeman, H. E. et al., "Nutrition and cognitive development among rural Guatemalan children," *American Journal of Public Health*. 70 (1980), pp. 1277–1285.

8 Jamison, D. T., "Child malnutrition and school performance in China", *Journal of Development Economics*. 20 (1986), pp. 299–309.

9 http://en.wikipedia.org/wiki/Public_education (Accessed April 2, 2007).

10 Sadow E., "Outline of Summary of Palestine," January 1927 to May 1927, The Zionist Archive, j /113/83.

11 Economic Advisory Council, Committee on Nutrition in the Colonial Empire, First Report, 1939, London, p. 13, The Zionist Archive, j /113/83.

Education as part of the lunch program

The goals of the lunch programs were the elimination of hunger, the promotion of unity, especially among children, under an Israeli flag, and the creation of a new, strong Jewish people, different from those in other countries. The lunch programs were used as a vehicle to educate the children on nutrition and healthy habits in the hope that the children, in turn, would introduce these ideas to their parents, thereby reducing the cultural differences among the immigrants in Palestine.

The proponents of school lunches espoused a revolutionary educational theory that then dominated Palestine, namely "the working learning idea," which stated that "you have to work in order to understand and know." Hence, the children were taught to cook their own lunches, and they also learned how to buy nutritious food economically. Moreover, their lessons included other aspects of home economics as well.[12] The kitchens also served as teaching kitchens for mothers and older women at night.[13]

The lunch program had another benefit as well: feeding the children at school during the middle of the day allowed for a longer study day. After the school lunch program came to an end in the 1970s, elementary schools, in particular, adopted shorter hours so that pupils could go home to eat sooner.

Photo 2. Boys preparing food as a part of nutritional practical education at a school in Jerusalem in 1938 (private archive of Sara Bavly).

12 Szold, Henrietta, A letter that was sent to the Hadassah in New York about the welfare organizations in Palestine, 2/6/1926, The Zionist Archive, Z"A/A/125/638.

13 Szold, Henrietta, Letter to Miss Julliet N. Benjamin about the management of the school luncheons, 12/5/1929, private archive of Sara Bavly.

Equality in the Lunch Program

The lunch program did not distinguish between religious or non-religious children, or even in theory between girls or boys. However, although both sexes participated equally in food preparation, the ancillary activities did differ. The girls studied other topics in home economics, and the boys learned either farming or other skills suitable for urban life.

The program was based on an equal investment, with each pupil having to prepare lunch for 10 other students. Students served for five days at a time, once every two months. Those who were serving their peers were involved in choosing, preparing, and serving the food, as well as washing the dishes. They were required to arrive at school by 7:30 a.m. and have the food ready by 10:30 a.m., though lunch was not served until noon. At 12:30, the children met with their teacher and discussed the recipes and the food values of the day.

Lunch programs were most successful in poorer neighborhoods that participated in the program as part of the school concept. In addition, the programs worked best in schools with fewer than 150 students, as larger schools had to get some of their food from outside caterers.[14] [15] [16] [17]

Photo 3. Children serving milk to the pupils in Jerusalem in 1938 (private archive of Sara Bavly).

14 Report on a study of school luncheons of Jerusalem, Haifa, and Safad made from January to March 1927, The Zionist Archive, Z"A/A/125/638, New York, File 321.

15 Cohen, E., "Report on the penny school luncheons fund," 1927, private archive of Sara Bavly.

16 Chaim Yassky, "Health Welfare in Palestine," Hadassah News Letter (June 1932), Hadassah Archive in New York, RG=5, Box 2, File 9b H.

17 "Memorandum, Joint Distribution Committee & Pekude Ve Amarkale Amsterdam," May 28, 1924, JDC (Joint Archives in N.Y.).

Teaching Teachers

Until 1930, it was difficult to find good teachers who knew how to teach and how to cook. The nutrition teachers worked for short periods, mostly for a few months at a time, and they were often fired because of a lack of professionalism. During summer vacations and holidays, they received no salary so that the lunch program could save money. One of Sara Bavly's first initiatives was to provide her teachers with decent nutritional education. She also gave the nutrition teachers employment rights that were equal to those of other teachers at the time.[18] [19] [20] [21] Her successes enabled her to convince the Tel Aviv school managers to join the program, rather than establishing their own lunch program provided by a caterer.

Teacher education was built up gradually, starting with a single course of a few months at the beginning of the 1930s. A two-year program at the pedagogical college of nutrition debuted in 1953. After later extending the program to three years,[22] the college continued to teach nutrition until the beginning of the 1990s. At the end of the 1980s, however, the Ministry of Education decided that there was no need for nutrition and home economics teachers in school and fired most of them.[23] [24] [25] [26] [27]

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18 Sara Bavly (Brumberg) was a young nutritionist and Zionist who came from the Netherlands to Palestine in 1926. She first taught nutrition in a village called Nahallal in the Israel Valley. Later, in Jerusalem, she became the manager of the nutrition services in the Hadassah hospitals. She ran the lunch program from 1930 until 1960. She also initiated and managed a college for nutrition education and nutrition teachers in 1952 with the help of donations from the United States.

19 Rothschild Hospital – Transfer of maternity ward to health center, 6/8/1933, Hadassah Archive in New York, RG=2, Box 32, Folder 8.

20 Richer, N., "Roots or horizons of the Israeli student in Israel in the years 1889–1933," *Katedra* (1983): 55–96.

21 *The Hebrew Encyclopedia*, Vol. 17, p. 347.

22 Brumberg, Sara, "Nutrition and Health," *The Palestine Post* (9/5/1939), private archive of Sara Bavly.

23 "Nutrition and cooking for boys," July 1934, Hadassah Archive in New York RG=5, Box 2, File 9b.

24 Bavly, Sara, "Lunch system in Palestine teaches cooking," *The Nation's Schools* 14:1 (July 1934), private archive of Sara Bavly.

25 Bavly, Sara, "Report to the Labor Office of the League of Nations: Methods of amelioration of nutrition among the working class in Palestine" (April 23, 1936), private archive.

26 Bavly, Sara, "Report of the work of Hadassah school luncheons, October 1936 to September 1937" (n.d.), The Zionist Archive, Z"A J/1/3386.

27 Rubin Shchory Zipora, "The cafeteria: the feeding program of Hadassah in the Hebrew schools," *Katedra* 92 (June 1999), 129.

The Lunch Program During the Summer – Day Camps

Many pupils obtained at least a third of their nutrition from the lunch program, so the summer recess posed a major nutritional challenge. In response, the management of the lunch program decided to widen the program to supply food to day camps during the summer.[28] [29] Since these day camps were located in the schools in Tel Aviv, Haifa, Jerusalem, and Tiberius, the nutrition teachers were used to cook the food. The summer programs were successful, as it was reported that children gained up to two kilograms during the course of the day camps.[30]

The Influence of Lunch Programs in Other Countries

At the time, lunch programs were a very common means of feeding children in the Western world, though many kinds of programs were in use. In the United States, for example, most of the programs were based on cooking in a central kitchen because of the large numbers of students who needed to be fed. The children ate in a cafeteria, choosing from a variety of food options. In such a setting, nutrition and home economics were taught as minor topics, as the children received little direct experience.

Schools in England began teaching nutritional skills in the 1930s, but only poor pupils received free food. According to Thomas McKeown (a professor in social medicine), "population growth was due primarily to a decline in mortality from infectious disease". This decline was driven by improved economic conditions that attended the Industrial Revolution, which provided the basis for rising standards of living and, most importantly, enhanced nutritional status by different means, including lunch programs that bolstered resistance to disease".[31] Bernard Harris tries to make a qualified defense of McKeown's hypothesis by saying that nutrition and economic conditions should be regarded as only one of a battery of factors, often interacting, which played a key role in Britain's transition from a high to a low rate of mortality[32]. The dominating view from the critics has been that nutrition did not contribute to the secular decline in mortality in Western Europe during the 19th century. Particularly the importance of the sanitary revolution in urban areas has been highlighted, but also factors such as the introduction of

28 A protocol of a meeting of the National Committee for Feeding Children, May 30, 1945, The Zionist Archive, Z"A J/1/7741.

29 Bavly, Sara, "Report on feeding in the summer day camp, organized throughout the country, and the contribution of the school luncheons of Hadassah in the project," The Zionist Archive, Z"A J/1/3386.

30 *Day camp circular* (1964), Israeli government archive, 1103/007.

31 Colgrove J., "The McKeown Thesis: A Historical Controversy and Its Enduring Influence," *American Journal of Public Health*, 92:5 (2002), 725–729.

32 Harris Bernard, "Public Health, Nutrition, and the Decline of Mortality: The McKeown Thesis Revisited," *Social History of Medicine*, 17 (2004), 379–407.

smallpox vaccination. Regarding the importance of curative medicine, however, most scholars have accepted McKeown's view that it did not play a major role before the introduction of chemotherapy in the 1930s and particularly with the introduction of antibiotics in the 1940s[33].

In Germany, some of the children participated in lunch programs and had to prepare the food by themselves. Research from later years also shows a use of the canteen system in eastern Germany, where most of the children received lunch at school[34].

Palestine thus employed a more modern and innovative approach to nutritional education than other, wealthier nations, using a model that combined the strengths of the English, German, and American systems.[35] This combination was a result of the varied nutritional and administrative origins of the managers of the lunch program, who were part of the melting pot that was typical to the beginning years of the country. For example, Sara Bavly, who was the manager of the lunch program, received her bachelor's degree in Holland and her master's degree done in Boston school of home economics in the United States. Her education in both countries and her experience under the British Mandate allowed her to combine facets of the three systems into the lunch program in Palestine.[36]

The Widening of the Lunch Program During the Second World War

By the start of the Second World War, the lunch program had spread throughout much of the country. The scope of the program in 1941 is illustrated in Table 1. By 1944, the lunch program had extended even farther to the smaller cities and into the countryside, employing 70 nutrition teachers on a full-time basis.[37] [38] [39] [40] [41]

As the Jewish communities in Palestine began to hear of the terrible events of the Holocaust, the school lunch program became part of the Zionist effort to create

33 Bernard Harris, (2004,) 379–407.

34 Pazola Z., [School feeding programs for children and adolescents in East Germany (personal observations)], *Problemy Medycyny Wieku Rozwojowego,* 11:1 (1982), 132–139.

35 "Nourishment for the child," 13/4/1944, The Zionist Archive, Z"A, J/1/8213.

36 Bavly, Sara, "Curriculum Vita of Sara Bavly, 1960," private archive of Sara Bavly.

37 Bavly, Sara, "A survey of the development and aims of the Hadassah school luncheons, October 1940," private archive of Sara Bavly.

38 Bavly, Sar, "A report on the work of the Hadassah luncheons for the period October 1 1943-September 30 1943," April 1944, private archive.

39 Bavly, Sara, Memo on the use of milk powder for school luncheons, 11/4/1944, The Zionist Archive, Z"A, J/ 1/ 8213.

40 "A memory of a conversation between the health center and the lunch fund of Hadassah," The Zionist Archives, 1945/8/5 J 8213/1/.

41 Bavly, Sara, "Report on the Hadassah/Vaad Leumi school luncheons project during the period October 1st 1944–September 30th 1945", The Zionist Archives J/1/7741.

powerful soldiers, or "Zebras" Jews who were strong enough to fight for their freedom.[42] [43]

A Cooperative Venture

In 1939, Sara Bavly established cooperation between Hadassah's lunch fund and the social work division of the Palestine National Committee. The social work division handled the collection of money and checked each family's ability to pay. Families were separated into three categories: Group 1 paid only 5 million per day, Group 2 paid between 5 and 10 mill a day, and Group 3 paid the real price of the meal.[44] Schools received additional funding according to the number of children in each group, with funds coming from Hadassah and other national organizations. Although the program did make an attempt to treat all the children as equals, the children knew who paid and who did not, so the gap between different classes remained.

Table 1. The spread of the lunch program in Palestine (Israel) in 1941.[41]

Location of lunch program	No of schools where children cooked lunch	No. of institutions	Kindergartens	Central kitchens	No of children receiving lunch program
Jerusalem	16	75	9	1	4,760
Tel Aviv	13	95	29	2	8,650
Haifa	12	32	6		2,438
Villages	25	100	8		7,265
Dormitories	12	18			1,772
Food supply special needs					500
Sum	78	320	52	3	25,385

Connections Between the Lunch Organization and Other National Organizations

Fiscally, the nutrition education program faced a complex situation, as Palestine was under British Mandate at the time, the program could not rely on taxes or other government funding to cover its costs. The Mandate government contributed 14% of the cost and agreed to cover an additional portion if matched by the Jewish population. The mandate government did not agree to pay anything for the lunch

42 A protocol of a meeting of the National Committee on Feeding Children, A"Z 1945/12/26J/1/7741.

43 Yafit, C. Ma., "Feeding children in schools," The Zionist Archives, 1945/12/6 J/1/7741.

44 Yafit, C. Ma., "A memory from a visit in Tel Mond," The Zionist Archive, A"Z 1945/12/19 J/1/7741.

program in the Arab schools because the Arabs did not give any contribution from their side. The Jewish teachers and administrators initiated a campaign to enlist the support of parents by teaching them about nutrition and thereby obtained a modicum of financial support. Moreover, Henrietta Szold and Sara Bavly were successful in inducing the American Hadassah women to help finance the lunch program. Dr. Bavly also gave lectures to parents on many occasions about the importance of the lunch program in an effort to build support.[45] [46] [47]

Thus, funding for the lunch program's budget came from several sources: Hadassah (30%); the Mandate government (14%); the Community Helps Organizations (22%); women's organizations other than Hadassah (2%); and parents' payments (32%). Other organizations gave administrative assistance. The National Council helped with the education of the teachers. Community food committees helped collect money from parents and ensured that the schools had enough food. The Mandate government appointed a supervisor to ensure that all children, both Jewish and Arab, received sufficient nutrition, particularly in those cities with a large Arab population, such as Jaffa, Haifa, and Jerusalem.[48] [49] [50]

An Attempt to Secure Government Funding

In 1948, Sara Bavly asked the new Israeli government to pass a law financing the lunch program, as was done in England at the time. The government rebuffed this recommendation, so the lunch program perforce continued to depend on contributions and donations.[51]

Municipalities contributed, but the national government provided no financial support. Presumably there were financial constraints, and nutrition and health were not considered priorities by the government, which was preoccupied with other events.

The rise of anti-Semitism in European countries, the growth of Zionism and the national movements brought about waves of Jewish immigration to Israel throughout the first half of the 20th century, reaching a peak after the establishment of the State of Israel with the arrival of 750,000 immigrants from all corners of the earth. Coping with the mass immigration of which the majority arrived penniless,

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45 "Women soldiers looking for their future," November 11, 1949, Hadassah archive in New York, RG=5, Box 2, Folder 1.

46 Valach, Y., "The beginning of the settlement until the country of Israel was established," *Atlas Carta for the History of Israel,* 2d ed. (Jerusalem: Carta, 1974), 101.

47 "25 years for the lunch fund of Hadassah," *Al Hamishmar* (March 22, 1949), p. x§32.

48 Bavly, Sara, "The activities of the Nutrition Department 1955," private archive.

49 Bavly, Sara, "From the nutrition department," *Culture and Education* 3 (July-August 1955).

50 Bavly, Sara, *Short description of the Nutrition Department,* September 6, 1959, Israeli government archive, 1717/8.

51 The Office of the State Comptroller—Nutrition Department—the Education Office on the Feeding of Children, March 1960, Israeli government archives.

presented complex economic and agricultural challenges to the government, including the production and coordinated distribution of sufficient quantities of food to feed the population. Thus, the lunch program was left to survive on donations without any legal backing.[52] [53]

The End of the Lunch Program

The lunch program continued its work until 1970, three years after the "Six Day War." In that time of prosperity, many felt that there was no need for an organized program to feed students. Avraham Reshef, the manager of the nutrition department and the administrator responsible for the lunch program in the Ministry of Health at the time, made the decision to end the lunch program.[54] A few years later, nutrition education was largely eliminated from the schools as well.[55]

A New Beginning

After more than three decades, the need for some sort of lunch program has once again been recognized. In 2003, of the more than 2,250,000 children in Israel, almost a third was living below the poverty line, (below 50% of median income available to a family in Israel) and that percentage is increasing. A survey conducted in 2002 by the Ministry of Health and the Joint Council on Accreditation of Healthcare Organizations showed that many children were not enjoying "food security" because of their economic situation. The definition of food security, according to WHO, is "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life." Commonly, the concept of food security is defined as including both physical and economic access to food that meets people's dietary needs as well as their food preferences. Food security is built on three pillars: food availability having sufficient quantities of food available on a consistent basis; food access having sufficient resources to obtain appropriate foods for a nutritious diet; and food use—appropriate use based on knowledge of basic nutrition and care, as well as adequate water and sanitation.[56] The inability to feed oneself in secure proper nutrition due to lack of resources and unhealthy eating

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52 Reshef, Avraham. et al., "The lunch program's contribution to children's nutrition," *Public Health,* 19 (1976), 319–328.

53 Guggenheim, K. Abramson, J. H. Perez, E and Reshef, A. "Diet and nutrition of children in selected Jerusalem schools," *Israeli Journal of Medical Science* 2:3 (May–June 1966), 344–349.

54 Avraham Reshef was the manager of the Nutrition Department in the Health Ministry from 1964 to 1997.

55 Reshef, Avraham, Personal interview, November 29, 2000.

56 http://www.who.int/trade/glossary/story028/en/ (March 31, 2007).

habits is one of the challenges of the 21st century, with obesity and malnutrition posing a global health threat Indeed, obesity is becoming an epidemic in Israel, as in other Western countries.

In response to that threat, the Knesset (the Israeli Parliament) proposed two new laws in 2004 with the aim of re-introducing school lunch programs. The first, Ruchama Avraham's Feed the Poor proposal, was meant to target only poor children; the second, Yulie Tamir and Eti Livni's Feed All proposal, was more egalitarian. Unfortunately, due mainly to economic and logistic considerations, the Feed the Poor proposal was passed.[57]

In 2004, the Ministry of Social Welfare funded a pilot program in 22 schools. An advisory committee was appointed to make recommendations regarding the program and the menus.[58] At the present time, hot cooked lunches are being provided at more than 60 elementary schools throughout the country, and there are plans to expand the program to encompass 500 schools with 154,000 pupils.

The Prime Minister's office has nominated a non-profit organization to run the program (the Sakta Rashi Fund). As in the past, funding the program requires the coordination of multiple revenue sources. The central government does subsidize the meals, but parents and municipalities must contribute up to 25% of the cost.

Conclusions

Since the beginning of the 20th century, many countries have had lunch programs of various sorts. Recent research conducted in schools in China shows that improving the quality of food and providing education on nutrition can change the behaviour of both children and parents.[59] Research in the United States indicates that the successful implementation of lunch programs requires not only the collaborative efforts of school administration and staff but also the support of parents, community, and the mass media in fostering healthy eating.

The managers of the new Israeli school lunch program have an opportunity to learn from past experience in order to achieve success in providing both nutrition and nutritional education. Reviving the lunch program without learning from the past would squander this opportunity. Henrietta Szold's initiative and the Penny Lunch Program spread throughout the country with just a few resources, but much

57 Shi-Chang, X. et al., "Creating health-promoting schools in China with a focus on nutrition," *Health Promotion International,* 19:4 (December 2004), 409–418.

58 In 2004, the Ministry of Social Welfare funded a pilot program in 22 schools. An advisory committee was appointed to make recommendations regarding the program and the menus. The following made up The advisory committee was made up of the following members: Prof. Z. Madar from the agriculture school; Hava Altman from the Nutrition Department in the Health Ministry; Anat Levi, a children's nutritionist; Dr. A. Stark, a research nutritionist; and. Dr. R. Endevelt, the head of the nutrition unit in the second biggest HMO in Israel.

59 Cho, H. and Nadow, M. Z. "Understanding barriers to implementing quality lunch and nutrition education," *Journal of Community Health* 29:5 (October 2004), 421–35.

enthusiasm. Sara Bavly understood the value of a lunch program not just as a means of feeding the poor, but also as a way to bolster both nutritional and general education (since school hours can be longer when children are fed at school).

The goals of the modern school lunch program should likewise be twofold, both nutritional and educational. The new program can benefit those suffering from inadequate nutrition due to poverty, and it can also teach children healthy eating habits at a time when obesity is becoming epidemic. The children of the 1930s and the children of today are not malnourished for the same reasons. Mainly economic reasons were previously responsible for inadequate nutrition, and concern about children being unable to concentrate because they were hungry. There were also big concern to get enough protein and for today, maybe too much concern over animal protein was one of the precursor for obesity.[60]

Nowadays it is also the variety of food choices and the lack of parents' knowledge and authority that lead to poor eating habits: the tempting surroundings, and lace of physical activity. Healthy nutrition is a precondition for a healthy population. Neglecting this issue will lead to serious and costly long-term health problems. Governmental policies should take this into account, ensuring that schools throughout the country participate in providing both nutrition and nutritional education. To do so, it is recommended that the government give full funding for a national lunch and nutrition program so that its benefits are not undermined by the constant need to seek financial support. Obesity is becoming an epidemic in Israel as in other western countries; a country wide lunch and nutrition program may help solve the program.

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60 Cannon, G., Nutrition: the new world map. *Asia Pacific Journal of Clinical Nutrition,* 11 (2002) (suppl.), S480–S497.

Migrant Men in Misery

Result from a Qualitative Life History Analysis on Individuals and Families Concerning Internal Migration, Health and Life Circumstances in Early 19th Century, Linköping, Sweden

Victoria Nygren

Introduction

The purpose of this paper is to present and evaluate the first results from an ongoing study, which aims to explore and understand, in a hermeneutic sense, under what life conditions, including their health, internal migrants lived, in a small pre-industrial Swedish town during a time of considerable social change, and also how these migrants coped with their everyday lives as new residents in town.[1] In other words, under what circumstances could these migrants better their lives in town and under what circumstances was their strive for improvement hindered? After an introduction to previous research, followed by a presentation of the method used in this study and a characterization of the context of the town, Linköping, examples of migrant life courses will be presented and discussed.

Aside from the fact that the migrants experienced a change in their own lives when they changed their geographical and social setting, they are also considered as important objects to study, since migration to the towns from the countryside in itself was a vital part of this process of social change, profound and accelerated in scale during the 19th century. The traditional agrarian way of life was in retreat and the industrialized

1 This approach is inspired by a life course perspective that investigates the "interaction" between the individual, the family and the possibilities and limitations within the structure, see Tamara K. Hareven, "The History of the Family and the Complexity of Social Change", *American Historical Review*, vol. 96, no. 1 (1991), pp. 95–124. Quotation p. 111; Jan Sundin, "Worlds we have lost and worlds we may regain: Two centuries of changes in the life course in Sweden", *The History of the Family*, vol. 4, no. 1 (1999), pp. 93–112.

way of life was yet to come.[2] A capitalistic market had started to replace the more "feudal" economic system.[3] At the same time, the rigid patriarchal order between different social groups in society was starting to loosen up. Still, there was some time before a more egalitarian and individualized social structure could emerge.[4]

Many people were proletarianised, mainly due to the increase in population and changes in the agrarian ways of production. A great deal of those were heading towards the towns looking for new ways to make their living and, hypothetically, for a more emancipated life. The regulations for permitting a migrant to stay in town were, however, strict during the first decades of the century and reflected the old social and economic system, both in the countryside and in the town, where everyone was expected to belong to a household under the surveillance of the head of the household, whether it was the owner of a farm or the master craftsman. The 'social welfare system' at work can retrospectively be judged as obsolete and not well-designed for the growing needs of these new groups of people 'in between' two systems of social structure.[5]

The "social issue" of this period of time was debated among various representatives of Swedish society.[6] It was, for instance, a popular conception among the ruling elite in towns that social misery, poverty, criminal and immoral behaviour and health problems had much to do with the invasion of migrants who came mostly from the countryside looking for a future.[7] These ideas were by no means exclusive to Sweden and when spread to the middle classes they have later influenced social theory and modernization theory.[8]

The topic of how migrants who settled in new places during structural change managed, is indeed not a new one in research. It has been a field of discussion marked

2 Hilding Pleijel, *Hustavlans värld: Kyrkligt folkliv i äldre tiders Sverige* (Verbum, Stockholm, 1970), p. 69ff, 103ff. See Börje Harnesk's definition on "patriarchalism" in which "difference", "reciprocity" and "wholeness" are important criteria in a patriarchalistic relationship, in "Patriarkalism och lönearbete", *Historisk tidskrift*, vol. 3, (1986), pp. 330–331. Quotations are translated by the author of this paper.

3 Sture Martinius, *Jordbrukets omvandling på 1700- och 1800-talen* (Liber förlag, Lund, 1982), p. 5.

4 H. Pleijel (1970), p. 69ff, 103ff.

5 H. Pleijel (1970), p. 69, 104; Arthur Montgomery, *Svensk socialpolitik under 1800-talet* (Kooperativa förbundets bokförlag, Stockholm, 1951), p. 99f; Günter Sollinger, *Sjuk- och begravningskassorna och andra understödskassor i Kungl. bibliotekets samlingar* (Kungliga biblioteket, Stockholm, 1985), pp. 20–28.

6 Birgit Petersson, "Debatten om 'Den sociala frågan'", in *Kontroll och kontrollerade: Formell och informell kontroll i ett historiskt perspektiv*, ed. Jan Sundin, Forskningsrapporter från Historiska institutionen vid Umeå universitet, no. 1 (Historiska institutionen vid Umeå universitet, Umeå, 1982), p. 88.

7 A. Montgomery (1951), p. 128f.

8 Charles Tilly, *Big Structures, Large Processes, Huge Comparisons* (Russell Sage Foundation, New York, 1984), pp. 1–13.

by a "paradigmatic"[9] shift in perspective since The Uprooted was first published in 1951. When Oscar Handlin focused on the dark side of the experiences of migration from Europe to North America in the 19th century, his critics modified this picture, a criticism against modernization theory that has been fundamental.[10] "[I]deological" and "methodological" matters are said to be involved in those cases where the more nuanced analysis has been rejected for the sake of a hypothesis to be proved.[11]

At the same time, demographic research has been able to show that male mortality in pre-industrialized 19th century Sweden was higher due to causes that can be linked to "social stress" and harsh life circumstances, notably in urban settings and in phases of life when men were most vulnerable, namely as unmarried adults. The gender role put a great deal of pressure upon men regarding breadwinning, and in a time of little predictability, the urban life gave easy access to alcohol abuse and other shady activities. Death rates were especially high among middle aged men.[12] Indeed, the phenomenon of "vulnerable men" has been noticed among some "uprooted" migrant groups as well, where the lack of social integration could endanger in particular young migrants' fragile new situation and lead to criminal and destructive behaviour.[13] In some industrialized towns during the 19th century in Belgium, demographic research has shown distinct vulnerability also among settled married migrant men and their dependent families.[14] Studies from the period of industrialization in two Swedish towns, Linköping and Sundsvall, also reveal divergent results pointing toward the importance of context. In Linköping, with small scale industry, there was a higher mortality among migrants compared to residents but in Sundsvall, with heavy indus-

9 Jan Lucassen and Leo Lucassen, "Migration, Migration History, History: Old Paradigms and New Perspectives", in *Migration, Migration History, History: Old Paradigms and New Perspectives*, eds., J. Lucassen & L. Lucassen (Peter Lang, Bern, 1999), p. 9.

10 For a historiography of migration studies, see James Jackson Jr. and Leslie Page Moch, "Migration and the Social History of Modern Europe", in *European Migrants: Global and Local Perspectives*, eds., Dirk Hoerder & Leslie Page Moch (Northeastern University Press, Boston, 1996), pp. 52–69.

11 Ibid., p. 63.

12 Jan Sundin and Sam Willner, "Social stress, socialt kapital och hälsa: Välfärd och samhällsförändring i historia och nutid", in *Samhällsförändring och hälsa: Olika forskarperspektiv*, eds., Jan Sundin & Sam Willner (Institutet för framtidsstudier, Stockholm, 2003), p. 19, 40–43, 66. Sam Willner, *Det svaga könet? Kön och vuxendödlighet i 1800-talets Sverige*. Linköping Studies in Arts and Science, 203 (Linköping, 1999), p. 279f.

13 William H. Sewell Jr., *Structure and Mobility: The Men and Women of Marseilles, 1820–1870* (Cambridge University Press, Cambridge, 1985), p. 221–233; J. Sundin and S. Willner, "Health and Vulnerable Men. Sweden: From Traditional Farming to Industrialisation", *Hygiea Internationalis*, vol. 4, no. 1 (2004), pp. 175–203. Quotation p. 194. [http://www.ep.liu.se/ej/hygiea/].

14 Michel Oris and George Alter, "Paths to the city and roads to death: Mortality and migration in east Belgium during the industrial revolution", in *Revue Belge d'Histoire contemporaine. Recent work in Belgian Historical Demography 19th and early 20th centuries*, eds., I. Devos & M. Neven (2001), p. 470, pp. 479–480, p. 487.

try, there was instead a lower mortality among migrants.[15] Hence, this field seems to need more research in order to understand a "complex" [16] and comprehensive issue.

One methodological approach that seems to have been somewhat neglected in previous research on migration history, is qualitatively oriented studies.[17] This allows an intensive analysis of a specific social and geographical context to be combined with an intensive analysis of the actual life histories of those who took part in this structural change. That approach has its roots in the life course analysis within the field of the history of the family where the lives of individuals are generally considered not to be adequately understood, unless the life history of the whole family is integrated.[18] It could be particularly useful in migration history since it has a potential to bring together two major issues of theoretical concern: primarily the question of what strategies and resources migrants used (or lacked) to integrate and survive in new, supposedly stressful, situations and settings[19] and secondly the general question of how family members or kin collaborated and reached out to each other during hard times and in different phases of life (referring to the "nuclear hardship hypothesis"[20] and its

15 Sören Edvinsson and Hans Nilsson, " Swedish towns during industrialization", *Annales de Démographie Historique*, vol. 2 (1999), pp. 63–96.

16 Ibid., p. 91.

17 This is also pointed out by Colin G. Pooley and Ian D.Whyte, "Introduction: approaches to the study of migration and social change", in *Migrants, Emigrants and Immigrants: A Social History of Migration*, eds., Colin G. Pooley & Ian D: Whyte (Routledge, London & New York, 1991), pp. 4–5; Colin G. Pooley and John C. Doherty, "The Longitudinal study of migration: Welsh migration to English towns in the nineteen century", in C. G. Pooley & I. D. Whyte, eds. (1991), p. 143f. Qualitative data in the form of migrants' oral "life stories" have however been documented and discussed by Virginia Yans-McLaughlin, "Metaphores of Self in History: Subjectivity, Oral Narrative, and Immigration Studies" in *Immigration Reconsidered: History, Sociology, and Politics*, ed., Virginia Yans McLaughlin (New York & Oxford, Oxford University Press, 1990), pp. 254–290. Quotation p. 254. Her postmodernistic approach can be compared with Tamara K. Hareven's more 'neopositivistic' approach in for example, T. K. Hareven, "What Difference does it make?", *Social Science History*, vol. 20, no. 3 (1996a), pp. 317–344; T. K. Hareven, "The generation in the middle: Cohort comparisons in assistance to aging parents in an American community", in *Aging and generational relations over the life course: A historical and cross-cultural perspective*, ed. Tamara K. Hareven (Aldine de Gruyter, New York, 1996b).

18 T. K. Hareven (1996a); T. K. Hareven, (1991), pp. 95–124. For a distinction of life course and family cycle, see T. K. Hareven, "Introduction: The Historical study of the Life Course", in *Transitions: The Family and the Life Course in Historical Perspective*, ed., T. K. Hareven (Academic Press, New York, 1978), pp. 1–16.

19 Leslie Page Moch, *Moving Europeans: Migration in Western Europe since 1650* (Bloomington & Indianapolis, 1992), p. 146. She stresses for example the function of social relations as important resources for the migrants. See also Dirk Hoerder, *Cultures in Contact: World Migrations in the Second Millennium* (Duke University Press, Durham & London, 2002), p. 18.

20 For an argument on this, see Peter Laslett, "Family, kinship and collectivity as systems of support in pre-industrial Europe: a consideration of the 'nuclear-hardship' hypothesis", *Continuity and Change*, vol. 3, no. 2 (1988), pp. 153–175. For a somewhat modified interpretation, see Tamara K. Hareven, "Aging and Generational Relations: A Historical and Life Course Perspective", *Annual Review of Sociology*, vol. 20 (1994), pp. 437–461.

critics[21]).[22] Both questions thus touch upon a controversial theme in social history research regarding the role of the individual, family and the development of the modern social welfare state.[23] In order to gain new and supplementary knowledge within this interdisciplinary area, it seems essential to synthesize demographic, social and family history data without omitting its closest context: the unique life history of each individual from which the data is derived. This requires a further downsized and scrutinized perspective and is the main reason for not performing a traditional demographic study from which statistical claims can be made.[24] However, a qualitative life history study also deals with a great amount of data, but put together and stressed differently. Nevertheless, the actual point with this method is that a specific, and even unique, life history reveals in itself pieces of information on societal structures that can be exposed, but only if the life course is studied holistically and chronologically, and considered along with the individual's interconnections with family members and interpreted in close connection to a wider socioeconomic context.[25] While doing this, the opportunity to learn something from the often neglected "private" life also reveals

21 See for example Barry Reay, "Kinship and the neighbourhood in nineteenth-century rural England: The myth of the autonomous nuclear family", *Journal of Family History*, vol. 21, no. 1 (1996), pp. 87–104; David I. Kertzer, "Household, History and Sociological Theory", *Annual Review of Sociology*, vol. 17 (1991), pp. 155–179; Muriel Neven, "The influence of the wider kin group on individual life-course transitions: results form the Pays de Herve (Belgium), 1846–1900", *Continuity and Change*, vol. 17, no. 3 (2002), pp. 405–435.

22 Compare the combination of issues brought up by Muriel Neven in "Terra Incognita: Migration of the Elderly and the nuclear hardship hypothesis", *The History of the Family*, vol. 8 (2003), pp. 267–295.

23 For examples of diverse opinions on this matter see respectively Barry Reay, "Kinship and the neighbourhood in nineteenth-century rural England: The myth of the autonomous nuclear family", *Journal of Family History*, vol. 21, No. 1 (1996), pp. 87–104 and David Thomson, "The welfare of the elderly in the past: A family or community responsibility?", in *Life, Death, and the Elderly: Historical Perspectives*, eds., Margaret Pelling & Richard M. Smith (Routledge, London & New York, 1991), pp. 194–221.

24 The approach in this study is partly stimulated by, but should not be conflated with, the several works in demographic research which perform life course analysis and analysis of family patterns, to name a few, see Lotta Vikström, *Gendered Routes and Courses: The Socio-Spatial Mobility of Migrants in Nineteenth-Century Sundsvall, Sweden*. Report no. 21 from the Demographic Data Base, Umeå University, 2003 (Umeå, 2003); Hans Nilsson and Lars-Göran Tedebrand, *Familjer i växande städer: strukturer och strategier vid familjebildning i Sverige 1840–1940*. Report no. 27 from the Demographic Database, Umeå University (Umeå, 2005); Martin Dribe, "Migration of rural families in 19th century southern Sweden. A longitudinal analysis of local migration patterns", *The History of the Family*, vol. 8, (2003), pp. 247–265; Matteo Manfredini, "Families in motion: The role and characteristics of household migration in a 19th century rural Italian parish", *History of the Family*, vol. 8 (2003), pp. 317–343; Ann-Kristin Högman, "Elderly migrants in a northern Swedish town in the nineteenth century", *Continuity and Change*, vol. 16 (2001), pp. 423–442.

25 See for example Nancy Green, "The comparative method and poststructural structuralism: new perspectives for migration studies", in J. Lucassen & L. Lucassen, eds., *Migration, Migration History, History: Old Paradigms and New Perspectives* (Wien, 1999); T.K. Hareven (1991).

itself.[26] This procedure does not aim to create a representative picture, in a statistical sense, of the migrants. Rather, the approach lies in the intersection of the search for "typical"[27] and exceptional lives of human beings. A qualitative evaluation of a certain combination of particular facts, rather than aggregate numbers, is thus primarily needed.

The major ongoing study, which this paper is a first report from, includes a primary cohort of nineteen randomly selected migrant men from the lower social strata, in their family contexts. The men are selected after having moved to town, when they are in their forties. At this age, they are expected to stay in town. However, the procedure of selection also means that the men survived at least until their middle age. Furthermore, an extended cohort of totally 61 men, including the primary cohort, has also been constructed, based on all men who have been found in the same source matching the same selection criteria. The primary cohort thus consists of c. 30% of the whole cohort.[28]

The life history analysis in the ongoing study is performed in a stepwise process.[29] In the particular phase, which is dealt with in this paper, a qualitative 'inventory' is made, aiming to discern certain "migrant profiles"[30], and understand what kind of life

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26 See for example Donna Gabaccia, "The Transplanted: Women and Family in Immigrant America", *Social Science History*, vol. 12 (1988), pp. 243–253.

27 J. Sundin and S. Willner (2003), p. 48.

28 The extended cohort, including the primary, consists of all men (61) in the lower social strata who were born 1800–1802, elsewhere than Linköping but living in that town (i.e. noticed in the church books called Husförhörslängder) at some point during the registration period 1840–1845. This means that they have previously moved into town. The analysis of the family context is limited to the primary cohort, and includes the men's wives and children as well as the spouses' parents and siblings and they are followed from the perspective of the primary cohort men and their spouses. The lower social strata is defined as consisting of "craftsmen without the master title, journeymen and apprentices, maids and farmhands, workers, paupers, widows, wives and fiancées, sons, daughters, servants, seamen, small scale tradesmen, mongers, crofters, widowers, not stated/readable", in accordance with Hans Nilsson´s classification in *Mot bättre hälsa: Dödlighet och hälsoarbete i Linköping 1860–1894* (Linköping, 1994), p. 49. However, two exceptions from Nilsson´s scheme have been made. Craftsmen with a master title as well as owners of buildings/ town houses (gårdsägare) have been included since these titles are proven to be in a grey area which could be of interest in a qualitative study like this. The extention of the cohort is constructed for reference purposes in order to build a kind of background with basic micro demographic information on the whole cohort. The extension was made after the random selection of the primary cohort.

29 The main areas of interest involve the migrants' social, cultural and geographical backgrounds, "culture of mobility", (according to Börje Harnesk, *Legofolk: drängar, pigor och bönder i 1700- och 1800-talens Sverige* (Umeå, 1990), p. 166), livelihood, housing arrangements, social resources (on an individual and structural level), the use of family bonds, gender and "social roles" (according to Johannes Siegrist, "Place, social exchange, and health: proposed sociological framework", *Social Science and Medicine*, vol. 51 (2000), pp. 1283–1293), opportunities for social integration, social mobility and emancipation, life events and social, demographic and health characteristics. These life circumstances are interpreted in close connection to the life courses and circumstances of the rest of the family.

30 This term has been borrowed from C. G. Pooley and J. C. Doherty (1991), p. 148. The method in their study is not identical with the method in this paper, but the intentions are similar.

courses actually were possible regarding life events and social and demographic characteristics. It means that the life histories of the primary cohort, consisting of the nineteen migrant men in their family context, are categorized. The first results derived from this procedure and presented in this paper concern a subgroup of nine men found to have a hard time in town. Their ´misery´ state has been qualitatively categorized from an estimation of their overall life and health circumstances primarily post migration to the town with a slight emphasis on the end of the migrants´ lives. Different kinds of 'problems' (in a wide, but severe sense) to carry on, and cope, with their lives, have been identified and acknowledged. The basis for the evaluation is the men's lives, and hence their lives will be compared to the partly intertwined life courses of their wives. A gender perspective has motivated the focus on men, since their roles seem to be exposed to certain risks in the transitional society.[31] Since the husbands had the role of family providers, their wives could be expected to share the problems found. However, the awareness of gender roles makes it theoretically risky to take for granted that the wives shared exactly the same experiences as their husbands.[32]

The main sources in the study are church registers, which in Sweden can be used for tracking individuals on a micro level, obtaining information about the individual's livelihood, conduct and health status. The intention was to cover these migrants' lives as detailed as possible but certain information was not within the range of the database which was used.[33] This meant that a manual search was added, predominantly on the sources covering the individuals' backgrounds.[34] Although the ambition was to be systematic, some information was just not available due to problems of finding the individuals. This time-consuming, but rewarding, work is however not yet completed.

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31 The gender roles are viewed as giving "positive rights" and "negative rights", according to Sheila Ryan Johansson, "Welfare, Mortality, and Gender. Continuity and Change in Explanations for Male/Female Mortality over three Centuries", *Continuity and Change*, vol. 6, no. 2 (1991), pp. 135–177.

32 See for example D. Gabaccia (1988), pp. 243–253.

33 Information on the migrants are followed backwards and forwards from the selection point of Linköping. The database is called Linköpings historiska databas (LHD), and is designed in cooperation with the Demographic Database in Umeå, Umeå university (DDB). DDB originally created the data base and owns the information. The database covers sources from the town of Linköping and 26 parishes around Linköping in the county of Östergötland. Moreover, DDB has an Internet-based database called INDIKO [http://www.ddb.umu.se/indiko/index.html], which contains church registers from another nine parishes around Linköping in Östergötland (and more than 30 other parishes). These two databases have a common ground with the exception that INDIKO does not convey information about the priests' notifications on their congregation members. Since this information is of importance to this study, INDIKO is only used in a complementary manner.

34 The Swedish church registers are available on the Internet, through Genline [http://www.genline.com/], a service for genealogical purposes which provides scanned microfilm of the original sources. These micro films were originally produced for and by the Mormons in Salt Lake City, Utah, USA and are kept at the Swedish National Archives in Stockholm. Genline's distribution of scanned church registers is an ongoing project. In some cases micro cards, which derive from the microfilms, also kept at the Swedish National Archives and distributed by SVAR, have been studied to fill some gaps of information on individual life courses.

When indicated, other sources were also consulted, for instance hospital journals, criminal records and records of poor relief for the purpose of getting as rich a picture as possible of the migrants' destinies. These 'other sources' will be further explored in the major, ongoing study, since previous research indicates that they could add to a modified and nuanced picture of migrant destinies.[35]

The Situation and Setting of Linköping During the First Half of the 19th Century

The context under study is the town of Linköping in the county of Östergötland, in the south east of Sweden, during the first half of the 19th century. It was a small town with approximately 3,000 inhabitants in the first decade of the century.[36] In the middle of the century, the population had grown to approximately 5,000 inhabitants.[37]

At this time, only about 10 % of the total population in Sweden lived in towns.[38] Yet, previous studies reveal that the migratory pressure on the town was quite heavy, but most of the migrants did not stay in town for more than a few years. In 1821–1830 for example, 361 persons moved in to Linköping, while 312 moved out (annual mean).[39] Still, the migrants were in majority in Linköping. In 1862, only 37 % of the population was born in Linköping.[40] This had to do with a lack of natural increase, due to high mortality despite high fertility.[41] The lack of natural increase was paralleled in all towns in Sweden before the 1840s.[42] In Linköping in 1821–1830, there were 34.7 deaths per thousand (annual mean).[43] There were however, huge gender differences. In 1815–1849, male mortality per thousand, ages 25–49, was 25.1 and for women 13.8. Such a large difference cannot be found in the surroundings of Linköping.[44] There was an increase of male adult mortality during the first half of the

35 See L.Vikström (2003), pp. 268–270.

36 In 1805, there were 2915 inhabitants in Linköping, according to statistics from Tabellverket, digitalized by DDB, Umeå University [http://www.ddb.umu.se/visualisering/Tabverk/FormF320].

37 In 1850, there were 5240 inhabitants in Linköping, according to statistics from Tabellverket, digitalized by DDB, Umeå University [http://www.ddb.umu.se/visualisering/Tabverk/FormF520].

38 Bo Öhngren, "Urbaniseringen i Sverige 1840–1920", in *Urbaniseringsprosessen i Norden, del 3. Industrialiseringens første fase*, ed., Grethe Authén Blom (Universitetsforlaget, Oslo, 1977), p. 271.

39 Folke Lindberg, *Linköpings Historia 3. 1576–1862 Samhälls- och kulturliv* (Linköping, 1976), p. 14.

40 Hans Nilsson and Sam Willner, *Inflyttare till Linköping under 1800-talet*. Rapport no. 6, Centrum för lokalhistoria i Linköping (Linköpings universitet, 1994), p. 6.

41 F. Lindberg (1976), p. 14.

42 B. Öhngren (1977), p. 279.

43 F. Lindberg (1976), p. 15.

44 S. Willner (1999), p. 59f.

century in Linköping, which has been interpreted as a probable influence of migration by rural proletarians.[45] This made the population of Linköping quite proletarian in its character. Despite that, the town was an educational and ecclesiastical centre. Expenses for poor relief were high. In 1836 poor relief was handed out to every 21st person in town.[46] The large expenses made the committee for poor relief worried, for instance, about the military musicians' company to settle in Linköping because of the expected burden put upon poor relief.[47] Most migrants had their origin in the nearest surroundings of the town and left an agrarian way of living for whatever job opportunities they could find in town. The majority were young and unskilled maids and farmhands.[48] They met a town based primarily on craft, supplemented by manufacture and agriculture.[49]

How these migrants managed, mortalitywise, in Linköping is only known for the period of industrialization. In a five year follow-up, during the years 1880–1885, mortality among migrants was found to be about 25 % higher compared to the general mortality in town. This was in spite of the migrants´ low age and when the migrants are compared to the same ages, their higher mortality is even more distinct.[50] The conclusion is that these migrants to Linköping seem to have been more likely to get infections, because of their previous residences in healthier environments. Knowledge about how health was influenced by the duration of time living in town could be of complementary value.[51] The question of any migrant-specific social conditions in this case cannot be ruled out either but it is harder to capture at an aggregate level.

Migrant Men in Misery

Nine of the nineteen men in the *primary cohort* confronted obvious problems and harsh life circumstances in town. To understand these men's lives, it is of interest to know what went wrong in their lives, in what life phases and locations it took place and if or how the misfortunes can be related to gender. This "migrant profile" is first illustrated by Sven and his wife Stina whose life courses are thoroughly explored

45 Ibid., p. 85.

46 F. Lindberg (1976), pp. 70–71.

47 J. P. Tollstorp, *Beskrifning öfver Linköping* (Föreningen gamla Linköping, Linköping, 1957, orig. 1834), p. 166.

48 Hans Nilsson, *Mot bättre hälsa: Dödlighet och hälsoarbete i Linköping 1860–94*. Linköping Studies in Arts and Science, 105 (Linköping, 1994), p. 84.

49 Mats Hellspong, "Städer", in *Land och stad: Svenska samhällen och livsformer från medeltid till nutid*, eds., Mats Hellspong & Orvar Löfgren (Gleerups, Malmö, 2001), p. 205.

50 H. Nilsson (1994), p. 187. See also Sören Edvinsson and Hans Nilsson, "Swedish towns during industrialization", *Annales de Démographie Historique*, vol. 2 (1999), pp. 63–96, where the same results are presented and compared to results from the town of Sundsvall.

51 S. Edvinsson and H. Nilsson (1999), p. 81, 91f.

below. Further, and briefer, examples of the other men's life courses will follow as well as comparisons with their wives' life courses.

An Explorative Example of Sven and Stina

Sven Persson,[52] was born in the parish *Wårdnäs* as a son of a farmer. His father owned the farm and his mother was herself a daughter of farmers. When Sven was about five years old his parents got divorced, which was a rare event in those days, especially in the countryside.[53] His mother moved away and after a short while the whole family was dispersed. However, Sven reunited with his mother on his grandparents' farm. When he was nine years old he got a stepfather who probably kept the farm of Sven's grandparents. Four years later his stepfather died and Sven was left again without a father. Two years after that he was fifteen and left home to begin to work as a farmhand. According to David Gaunt, Sven now entered his "lost years" [54], a kind of "limbo" state of life when the servants were not old enough to get married but old enough to work hard in someone else's household.[55] This period coincides with a "culture of mobility" among servants, a concept stated by Börje Harnesk who interprets the servants' frequent moves as a sign of struggle for emancipation.[56] Before Sven moved to Linköping in 1826 he had changed residence and employer at least five times. When he was in his twenties, he had already experienced problems with his knees, which hindered him in working and paying his taxes. When he entered Linköping 27 years old, he had however been recovered for several years. In town he continued working as a farmhand[57] but he did not stay in Linköping more than one year. He then returned to the countryside for farmhand work and ended up with his sister who was married to a farmer. He only stayed there for a few months before he decided to leave them to work in a different parish and a different household. This turned out to be a crucial decision since he met his wife to be, *Stina Sophia Jonsdotter*,[58] born in *Slaka*, in the new household where she worked as a maid. As a daughter

52 Sven Persson was born 17991110 in Vårdnäs, according to Genline, födelseboken för Vårdnäs 1799, vol. C: 3, p. 100. However, according to DDB/LHD, husförhörslängderna för Linköpings Domkyrkoförsamling, 1841–1845 (i.e. point of selection), he was born 18001112. This circumstance has not been considered to disqualify him from the cohort.

53 Marja Taussi Sjöberg, *Skiljas: Trolovning, äktenskap och skilsmässa i Norrland på 1800-talet* (Författarförlaget, Stockholm, 1988), p. 68, 171, table 1.

54 David Gaunt, *Familjeliv i Norden* (Gidlunds, Stockholm, 1983), p.114.

55 Ibid., p. 22.

56 B. Harnesk (1990), p. 166.

57 The terms farmhand (dräng) and maid (piga) are also used for unmarried men and women, which makes it hard to know for sure what occupation they had, see B. Harnesk (1990), p. 173.

58 Stina Sofia Jonsdotter was born 1805-01-30 in Slaka, according to Genline, födelseboken för Slaka 1805, vol. C: 3, p. 224.

of crofters she had left her parents when she was 20 years old. Her family advanced to be owners of a piece of land after she had moved away. [59]

Stina and Sven got married within a year after Sven's arrival in the household. The bride was 23 years old and the bridegroom was 29. They had a son 3 ½ months after the wedding ceremony, which reveals a premarital conception. Their son was born and baptized in the parish where Sven's mother and a stepsister lived. The boy stayed for seven months with Sven's mother and stepsister where Sven had lived as a child. It seems likely that Stina had to go to Sven's mother to give birth to the child since this was not allowed to happen within their employer's household. A while after their marriage, they moved to another place. Since married couples were not usually hired within a farmer's household, Sven soon started to work as a labourer at a farm, while having his own household (*statdräng)*. Stina was supposed to work as well, milking the cows. Such working and living conditions are known to have been harsh and characterized by frequent moves between different employers.[60]

In 1833 the family, now extended with a one year old daughter, moved to Linköping a second time. Would this stay be permanent or would he and his family keep on moving every second or third year as they have been doing so far? If they stayed, how did they manage to settle in town and make a living? What continuities and discontinuities would there be compared with their former way of living? What strategies could they use to better their lives or at least get by?

Sven continued working as a *statdräng* in Linköping. They got another son who died when he was eight months old from "aches in the stomach" ("*magplågor*"*),* a diagnosis which can be related to sanitary insufficiencies, worsened by summer heat and, often, the lack of protective breastfeeding.[61] Next year, Sven started working as an unskilled worker *(arbetskarl*), a vague but common term for any kind of manual work. The family got another daughter and the eldest son began school when he was 8–9 years old. 1839 they had one more son and the following year Sven was hired to work for the mayor in Linköping.

Until now, Sven and his family appear to have been able to get by, but in the beginning of the 1840s they reached a turning point. A daughter was born but died

59 According to Christer Winberg, *Folkökning och proletarisering: Kring den sociala strukturomvandlingen på Sveriges landsbygd under den agrara revolutionen*. Meddelanden från Historiska institutionen i Göteborg (Göteborg, 1975), p. 39, 42, 45, there was a grey area between different social categories during this period of time in the agrarian society. Stina's parents are illustrating the difficulties when it comes to distinguish the propertied classes from others.

60 Sten Carlsson, *Yrken och samhällsgrupper: Den sociala omgrupperingen i Sverige efter 1866* (Almqvist & Wiksell, Stockholm, 1968), pp. 53–56.

61 Anders Brändström, *"De kärlekslösa mödrarna": Spädbarnsdödligheten i Sverige under 1800-talet med särskild hänsyn till Nedertorneå*. Umeå Studies in the Humanities, 62 (Umeå, 1984); Magdalena Bengtsson, *Det hotade barnet:Tre generationers spädbarns- och barnadödlighet i 1800-talets Linköping*. Linköping Studies in Arts and Science, 145 (Linköping, 1996), p. 160f.

from "sudden death" ("*Slag*") four months later.[62] 15 months after her birth a son was born. After his first birthday the boy and Stina were hospitalized for having a venereal disease. They stayed three months at the hospital, called *Kurhus*,[63] a hospital or hospital department reserved for patients with venereal diseases developed in order to isolate the sick while curing them.[64] The medical doctor concluded that Stina had been "infected by her child" who in his turn had been "infected by a woman [---] who had breastfed the child."[65] This could indicate a vulnerable social situation because syphilis *(syfilis*) was known to be spread between wet nurses and children or between foster children and their foster families.[66] However, this kind of transmission was not reported by the medical doctor in Linköping that year.[67] Even if Stina did not leave her son to a wet nurse because this was more of an upper-class habit, she might have left him to someone for temporal care who might have infected him. It is not unlikely that such a care included breastfeeding since this was not taboo in these days.[68] If Sven and Stina were not integrated in town, this could mean that they had to leave their child with unscrupulous or socially exposed individuals.[69] The strained situation is further confirmed when Sven's ability to support the family is considered. He was left alone with four children to support and take care of at the time his wife fell ill and their first born son had moved away. By now, the priest noticed that he was "poor".[70] Their youngest son died two years old, probably not fully recovered from syphilis,

62 The diagnosis "Slag" meant sudden death among infants and children. It can often be related to diarrhoea and dehydration in the beginning of the nineteenth century Linköping, according to M. Bengtsson, "The Interpretation of Cause of Death Among Infants", *Hygiea Internationalis*, vol. 3, issue 3 (2002), p. 53–73. [http://www.ep.liu.se/ej/hygiea/].

63 DDB/LHD, husförhörslängd för Linköpings Domkyrkoförsamling 1841–1845, vol. 37, p. 348; Hospital record from Lasarettet i Vadstena, Överläkaren, Journal vid Wadstena Curhus, 1844. D1a25. Patient No: 97 and No: 98. Landstingets arkiv i Östergötland.

64 Rolf Å. Gustafsson, *Traditionernas ok: Den svenska hälso- och sjukvårdens organisering i historie-sociologiskt perspektiv* (Esselte studium, Solna, 1987), p. 292.

65 Hospital record from Lasarettet i Vadstena, Överläkaren, Journal vid Wadstena Curhus, 1844. D1a25. Patient No: 97 and No: 98. Landstingets arkiv i Östergötland.

66 Nils Thyresson, *Från franzoser till Aids: Kapitel ur de veneriska sjukdomarnas historia i Sverige* (Carlssons, Stockholm, 1991), p. 96; C. A. Rosborg, Årsberättelse från Provinsialläkare, 1860 i Trosa. Medicinalhistorisk databas, Medicinalstyrelsen, RA/420177.03. Rapport 90/181, Diarienummer 1220/61, vol. SK:30. [http://www.2.histstud.umu.se/dokument/provlak/1860/p8600488.htm] 2005-01-19.

67 L. Lindgren, Årsberättelse från Provinsialläkare 1844 i Linköping. Vård- och omsorgshistorisk databas. Medicinalstyrelsens föregångare/Sundhetskollegium, RA/420177.03, Rapport 22/90, Diarienummer 1453/1845, vol. 14. [http://www.2.histstud.umu.se/dokument/provlak/1844/p8440580.htm] 2005-01-19.

68 Susanna Hedenborg, "To breastfeed another woman's child: wet-nursing in Stockholm, 1777–1937", *Continuity and Change*, vol. 16, No. 3 (2001), pp. 399–422, p. 412f.

69 It must be added, however, that venereal disease was frequent among poor people, see Anna Lundberg, *Care and Coercion: Medical Knowledge, Social Policy and Patients with Veneral Disease in Sweden 1785–1903*. Report no. 14 from the Demographic Database (Umeå, 1999).

70 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling 1841–1845, vol. 37, p. 348.

from "sudden death" ("*slag*"), like his sister had done two years earlier. Sven was pauperised and died seven months later, 47 years old from Wasting ("*Tärande*") disease.[71] This means that he was suffering from a chronic degenerative illness, often cancer or tuberculosis.[72] From the diagnosis it can thus be assumed that Sven had been sick for a while which might have urged Stina to leave the children to someone else while working.

Stina was hereafter a widow living on poor relief, left alone with three children between seven and fourteen who left home when they were 15, 17 and 18 respectively. When the eldest son came back from Stockholm 1853, he had become a shoemaker and was soon able to marry a girl from Linköping. When he moved to start a family of his own in town, Stina went along. She lived with her son's family for the next few years. Her son bought a house in town where he established himself as a shoemaker which was a social advancement. It seems like he had capacity to help his mother because she was no longer registered as pauperised. Research from a similar milieu, the town of Örebro, shows that most households could not afford cohabiting with old parents.[73] From a gender perspective it is told to be rare too since in most cases the caring burden was put upon the women.[74] Yet, when Stina was 58 years old, and seemingly in a quite stable social position, she moved to Gothenburg, a city more than 300 kilometres away. By now she had lived 17 years without Sven, and 30 years in Linköping. What was behind this decision? People who had been treated for venereal disease were slightly overrepresented when it came to long distance moves within the country, but aside from that they showed no specific signs of marginalisation in society.[75] Her move was instead most likely caused by the fact that her daughter had previously moved to the same city.[76] It is not presumable that women moved far away without any connections at all at the destination.[77] Stina died when she was 59 years old in Gothenburg, one year after she had left Linköping.[78]

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71 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling 1846, vol. 609, p. 247. He died on the 25th of January, which means he would not turn 47 until November. However, in this study only the calendar years have been considered in the calculation of age etc. See table 1.

72 S. Willner (1999), p. 310; J. Sundin (1999), p. 100.

73 Elsa Lunander, "Bland handlare och hantverkare i en svensk landsortsstad under 1800-talet: Om hushåll och familjestruktur i Örebro", in *Den utsatta familjen: Liv, arbete och samlevnad i olika nordiska miljöer under de senaste två hundra åren*, ed., Hans Norman (LTs förlag, Stockholm, 1983), p. 157.

74 Iréne Artæus, *Kvinnorna som blev över: Ensamstående stadskvinnor under 1800-talets första hälft– fallet Västerås*. Studia historica upsaliensia, 170 (Uppsala, 1992), p. 100.

75 A. Lundberg (1999), p. 137, 144.

76 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 50, p. 222; Utflyttningslängden för Linköpings Domkyrkoförsamling, vol. 406, p. 0331.

77 I. Artæus (1992), p. 88, 101.

78 The cause of death is not known. The fact that she is supposed to have died at the same day she arrived in Gothenburg is telling something about the muddy circumstances around her. Genline, Göteborgs Gustavi domkyrkoförsamling, husförhörslängd 1861-1865, AIA:9. Förteckning över inflyttade ogifta personer vid Gustavi Domkyrkoförsamling 1861–1865.

First of all, both Sven and Stina were migrants, but when their life courses are compared, certain differences appear. Sven moved to Linköping twice. The second time he stayed for the rest of his life. Stina moved to Linköping once but left town after more than 30 years. This information underlines the often requested need of a more nuanced way of interpreting migratory behaviour than which has normally been the case, because both Stina and Sven contributed to different migration types over their life course. In aggregated surveys this is hidden, putting us at risk of assuming that different individuals always participate in different types of migration. Furthermore, Sven's and Stina's migratory behaviour clearly shows the need to interpret the individuals' life courses in close connection to life courses of other family members or kin, since motives for migration can be revealed.

When Sven's and Stina's lives are compared, gender roles seem to influence their partly different life events. Stina lived 13 years longer than Sven, and after their shared life crisis she survived another 18 years despite her risky situation as a widow with children to take care of.[79] Stina's childhood and youth was however more stable than Sven's. If her life course is considered, the most crucial phase of life seems to have been the parenting stage, while living in town married to a sick provider with a lost ability to support his family. To fully understand how this critical situation was coped with, Stina's and Sven's different gender and social roles must be connected to their available social resources, as well as generational relations. This will be dealt with in further steps in the analysis, beyond the direct scope of this paper. Here, some additional examples of migrant men with a similar life pattern will be shown.

Extracts from Migrant Life Courses: Childhood and Adolescents

Johannes Tollsten,[80] was born in *Sankt Lars*, a parish nearby Linköping. His father was a crofter and a tailor. Johannes' mother died when he was three years old and he got a stepmother when he was four. At age fourteen he became an apprentice in his sister's household since she was married to a tailor. *Peter Ericsson*,[81] was born in *Västerlösa* and was brought up in a soldier's croft. When his father resigned from the army Peter was 12–13 years old and they moved to a small and simple cabin called *backstuga*. His father died when he was sixteen but by then Peter had already moved away in order to work. Shortly after, he returned and since he was "small" and "weak", he was consid-

79 The exposed situation of widows are wellknown, for an overview of this research field within a wider context of the household and the family, see Michel Oris and Emiko Ochiai, "Family Crisis in the Context of Different Family System: Frameworks and Evidence on 'When Dad Died'", in *When Dad Died: Individuals and Families Coping with Distress in Past Societies*, eds., Renzo Derosas & Michel Oris (Peter Lang, Bern, 2002), pp. 17–79.

80 Johannes Tollsten was born 18000409 in Sankt Lars, according to DDB/LHD, födelseboken för Sankt Lars, vol. 305, p. 93.

81 Peter Ericsson was born 18000824 in Västerlösa, according to Genline, födelseboken för Västerlösa 1800, vol. C: 4, p. 9.

ered "unable to work". He kept moving back and forth to his mother who was "destitute".[82] *Johan Carl Stenqvist*,[83] was born in *Landeryd.* He was an illegitimate child with an "unknown" father. His mother got married the year after Johan's birth and they settled in *Sankt Lars.* His stepfather was a farmhand and they lived in a *backstuga* but soon he became "ill" and got "blind",[84] not being able to support his family and receiving poor relief.[85] It was not unusual that unmarried women with children were thrown to the 'leftovers' at the marriage market.[86] The new husband died when Johan was ten years old. Johan´s mother was pauperised and got into trouble with the law.[87] Two years later, she married once again, this time with a day labourer and *statdräng* who drowned three years later.

Johan Zettergren,[88] was born in *Asker* as the son of the village smith. When Johan was around 10, the family moved from the village and his father, as time went on, settled as a crofter.[89] When Johan was 17 years old he left his parents, who both still lived, and went to the town of *Örebro* to work as an apprentice to become a tailor.[90] A couple of years later, he was engaged to be married (*trolovad/förlovad*). His first son was born 1822 and a couple of months later Johan married his wife as he had become a journeyman (*geséll*). Johan and his family moved to another town, *Askersund*, two years later, where he became a master. Here, Johan was "accused of theft", according to the priest's notification.[91] *Lars Petter Zetterström,*[92] was born in *Rönö* where his father was a tailor and a crofter, like Johan Tollsten's. However, his background differs from the others because his parents survived his childhood, he had good grades when the priest examined his skills in reading and catechism and he was put in school in the nearby small town, *Söderköping*, when he was thirteen years old. When he was seventeen he went to the city of *Stockholm* but returned one year later to his parents'

82 Genline, Västerlösa husförhörslängder, vol. A1:6, p. 32 and A1:7, p. 30.

83 Johan Carl Stenqvist was born 18020113 in Landeryd, according to DDB/LHD, födelseboken för Landeryd, vol. 303, p. 107.

84 DDB/LHD, Husförhörslängden för Sankt Lars församling, vol. 4, p. 66.

85 Genline, Dödboken för Sankt Lars församling 1812, vol. C1:5, p. 359.

86 Marja Taussi Sjöberg, *Dufvans fångar: Brottet, straffet och människan i 1800-talets Sverige* (Författarförlaget, Stockholm, 1986), p. 30.

87 DDB/LHD, Husförhörslängden för Sankt Lars församling, vol. 5, p. 70. Johan Carl's mother had, most likely, been accused of theft. The Swedish expression was "Stått tjufvrätt".

88 Johan Zettergren was born 18010214 in Örebro, Asker, according to Genline, födelseboken för Örebro Asker, vol. C:3, 1783–1811. GID 284.59.38300.

89 Genline, Närke och Värmland: Örebro Norrbyås Husförhörslängd, vol. A1:11, 1811–1816. GID 201.28.23700.

90 Genline, Närke och Värmland: Örebro Norrbyås Husförhörslängd, vol. A1:12, 1816–1820. GID 201.29.35300; Örebro stad, Inflyttningslängd 1818–1820, vol. A1:16B GID 2316.102.66300; Örebro stad, Husförhörslängd, vol. A1:17A, 1821–1825 GID 2316.103.78500.

91 Husförhörslängd för Askersunds stadsförsamling, AI:7, 1816–1825, p. 243 and 281 (Microcard, SVAR: No 16314, card 6/7); In- och utflyttningslängd för Askersunds stadsförsamling 1824 and 1825, B:1 1822–1835 (Microcard, SVAR: No 16318, card 2/3 and 3/3).

92 Lars Petter Zetterström was born 1802-08-01 in Rönö, according to Genline, födelseboken, vol. C1: 1, p. 336.

croft. *Johan Henric Petterson*, [93] also had a different childhood. He was born in *Bjälbo* as a son of an organist and bell ringer.[94] The holder of such an occupation did not belong to the lowest social strata and had educational tasks among the population.[95] However, Johan's father died when Johan was eleven years old and his mother died when he was seventeen. Both parents died from "consumption".[96] This diagnosis is related to social circumstances, especially housing and working conditions and could, like wasting disease, be prolonged in its course.[97] The eldest brother took over the work as organist when their father died. Johan lived with his brother's family before he left home when he was about twenty years old.[98] *Peter Persson,* [99] was born in *Vreta Kloster,* but any information on his childhood is unavailable. The earliest information about him dates to his twenties, when he was working as a farmhand in the parish of *Kaga*. When he was 27 years old he moved to the parish *Sankt Lars*, nearby Linköping, where he, 29 year old, met his wife.[100] *Johan Edoff,*[101] was born in *Sund*. He was an illegitimate child of a maid who had failed to make the father acknowledge the fatherhood. His siblings had the same status. They lived in a cabin as lodgers and the mother was "poor". She took care of her mother who was "destitute" and "sickly". Johan left home before he was eighteen years old.[102]

When studying these migrant men's upbringing and youth, it becomes evident that in almost all cases, they had faced problems before they entered Linköping. Several of the migrant men in this group were sons of proletarians, yet the demarcation line between different agrarian social groups is not always easy to define.[103] Their socioeco-

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93 Johan Henric Pettersson was born 18021024 in Bjälbo, according to Genline, födelseboken för Bjälbo, vol. C: 2, p. 385.

94 Genline, Födelseboken för Bjälbo församling 1802, vol. C:2 1772–1827, p. 385.

95 S. Carlsson (1968), p. 168f. Johans mother was called "madame", which according to S. Carlsson (1968), p. 278, was a title no longer used among the uppermost classes but neither used among proletarians.

96 Genline, Dödbok för Bjälbo församling, 1813 and 1819.

97 B-I Puranen *Tuberkulos: En sjukdoms förekomst och dess orsaker. Sverige 1750–1980*. Umeå Studies in Economic History, 7 (Umeå, 1984), p. 346f.

98 Genline, Husförhörslängderna för Bjälbo församling, vol. A1:6, 1810–1820, p. 67, p.21 and vol. A1:7, p. 31 (It is difficult to make out, due to handwriting, the exact year when Johan left home.)

99 Peter Persson was born 1802 in Vreta Kloster, according to DDB/LHD, husförhörslängderna för Linköpings Domkyrkoförsamling, vol. 37, p. 358. This can not be confirmed, due to doubt on who his parents were. There are several Peter born in the parish, who are candidates.

100 DDB/LHD, Husförhörslängden för Kaga, vol. 2, p. 56; utflyttningslängden för Kaga, vol. 403, p. 55; inflyttningslängden för Sankt Lars, vol. 203, p. 21; husförhörslängden för Sankt Lars, vol. 10, p. 221; husförhörhörslängden för Sankt Lars, vol. 12, p. 227; husförhörslängden för Sankt Lars, vol. 12, p. 238.

101 Johan Edoff was born 18020219 in Sund, according to Genline, födelseboken 1802, vol. C: 5, p. 118.

102 Genline, Födelseboken för Sund, 1802, vol. C:5 1793–1852, p. 118; Husförhörslängden för Sund, vol. A1:3 1805–1813, p. 105; Husförhörslängden för Sund, vol. A1:4 1813–1819, p. 32; Husförhörslängden för Sund, vol. A1: 5 1820–1824, p. 51.

103 C. Winberg (1975), p. 39, pp. 42, 45.

nomic background was however shared by most of the migrants who headed towards the town. Sven, Johannes, Peter E., Johan Carl and Johan E. did, in addition, experience a childhood in despair. Their homes were split up, pauperised and marked by sickness. Even in cases when the social belonging was somewhat better, like Johan Henric's, problems can be seen. Growing up without both parents could be risky for a child, with different ramifications if it was the mother or the father who deceased.[104] Children over five years at the time of a parent's death had a better prognosis compared to younger children. Interestingly, if the child survived childhood, studies have shown an upward social mobility among them which was not paralleled among other children.[105] However, split homes, poverty and social misery are also backgrounds common to children who became criminals later in life.[106]

When Lars Petter, Johan Z and Peter P. are concerned, their problems, given what is known, seems to have started somewhat later in life, after arrival in town. This migrant exposé now turns to what happened to this group of migrant men after they entered town.

Extracts from Migrant Life Courses: Settlement in Town

To start with, an overview is constructed showing the migrant men's status of occupation/livelihood on three occasions in life: right before entering town, in their forties (point of selection) and prior to death along with age of marriage, years spent in Linköping, their age at death and cause of death.

All of these men died in Linköping. Johannes, Lars and Johan Henric died from wasting disease as Sven did. Johan Z. died from alcohol abuse and Johan Carl died from dropsy, which is a disorder known to be related to alcohol abuse, malnutrition or organ dysfunction.[107] Peter E. reached old age but since he had been sick and without means for a long time before he died, his life should be considered together with this group of men. Peter P. and Johan E. were even older when they died but, as Peter E., they had been poor for a long time. There are no signs of upward social mobility even

104 See for example, Erik Beebink, Frans van Poppel and Aart C. Liefbroer, "Parental Death and Death of the Child; Common Causes or Direct Effects?", in *When Dad Died: Individuals and Families Coping with Distress in Past Societies*, eds., Renzo Derosas & Michel Oris (Peter Lang, Bern, 2002), p. 258–260; Marco Breschi and Matteo Menfredini, "Parental Loss and Kin Networks: Demographic Repercussions in a Rural Italian Village", in eds., R. Derozas & M. Oris (2002), p. 382–387.

105 Sune Åkerman, Ulf Högberg and Tobias Andersson, "Survival of Orphans in Nineteenth-Century Sweden", in *Orphans and Fosterchildren: A Historical and Cross-Cultural Perspective*, ed., Lars-Göran Tedebrand, Report No. 11 from the Demographic database (Umeå, 1996), p. 85, 89–90.

106 M. Taussi Sjöberg (1986), p. 36.

107 See for example, S. Willner (1999), p. 309f.

Table 1. Migrant men in misery: status of occupation/livelihood on three occasions in life: right before first moving into town, in their forties (point of selection) and prior to death along with age of marriage, years spent in Linköping and their age at death and cause of death.[108]

Migrant ID	Before entrance	In the forties	Prior death	Age of marriage	Years spent in Linköping (approximate)	Age at death	Cause of death
Sven	farmhand	unskilled worker	f. unskilled worker/ pauper	29	14	47	Wasting
Johannes	farmhand	f. prison guard	f. guard	23	22	45	Wasting
Peter	farmhand	unskilled worker	f. unskilled worker/ pauper	27	44	70	General weakness
Lars	town clerk f. manservant	caretaker	f. town clerk/ pauper	37	19	49	Wasting
Johan Z.	tailor	f. tailor	f. tailor/ pauper	21	25	49	drunken-ness
Johan Carl	drummer	drummer	f. drummer	18 (31 and 52*)	17	56	Dropsy
Johan H	farmhand	extra guard	f. guard	40 (45**)	19	50	Wasting
Peter P.	farmhand	farmhand	(f.) worker/ pauper	29	52	83	old age-wasting
Johan E.	manservant	manservant	f. manservant/ pauper	30	46	86	old age-wasting
Mean:				28.22	28.66	59.44	
Median:				29	22	50	

Sources: DDB/ LHD, Church registers; Genline, Church registers; SVAR, Church registers on Micro cards. * Second and third marriage respectively. ** Second marriage.
Comment: second and third marriages are excluded when calculating mean and median age of marriage respectively.

though they spent approximately 22 years in Linköping which is quite a long time before they died at a median death age of 50. A closer look reveals further information about what happened to these men after their arrival in town.

Johannes arrived in Linköping as a recently married 23-year old, "tailor hand" ("*skräddaredräng*"). The bride was from Linköping so they settled there. The first years in town he might have continued working as a tailor hand, although he is just called *dräng*. Soon after his arrival he changed his occupation, now being a guard at the castle (where prisoners were kept), later on he was a gardener (probably in the park of the castle) and finally a guard during transportations of prisoners ("*Fångtransport Gevaldiger*"). He quit working when he was 37 years old. By then he had five children and a wife to provide for. The year before, the family had lost their baby daughter of seven months, from *slag* and Johannes mother- in- law, who had lived with the family for a long time and who died from a chest disease ("*Bröstsj.*"). She had received poor relief. Elderly women supported both by poor relief and by their children's household are not particularly rare, according to another study. The elderly women might have contributed with keeping the home clean and taking care of the children. If so, this

108 Number of years spent in town and age of death is calculated by calendar year, i.e. without considering months of birth or any other dates. This procedure means that some of the men have not yet reached the age stated in the table.

was an arrangement surviving from the traditional agrarian society.[109] Johannes died from a "Wasting" ("*Tärande*") disease when he was 45 years old.[110] He had probably, as Sven, been unable to work due to his illness the previous years before death but there are no indications that he had been given any poor relief. He left his wife with two daughters still in the household.

Peter moved to Linköping when he was 26 years old. He married a maid who had moved to Linköping before Peter. There he started to work as an unskilled worker (*arbetskarl*) but when Peter was in his thirties he got "sickly"[111] and never recovered. In his forties he was out of means and could not pay taxes.[112] By then, they got five children to feed. Peter and his wife spent their old age in different locations. Peter's wife moved away and took the children with her. Peter lived his last six years at the poor house where he died from "general weakness", 70 years old.[113]

Lars Petter moved to Linköping when he was 32 years old. He was registered as a "former manservant" ("*betjent*") and a town clerk ("*statsfogde*"/*stadsfogde*).[114] This was not work just anyone could be trusted with. However, he had an illegitimate affair with a maid in town who previously had given birth to another illegitimate child. They had a daughter who lived with her mother until they began their life together three years later. He took her as his wife in a religious procedure called *kyrktagning*.[115] It took seven years until the real wedding ceremony took place and he lawfully married the mother of his child. By then he had got himself a job as a caretaker ("*vaktmästare*"). His career as a town clerk was most likely over and seems to coincide with his moral escapade.[116] Lars became a pauper probably because of the wasting disease which he eventually died from, 49 years old. Besides Lars illness, there was "consumption"[117] in the household. His mother-in-law died from it a couple of months before Lars died. She had been living with Lars' family from the start and she was out of means the last years of her life.

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109 Birgitta Plymoth, *Fostrande försörjning: Fattigvård, filantropi och genus i fabriksstaden Norrköping 1872–1914* (Almqvist & Wiksell International, Stockholm, 2002), p. 177ff, 181.

110 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 607, p. 791.

111 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 29, p. 404.

112 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 41, p. 584.

113 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 60, p. 103 and Dödboken för Linköpings Domkyrkoförsamling, vol. 612, p. 836.

114 DDB/LHD, Inflyttningslängden för Linköpings Domkyrkoförsamling, vol. 203, p. 0120.

115 It was a kind of betrothal within folkloristic traditions, see further, Ann-Sofie Ohlander, "Att vänta barn på bröllopsdagen: Föräktenskapliga förbindelser och giftermålsmönster i 1800-talets Sverige", in *Kärlek, död och frihet: Historiska uppsatser om människovärde och livsvillkor i Sverige* (Norstedts, Stockholm, 1986), p. 68ff; D. Gaunt (1983), p. 69.

116 To be noted though, when he was 37 years old, he announced in the local newspaper, in his search for people who might have a claim on or be indebted to a certain deceased widow of a town servant ("Stadsbetjent"). He signed the announcement by using the title, "former town clerk". It is not clear whether he did this in his professional role. See *Östgöta Correspondenten*, 18390817.

117 Genline, Dödboken för Linköpings Domkyrkoförsamling, vol. C: 9, p. 297.

Johan Z moved to Linköping as a tailor master with a pregnant wife and a son, in 1825.[118] The following year he was at the height of his career, being called "Mr." ("*Herr*").[119] His family was extended with four sons and a daughter. In 1835 he was accused of theft which was punishable by the church.[120] After that incidence, Johan's professional life was over and he was from now on called "former tailor",[121] at the age of 35. He had trouble supporting his large family, which eventually was separated. The daughter was sent away as a foster child.[122] One son was looked upon as "vicious" and received corporal punishment for "shoplifting".[123] Johan's life was ended at the poorhouse where he lived for four years and finally died from "drunkenness".[124] The year before he died he had been accused of another theft. Two of his sons, the daughter and his wife also lived at the poorhouse for a while.

Johan Carl moved to Linköping when he was fifteen years old but returned the year after to his mother.[125] He was probably already assigned to be a military musician at the regiment in Linköping, since he was called a "drummer".[126] He moved back to Linköping when he was eighteen and married a woman who was 43 years old and who had three illegitimate children.[127] They moved back to his mother where Johan's wife contributed to the household economy by selling liquor without permission.[128] One of her children, now a stepdaughter of Johan Carl, got relief from a friendly society.[129] She moved away at the age of twelve to Linköping, probably as a foster child.[130] Ten years later Johan became a widower.[131] He remarried the year after and moved to Linköping again with his new wife. When Johan retired from his work as a military musician he was 47 and his family moved back to his mother. Johan received a pen-

118 DDB/LHD, Inflyttningslängden för Linköpings Domkyrkoförsamling, vol. 202, p. 0108.

119 DDB/LHD, Husförhörslängderna för Linköpings Domkyrkoförsamling 1831–1835. Herr means mister or master but was used among the four estates in Sweden until 1867, see S. Carlsson (1968), p. 281.

120 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 34, p. 134.

121 The first notification can be seen in DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 36, p. 134.

122 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 41, p.418 and vol. 47, p. 252. In the latter churchbook she was called "fattigbarn", which meant that she was a poor child.

123 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 41, p. 418.

124 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 43, p. 234; Dödboken för Linköpings Domkyrkoförsamling, vol. 609, p. 282.

125 He has not been found in the church registers of Linköping. It is not certain that this was his first move to Linköping since he had moved to an unknown destination before.

126 DDB/LHD, Husförhörslängden för Sankt Lars församling, vol. 6, p. 130.

127 Genline, Husförhörslängden för Sankt Lars församling, vol. A1:6, p. 130. According to the priest she had five illegitimate children. However, only three are identified in the church register and are also mentioned later on by the priest.

128 DDB/LHD, Husförhörslängden för Sankt Lars, vol. 8, p. 150.

129 DDB/LHD, Husförhörslängden för Sankt Lars, vol. 8, p. 150. The friendly society was called Serafimergillet.

130 DDB/LHD, Husförhörslängden för Sankt Lars, vol. 8, p. 150.

131 DDB/LHD, Dödboken för Sankt Lars församling, vol. 606, p. 285.

sion from the army.[132] He lost his wife, and was once again a widower. He also lost his five years old daughter, from a "Chest disease"[133] and now he was on his own because their first child had died some years before from "Sudden death" ("*Slag*")[134], five months old. He remarried three years later and moved to Linköping once again where his wife already lived with her illegitimate child from before. They lived for the first part of their marriage with Johan's father-in-law and his wife. Three years later Johan was sent to prison for theft. He was punished to work there for one year and shortly before he had made amends for his crime and was to be let out, he died from "Dropsy" ("*Vattusot*"), [135]while still in prison, 56 years old.

When Johan Henric came to Linköping he was a 31 years old farmhand.[136] He held this title until he changed occupation and became "Extra Guard" ("*Extra Vaktkarl*").[137] He married a maid in town soon after that, 39 years old. [138] In the middle of his forties he bought a house in town. This could be an indication of success in some sense and was maybe related to his occupation since this has been found in two other cases for persons with the same occupation.[139] However, within a couple of months he became a widower, 44 years old, and was also hospitalized for "Rheumatism" in his knee. The hospital record shows that he was infected with "syphilis which however not at present is contagious". He was also found to have a flat nose due to a punch on it. Furthermore, it was noticed in the record that "he is keen on hard liquors".[140] His wife had recently died in connection with the delivery of their second son.[141] Half a year after he left the hospital, he remarried.[142] He had a son with his new wife but the infant died from "Sudden death" ("*Slag*"), eleven days old.[143] They had a daughter who died 3 ½ years old, from "Sudden dealth" ("*Slag*"), as well.[144] By then Johan Henric had been dead for about two months. He died from

132 DDB/LHD, Husförhörslängden för Sankt Lars församling, vol. 18, p. 163 and vol. 20, p. 163.

133 DDB/LHD, Dödboken för Sankt Lars församling, vol. 607, p. 201.

134 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 607, p. 791.

135 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 610, p. 412.

136 DDB/LHD, Inflyttningslängden för Linköpings Domkyrkoförsamling, vol. 203, p. 0132.

137 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 37, p. 528. In the estate inventory made after his death, he is called "the former guard of the castle" ("förre Slottsknekten").

138 DDB/LHD, Vigselboken för Linköpings Domkyrkoförsamling, vol. 5070, p. 538.

139 DDB/LHD, Husförhörhörslängden för Linköpings Domkyrkoförsamling, vol. 41, p. 206. Another "Extra Vaktkarl" owned the house where Johan Henric lived for a while, see DDB/LHD, husförhörslängden för Linköpings Domkyrkoförsamling, vol. 37, p. 528. Another man in the migrant primary cohort (but not included in this migrant profile category), was a guard and owned a house as well.

140 Patient record, Lasarettet i Vadstena, Patient N:o 129, 18461024.

141 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 609, p. 248.

142 DDB/LHD, Vigselboken för Linköpings Domkyrkförsamling, vol. 5090, p. 185.

143 DDB/LHD, Dödboken för Linköpngs Domkyrkoförsamling, vol. 609, p. 264.

144 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 609, p. 314.

"Wasting disease", when he was 50 years old in 1852. [145] By the time of his death, he no longer owned a house, was out of work and "crippled".[146] Five days after his death, another son was born.[147] He and his mother and his siblings were left with an indebted household. Among other things there was a debt for renting a dwelling.[148]

Peter P was already married when he moved to Linköping, 31 years old. He got a job, still called farmhand. The couple had two daughters. In addition, his wife had an illegitimate son from before. Their second daughter died however from dysentery ("*Rödsot*"), almost three years old. Next year, a son was born who died from "chest disease" when he was an infant. When Peter was about 40 years old, the family's problem became more apparent. His wife was a "pauper". Peter was said by the priest to be "drinking". This judgement followed him later on in the church registers. He and his wife had another daughter who died from "Sudden death" ("*Slag*"), one week old. When Peter was about 50 years old, he was out of work ("*Försvarslös*"). His wife was now "crippled". In 1867, when he was 65, he moved to the poor house and never returned home. 18 years later he died there from "old age wasting".

At the same poorhouse Johan E. spent his last 20 years of life before he died from old age wasting, 86 years old. He had come to Linköping as a 26 years old manservant but he moved out again shortly after. He came back along with his family when he was 40 years old. He worked as a manservant in Linköping until he was about 45 years old and for some reason quit working. By then he had two daughters, besides his wife, to support at home. His wife was convicted of first time theft 1859. She died the same year, leaving Johan E. alone. He never remarried and eight years later he moved to the poor house.

How can these migrant men's destinies be understood? When studying their settlement in town certain patterns can be noticed. Like Sven, they managed to get through the first eye of the needle, which was to get a job, *i.e.* "Legal defence" ("*Laga försvar*"), as demanded to be permitted to stay in town.[149] To be noticed though, is that not all of them "settled" their first time in town. In a migratory turbulent town like Linköping, at least five years of stay has been considered a criterion of being "settled"[150]. Johan Carl, for example, who moved, even while married, back and forth several times between his mother in a nearby parish and Linköping is a reminder, as also

145 DDB/LHD, Dödboken för Linköpings Domkyrkoförsamling, vol. 609, p. 311.

146 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 45, p. 486.

147 DDB/LHD, Födelseboken för Linköpings Domkyrkoförsamling, vol. 310, p. 20.

148 Landsarkivet i Vadstena, Boupptecknin, vol. B 66, p. 53ff.

149 A. Montgomery (1951), pp. 55–65. Legal defense meant that a person was forced by law to be employed if there were no private means to support oneself. Otherwise, the person risked being sent to an institution for forced labour. Between 1919 och 1933 the Act of Legal defense was reformed, meaning that only beggars and criminals without Legal defense were threaten with institutionalization with forced labour.

150 Anders Brändström, Jan Sundin, Lars-Göran Tedebrand, "Two Cities: Urban Migration and Settlement in Nineteenth-Century Sweden", *The History of the Family*, vol. 5 No. 4 (2000), pp. 415–429, quotation p. 416.

Sven is, that the same individuals could appear in the migration statistics for a town more than once. Usually though, it "meant the end of a migration career" to get married.[151] This was true for the other migrants' settlement during which all got married, if they were not already married when they arrived in town. As table 1 shows, their mean age of marriage was 28.

Notably, these migrants' hardest time in town appears to be when these migrant men had a family to support. Due to different circumstances they failed in doing so. Life events which affected the whole family came to the surface. Their miserable situation is indicated by the often repeated infant and childhood mortality among these families, which often coincided with what appears to be a time of culminated crisis.[152] Several of these men were hit by chronic and degenerative illnesses, where in some cases binge drinking can be *suspected* to be involved. A prolonged period of illness must have caused inability to work and provide for their families' and their own well-being. Failure to keep a job, even if not being ill, seems to have been the case for some of them too, as well as incidents of criminal or immoral behaviour, according to the standard of the time. Some of these men had even begun a professional career (although modest), which was interrupted in town, like in Lars' or Johan Z.'s case. In those examples nothing but a moral sidestep can be detected when trying to understand what happened in these men's lives. Thus, the men in this study do not seem to have faced their most risky and difficult time as single, young men who recently had arrived in town, compared to what is known from previous studies.[153] There can of course be a hidden chronology of despair in their lives as well, hence accumulating effects of hard times. The procedure of selection not to forget, guarantees that this group of men was alive in their forties as well. In any case, the socioeconomic problems that several of these men had already experienced earlier in life seems to recur or be aggravated in town in a phase of life when they were settled with wife and children.

151 Ibid., p. 427.

152 M. Bengtsson (1996), p. 173ff., 195. Bengtsson demonstrates that during the middle of the nineteenth century the family had a decisive impact upon infant mortality. The risk of dying as an infant was three times higher if a close sibling had died previously compared to those infants with a close sibling who had survived the first year of life.This was a fact regardless of social belonging. Moreover, the frequent diagnosis, "Slag", had a social dimension and was most prevalent among the lowest layers of the social hierarchy.

153 W. H. Sewell, Jr. (1985), p. 221–232; L. P. Moch, *Paths to the City: Regional Migration in Nineteenth-Century France* (Sage Publications, Beverly Hills, 1983), pp. 125–132; L. P. Moch, *Moving Europeans: Migration in Western Europe since 1650* (Indiana University Press, Bloomington & Indianapolis, 1992), p. 144f.; S. Willner (1999), p. 236–247; J. Sundin, "Äktenskap, ensamskap och hälsa förr och nu: Tankar kring ett forskningsfält", in *Individ och struktur i historisk belysning. Festskrift till Sune Åkerman*, eds., Tom Ericsson & Agneta Guillemot. Forskningsrapport nr. 10. Historiska institutionen, Umeå universitet (Umeå, 1997), pp. 219–245.

This is interesting, since marriage is looked upon as "a key step toward becoming integrated in the urban environment".[154] *Social integration* is a concept referring to social relations and social commitments in society and the meaning of social belonging to individuals.[155] It is often viewed as an important health determinant.[156] The phenomenon of higher mortality among unmarried men than among married in contemporary societies can for instance be interpreted, inspired by Emile Durkheim, as related to lack of social integration and social control which husbandhood and parenthood can provide, probably with important consequences for health conduct.[157] The husband and fatherhood role can however be affected if other "core social roles", like the work role, are unsatisfactorily fulfilled. This could lead to stress and a yearning to eliminate that stress, sometimes by applying a destructive health behaviour, like smoking and drinking.[158] Here, gender is an issue, because the socially accepted behaviour of men and women differs, and these differences change over time. Men and women in nineteenth century Sweden did not have the same "rights" behaviourwise. Some were "positive" and some were "negative", viewed from a health perspective.[159] In this context of understanding, it could be fruitful to turn the interest to the spouses of migrant men. Who were they and how do their life courses appear when compared to their husbands'?

Spouses of 'Migrant Men in Misery'

Among those five migrants who got married in Linköping, only Johannes and Johan Carl married women born in Linköping. Still, Johan Carl's first bride was a woman born elsewhere than Linköping. Migrants' inclination to marry other migrants has been noticed in earlier demographic research of Linköping, as well as Sundsvall, and is interpreted as part of a marriage behaviour pattern aiming to maintain cultural steadi-

154 A. Brändström, J. Sundin, L-G. Tedebrand, "Marriage and Urban Adaption: Sundsvall and Linköping in XIXth Century Sweden", *Annales de Démographie Historique*, 2 (1999), pp. 97–114, quotation, p. 103.

155 Social integration is a concept originally used by Emile Durkheim in his classic study of suicide (Le Suicide, orig. 1897), *Självmordet* (Argos Förlags AB, Uppsala, 1968), see p. 155. "The more lively interaction and the more contacts between members of the group, the stronger is the group integrated." Quotation are translated by the author of this paper from the Swedish translation.

156 When migrants´ possibilities to integrate in a new place are evaluated, their health status has, on the other side, also been used as an indicator of their potential success. See S. Edvinsson and H. Nilsson (1999), p. 63.

157 Debra Umberson, "Family Status and Health Behaviours: Social Control as a Dimension of Social Integration", *Journal of Health and Social Behavior*, vol. 28, No.3 (1987), pp. 306–319.

158 Johannes Siegrist, "Place, social exchange and health: proposed sociological framework", *Social Science and Medicine*, vol. 51 (2000), pp. 1283–1293.

159 S. R. Johansson (1991), pp. 135–177.

ness in new situations and surroundings.[160] This has to be considered along with the fact that migrants actually were in the majority in Linköping.[161]

However, the endogamy was also "social"[162], and indicates a socially stratified marriage market, where a person born in town was highly valued.[163] The 'migrant men in misery' married women with a similar social background. Johan Carl got married three times and Johan Henric got married twice while the others only got married once. Out of twelve wives, childhood information on 10 wives has so far been possible to gather. As has been shown above, Sven and Stina had a common history as servants in the same household at the time of their engagement. Stina was a daughter of a crofter, who eventually became owner of a small piece of land. Johan Carl's first wife, *Cristina Malmberg*[164], had been living in the same cabin ("*backstuga*") as Johan Carl before him and hence shared his geographical and social background. She was however 25 years older than him and had three illegitimate children. This social circumstance was familiar to Johan Carl who himself was an illegitimate child. His second wife, *Sara Sofia Tollsten*[165], was a half-sister to Johannes Tollsten (a member of the cohort) and although she grew up in another parish than him and did not lose her mother as a child, she could be said to share a similar social background as him. Johan Carl's third wife, *Dorotea Wilhemina Sandberg*[166], was born in Linköping but, like Johan Carl, she was a child born without an official father. Her mother was a maid almost in the same age as Johan Carl. Dorothea lost her mother when she was 16, but by then she had a stepfather. Johannes wife, *Anna Stina Brunelius,*[167] was born in Linköping. Her father was a military carpenter ("*Timmerman*") but he died when Anna Stina was a young teenager. Her mother was "sickly" and received poor relief.[168] After a prolonged time of relationship, Lars married a maid who was living in the same neighbourhood as Lars when he moved to Linköping. *Brita Christina Wiman's*

160 A. Brändström, J. Sundin, L-G. Tedebrand (1999), p. 109ff; L. Vikström (2003), p. 192. However, Vikström did not find a pattern where the spouses were born in the same parish or arrived to Sundsvall from the same parish.

161 See also Michel Oris, "The age at marriage of migrants during the industrial revolution in the region of Liège", *The History of the Family*, vol. 5, No. 4 (2000), pp. 391–413.

162 A. Brändström, J. Sundin, L-G. Tedebrand (1999), p. 110.

163 See also Margareta Matovic, "Migration, Family Formation, and Choice of Marriage Partners in Stockholm, 1860–1890", in *Urbanization in History: A Process of Dynamic Interactions*, eds., AD van der Woude, Akira Hayami & Jan de Vries (Clarendon Press, Oxford, 1990), p. 230, 239.

164 Christina Malmberg is told in the churchbook of DDB/LHD, Linköpings Domkyrkoförsamling, vol. 22, p. 514, to have been born 1777 in Jönköping, but this has not been possible to confirm.

165 Sara Sofia Tollsten was born in Kärna 18160515, according to Genline, Kärna födelsebok 1816, vol. C:3 1808–1856, p. 41.

166 Dorothea Wilhemina Sandberg was born in Linköping 1827-04-14, according to DDB/LHD, Födelseboken för Linköpings Domkyrkoförsamling, vol. 307. p. 24.

167 Anna Stina Brunelius was born 1770314 in Linköping, according to DDB/LHD, Födelseboken för Linköpings Domkyrkoförsamling, vol. 303, p. 414.

168 DDB/LDDB, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 15, p. 164.

[169] father was a manservant and they moved to Linköping when Brita Stina was four years old. When she was seven years old, she lost her father. *Anna Lisa Follin*,[170] the wife of Petter E., was fatherless too as a child. Her father was an unskilled worker at the town customs office. He died when Anna Lisa was seven years old. Her mother remarried six years later with another unskilled worker. Johan Henric's second wife, *Anna Greta Sandberg*[171], was a daughter to a farmer who did not own the land himself ("*brukare*"). He added to his income by making buttons. Her mother was "sickly" and was recommended by the priest to be dismissed from paying taxes.[172] When Anna Greta was 14 years old her father died in a poor state. Johan Zettergren's wife, *Lisa Qvarnström*,[173], was the daughter of a miller. He died from "chest disease" when Lisa was 13 years old.[174] Lisa moved to stay within another household some time after. She moved to the town Örebro when she was 20, where she soon met her husband to be.[175]

Unlike the above mentioned spouses, there are no indications of social distress in the childhood of Johan Henric's wife, *Johanna Carlsdotter*[176], who was the daughter of a quite wealthy farmer (*rusthållare*[177]) and Peter P's wife, *Carin Jonsdotter*,[178] who was born in a farmer family. However, the information on these women's childhood is limited. There is no information found on the childhood of Johan E.'s wife, *Helena Catharina Persdotter*,[179] as was the case with *Christina Malmberg*, the wife of Johan Carl.

Knowing that these migrant men in most cases married migrant women (defined as not born in Linköping) and women from the same social layers, it is of interest to see how these women's lives went on in town. Age of marriage with cohort migrant man,

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169 Brita Stina Wiman was born i Kärna, 18070222, according to DDB/LHD, Födelseboken för Kärna församling, vol. 302, p. 412.

170 Anna Lisa Follin was born in Skänninge, 1804-11-02, according to Genline, Födelseboken för Skänninge stad 1804, vol. C:3 1795-1841, p. 97.

171 Anna Greta Sandberg was born in Slaka 1822-01-09, according to DDB/LHD, Födelseboken vol. 305, p. 53.

172 DDB/LHD, Husförhörslängden för Slaka, vol. 6, p. 338.

173 Lisa Qvarnström was born in 17991124 in Bergslagen, Filipstad, according to Genline, Födelseboken för Filipstad, Bergslagen, vol. C:7, 1779–1809, p. 349.

174 Genline, Dödboken år 1812 för Kvistbro, Örebro, vol. C: 6, 1801–1815.

175 Genline, Husförhörslängden för Örebro, Askersunds Landsförsamling, vol. A1: 4B, 1816–1820, p. 144; Inflyttningslängden för Örebro, 1819, vol. A1: 16B, 1816–1820 GID 2316.102.66700.

176 Johanna Carlsdotter was born in Flistad, 18131007, according to Genline, Födelseboken för Flistad 1813, vol. C: 2 1794–1837. Her childhood has not been possible to follow after she was about six years old.

177 This means that the farm had capacity to contribute to the army with a horse and armour.

178 Carin Jonsdotter was born in Östra Ryd, 18010814, according Genline, födelseboken för Östra Ryd, 1801. Her childhood has only been possible to follow until she was about eight years old.

179 Helena Catharina Persdotter was born in Vetlanda 18070623, according to Genline, födelseboken för Vetlanda 1807. She has not been found in the church register, called Husförhörslängderna.

Table 2. The spouses of migrant men in misery: Age of marriage, years of marriage, years spent in Linköping, widow of migrant man/age, out migration from Linköping as a widow to a migrant man /age, age of death and cause of death.[180]

Spouse ID	Age of marriage	Years of marriage	Years spent in Linköping (approx.)	Age of being widow	Age of migration from Linköping as a widow	Age of death	Cause of death
Stina	23	18	30	41	58	59	Unknown
Brita Christina	32	12	42	44	45	unknown	Unknown
Anna Stina	24	22	50	46	no	52	Consumption
Anna Lisa	23	43	51	66	no	69	Consumption
Johanna	29	4	6	no	no	33	Childbirth
Anna Greta	25	5	12	30	35	unknown	Unknown
Carin	30	44	42	no	no	74	Consumption
Helena C	25	27	17	no	no	52*	Unknown
Lisa	23	28	31	51	no	57	Wasting
Christina	43	12	8	no	no	55	Sudden death (”*Slag*”)
Sara	17	18	12	no	no	35	Poxes
Wilhelmina	27	4	54	31	no**	62	Cancer in liver
Mean:	26.75	19.75	29.58	44.14		54.8	
Median:	25	18	30.5	44		56	

*This information has not been possible to confirm in the mortality register (*Dödboken*).
**She moved out as a remarried widow at the age 35.
Sources: DDB/LHD, Church registers; Genline, Church registers; SVAR, Church registers on Micro cards.

years of marriage with cohort migrant man, years spent in Linköping, widow of cohort migrant man/age, out migration as a widow, age of death and cause of death, are summarized in table 2.

The women spent in average 19 years of their lives along with their men, which is quite a long period of time. In fact it was probably even longer since in seven out of twelve marriages there was a pre-marital conception.[181] This was a common pattern in several districts in Sweden among the poorer social layers and is interpreted as an accepted behaviour when the couple already had decided to get married.[182] These women spent on average almost the same number of years as the migrant men in town, but the variation was large between the women. The women died predomi-

180 All numbers are calculated by calendar year, i.e. without considering months of birth or any other dates. This means that some of the women have not yet reached the age/time stated in the table. The women´s age of marriage is not restricted to first marriages, as is the case with the men's mean and median age of marriage respectively in table 1.

181 In the case of Johan Edoff and his wife, their first born daughter was called “illegitimate” by the priest. See Genline, Födelseboken för Västerlösa 1832, vol. C: 4, p. 155.

182 A-S. Ohlander (1986), p. 81.

nantly from chronic diseases, except the diagnosis childbirth, poxes and sudden death (which might however be stroke). Their age of death varied too, like the migrant men's in the cohort, which makes it hard to see any gendered patterns.[183] All (among whom the age of death is known) but three men and three women died before their 60th birthday. The few men and women who managed to reach old age, apparently did so despite their miserable lives. However, age of death is not the only factor that needs to be taken into consideration when comparing these spouses' lives.

In fact seven out of twelve wives outlived their husbands. Viewed from the men's perspective, all men but Petter P. and Johan E. (who both became very old) left a widow when they died. To count the widows' survival years requires that the spouses' age at marriage is regarded as well, which is shown below in table 3.

In this selected group, shown in table 3, the men got married within the wide span of age 21 and age 52 and the women got married between age 23 and age 32. The mean age of marriage among all nine men was 28 and among all 12 women nearly 27, as is shown in tables 1 and 2, respectively. Previous research regarding marriages *in Linköping* 1850–1855, shows that men had a mean age of 29 and women 27.6.[184]
When it comes to migrants, it has been shown that migrant men in 19th century pre-industrial Sundsvall had a mean marriage age of 28.6 and migrant women 28.1, respectively. The age difference between the spouses was found to be slighter than was the case among the spouses in table 3, where the age difference was quite distinct. Vikström´s cohort was however selected on different grounds.[185] When the age differences between the spouses in table 3 are taken into account, only Stina's number of survival years seems outstanding. Does this imply that these couples shared the heavy burden of life in town in a similar way?

When each couple is matched together and viewed qualitatively, and the focus is put on the apprehended 'life crisis', some of these women, as mentioned before, were certainly not excluded from difficulties. As in Stina's case, Anna Greta was infected with venereal disease and was hospitalized for about a month.[186] Since her husband to be, Johan Henric, also was infected at the time, there seems to be a connection.

183 The 10 women of whom the age of death is known, had a median age of death that was higher than the 9 men's but the women´s mean age of death is lower than the mean age of death of the men in the cohort. The latter is contradictory to L. Vikström's (2003), p. 150–151, findings concerning 19th century industrialized Sundsvall, where migrant men had a tendency to die at a younger age than migrant women, which is also in line with the theory of "vulnerable men". However, Vikström has not made any comparison between spouses regarding longevity. Nevertheless, the numbers in the present study are far too small to draw any safe conclusions. Furthermore, the comparison between the spouses is complicated by the fact that the spouses started their married life together at different ages.

184 A. Brändström, J. Sundin, L-G. Tedebrand (1999), p. 108, table. 9.

185 L. Vikström (2003), p. 189. The compared cohorts in Vikström´s study are much larger, containing 97 men and 79 women.

186 Hospital record, Länslasarettet i Vadstena, Vadstena Kurhus, Överläkarens arkiv, patient N:o 125, år 1846. The diagnosis was called "Dröppel".

Table 3. Couples where the wife outlived the husband. The spouses age of marriage and number of survival years among the widows.[187]

Groom		Bride		No of survival years of widow after husband's death
Name	**Age**	**Name**	**Age**	
Sven	29	Stina	23	18
Johannes	23	Anna Stina	24	6
Peter E	27	Anna Lisa	23	3
Lars Petter	37	Brita Christina	32	Min. 1 (out migration)
Johan Z	21	Lisa	23	6
Johan Carl	52	Wilhelmina	27	31
Johan Henric	45	Anna Greta	25	Min. 5 (out migration)
Mean	33.42		25.28	
Median	29		24	

Sources: DDB/LHD, Church registers; Genline, Church registers; SVAR, Church registers on Micro cards.

Anna Lisa and Peter E. spent their last years as married in separate locations. Anna Lisa lived at an institution, probably in order to work for her support. She became a pauper the last year of life. Lisa had to move to the poor house when her husband Johan ended up there. However, she spent her last years elsewhere than the poor house. Among the other spouses who died before their husbands, Carin was "crippled" when she was in her middle age[188] and Helena Christina was accused of first time theft and breaking of the Sabbath the same year she died. A criminal act was also committed by Johan Carl's first wife Christina who was said to be selling aquavit, without a license.[189] However, no other striking indications of the women's individual role in the problems (like sickness or criminal behaviour) they faced as a family, have been found among these spouses of migrant men in misery.

When comparing the known life circumstances in town for the men and their spouses, it is not easy to come to a straightforward conclusion. Rather, the findings are somewhat ambiguous. Pure mathematics has not revealed any remarkable differences between the couples. There seem to be no apparent advantages for the women as far as their demographic features can tell. The small numbers contained quite scattered figures though and require an interpretation with great caution. For instance, the society in change that they lived in can be expected to give chance a greater role for the outcomes of these individuals' lives, than what would probably be the case in a more sta-

187 All numbers are calculated by calendar year, i.e. without considering months of births or any other dates. This means that some of the men and women have not yet reached the age/time stated in the table. The brides' age of marriage is not restricted to the first marriages, as is the case with the grooms' mean and median age of marriage, respectively.

188 DDB/LHD, Husförhörslängden för Linköpings Domkyrkoförsamling, vol. 47, p. 606.

189 According to Iréne Artæus these women should not be looked upon as criminal in the real sense, since they seldom committed any other crimes. See I. Artæus (1992), p. 157.

ble society.[190] When the whole life history analysis is reflected upon, there is nevertheless a lingering impression of imbalance between the life courses of the men and their spouses, regarding the different roles involved in what has been considered as the nature of their problems in town. Although the women most likely suffered from their dreadful family situation, their 'stand back' role might have made them able to cope with their lives somewhat better. Indeed, this hypothesis requires a continued analysis, since the data from the life histories touched upon here reaches only the top of an iceberg.

Discussion

In this paper, the life courses of a small group of migrants and their spouses have been analyzed, as part of an ongoing study, which aims to explore and investigate under what health and life circumstances internal migrants lived, and how they coped with their everyday lives as new residents in a small pre-industrialized town. The first results concern a discerned "migrant profile" of men who faced problems in town. These problems were found to be at their heights when the men had a family to provide for but failed in doing so. Hence, it could be said to be a gender-related problem since it was expected that these men should support their family. Their failures could be due to different circumstances but their phase of life, is not an unimportant factor. Demographic findings from the industrialized 19th century Belgium suggest that family members of married migrant men have been found to suffer from an exposed socioeconomic situation and a high mortality.[191] The conclusion from the Belgian study is that:

> …the real challenge was not migrating to the boom towns at the heart of the industrial revolution, but raising a family in this new environment. Obviously, family history must become central to a new social history of the formation of the nineteenth-century working class.[192]

Although this paper deals with a different context and a different epoch with its particular small-town, pre-industrialized characteristics, there seem to be some common patterns here. One such pattern, besides the material conditions, which might have been even worse before industrialization brought about more job opportunities, could be the lack of social integration, which is related to social control and gender roles. Since the migrants in this study had spent a long period of time in town and were

190 Jan Sundin, "Livet i den förindustriella staden: Om det goda livets sociala villkor", in *Det goda livet*, ed. Per Månson (Daidalos, Göteborg, 2001), p. 98.

191 M. Oris and G. Alter (2001), p. 470, 480. Middle aged men has also been shown to have a high mortality in early nineteenth century Sweden. See J. Sundin and S. Willner (2003), p. 66.

192 M. Oris and G. Alter (2001), p. 487.

married when their problems were intensified, this would imply that they were socially integrated but this cannot be taken for granted and must be further explored.[193] Previous research on individual, but "typical", cases in pre-industrialized Linköping, suggests that the proletarians were exposed to "social stress", worsened by the lack of social connections, which seems to be common among those who had previously moved to town.[194]

One step towards an understanding of this multifaceted issue, is to study the group of individuals around the spouses, for example acting as godparents of the migrants' children.[195] Already started studies have shown that neighbours or workmates can be recognized as well, implying what social resources were at hand. This could help to indicate whether the migrants had strong bonds to their old homes or had acquaintances in town and if this could be gender related.[196] Research concerning the town of Sundsvall indicates that migrant women seemed to have closer contact with their previous homes than migrant men and therefore might have had an easier task adapting in town.[197]

Finally, this study shows only a fragment of the picture of the migrant men's destinies in a family context. A comparison must be made with the other individuals in the cohort who are not found to be 'migrant men in misery'. The results suggest that a focus in the continuing study can be put on the migrants' parenting phase of life in further thematic investigations, viewed from a gender perspective. The impact of time and setting, could be highlighted by a generational approach regarding these matters.

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193 See for instance, Jan Lucassen and Leo Lucassen, "Migration, migration history, history: Old paradigms and new perspectives", in *Migration, migration history, history: Old paradigms and new perspectives* (Peter Lang, Berlin, 1999), p. 21ff. They view social integration, regarding immigration, as a prolonged process extended over generations.

194 J. Sundin and S. Willner (2003), p. 48.

195 Compare M. Oris (2000), p. 410. He suggests a similar study, looking for marriage witnesses.

196 These results will be reported in the ongoing study.

197 L. Vikström (Umeå, 2003), p. 150f.

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New books

Sam Willner

Anne-Emanuelle Birn *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico.* University of Rochester Press, 2006. 434 pp.; ISBN 1580462227 (ppk)

In 1932 the Mexican artist Diego Rivera was invited to paint a mural for the Rockefeller Center in New York. The revolutionary artist created a work full of anti-capitalistic symbols and visions of a socialist society. The Rockefellers sought in vain to make Rivera to modify the motive. The painter was eventually dismissed and the mural was demolished.

This episode could illustrate the unlikely and sometimes stormy relationship between revolutionary Mexico and the Rockefeller Foundation, mainly in the field of public health projects. A relation that came to last for several years, dealing with public health campaigns against yellow fever and hookworm disease, founding of cooperative health units, education of public health professionals *etc*. Anne-Emanuelle Birn, associate professor at the University of Toronto, offers an interesting analysis of this interaction between the Rockefeller Foundation and Revolutionary Mexico from the 1920s to the mid-20th century in her book *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico*.

Marcos Cueto *The Value of Health: A History of the Pan American Health Organization.* University of Rochester Press, 2007. 239 pp.; ISBN 1580462634 (ppk)

Marcos Cueto, professor in the School of Public Health at the Universidad Peruana Cayetano Heredia in Lima, Peru, offers a well documented narrative regarding the origins of international public health in the American continent and the history of the Pan American Health Organization, created as “a product of the expansion of international commerce, medical advances, and a new political and diplomatic

relationship among the countries of the Americas". The book begins by telling the history of the quarantine system and the international exchange of epidemiological information, concerning control of yellow fever and prevention of cholera and bubonic plague, and the rise of the United States as a power in the late nineteenth and early twentieth centuries. The final chapter deals with "new" challenges faced in late 20th century, such as the cholera outbreak in Peru in the 1990s, the struggle against the HIV/AIDS epidemic and the persisting inequities in health in the region. This (and the previously reviewed) book contributes to new insights and a deeper understanding of the history of public health on the American continent in the twentieth century.