Greece’s National Health Service isn’t feeling very well

Manos Matsaganis (Athens School of Economics and Business)

Question: Greece's National Health Service (ΕΣΥ), created a quarter of a century ago amidst high hopes to “decommercialize health”, is in the grips of an ever worsening crisis. Public confidence in ΕΣΥ, user satisfaction with the quality of services provided, and access to health care on the part of low-income patients are all plummeting. On the other hand, even though public spending on health has risen considerably since 1983, the size of the private health sector (nearly 50% of total health spending, or 5% of GDP) fast approaches US levels and makes Greece a definite outlier in Europe. The paper attempts to explain “what went wrong”, i.e. the distance between the aspirations of policy makers and the general public back in 1983 on the one hand, and today’s grim reality on the other.

Methods: The paper belongs to the broad tradition of policy analysis. Its method is to draw on economics, political science, history and philosophy in an attempt to account for recent developments in the area of health policy.

Sources: The paper relies on secondary sources (books and papers in scientific journals, statistical series, policy reports, press articles, parliament proceedings etc).

Results: The paper concludes that the evolution of Greece’s National Health Service can only be described as a case of systemic policy failure. At the heart of the matter seems to lie a gradual shift in the norms of the medical profession and the culture of health care provision, away from the ethos of public service (or, in Julian Le Grand’s terminology, “knightly behaviour”) towards the aim of personal enrichment fast and at almost any cost (“knavely behaviour”). The paper concludes by setting out some of the necessary conditions for a potential revival of public provision of health services in Greece.

Special advisers and the development of British health and social welfare policy in the twentieth century

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From the 1960s the British government increasingly made use of 'Special Advisers' in its policy formation. These were usually academics who took whole or part-time secondments from their universities to assist government ministers. Such (initially informal) arrangements were mutually beneficial: the minister gained access to expertise that he/she did not personally have, or could not obtain from the Civil Service; the Special Adviser had the privilege of helping to steer policy formation based on his/her own research agenda. This paper will focus on one Special Adviser: Professor Brian Abel-Smith (1926-1996), to illustrate how this role and relationship emerged in Britain.

Brian Abel-Smith, a health economist and political adviser, had one of the longest associations with the development of health and social welfare policies of anyone in the twentieth century. From his seminal research with Claude Guillebaud on the cost of the British National Health Service in 1956, he soon developed a reputation as an academic who could be relied upon to quickly produce effective reports. He served as a Special Adviser to a number of Labour government ministers in the 1960s and 1970s, including Richard Crossman and Barbara Castle. His research collaborations, especially with Richard Titmuss and Peter Townsend, stimulated some of the most innovative policies to address issues such as poverty, levels of social security benefits and pensions. Overseas, he pioneered international comparisons on health services finance for the WHO in 1958, and until his death in 1996 made numerous visits to over 80 countries – ranging from short reports to (in the case of Mauritius) the creation of a fully-fledged social welfare system.

What can be gained from a close study of one policy adviser's life? How can biographical research be usefully integrated into institutional or administrative histories? This event will focus on the 'lives' of Brian Abel-Smith, and draw on the papers he deposited with the London School of Economics archive, along with the diaries of some of the government ministers he worked with. It will also discuss the wider contemporary implications of the role of Special Advisers in the formation of health and social welfare policies.

The introduction and institutionalisation of Vaccination against Smallpox in Sicily and the Central Mediterranean 1800-1870: its medico-political uses.

John Chircop, University of Malta.

As on other occasions when war served as the catalyst of new medical advances, so was Jenner's cowpox vaccination carried to the Mediterranean –in Gibraltar, Minorca and Malta – during the British naval-military campaign against the French in 1800/1801 by Joseph Marshall and John Walker. On their voyage, these two made trials by inoculating low-rank sailors, and started vaccinating groups of the island populations which came under British control, with an ardour which had of the colonial 'civilising mission'. With similar zeal Marshall introduced this method in Sicily – at the time also under British 'protection' –making a Jesuit Seminary in Palermo the centre for free vaccination for the poor. With the restoration, the g*overno Borbonico* took up the vaccination project fervently, using it to spearhead its project of a secular public health system.

Based on research in the original records of the *Commissione Centrale di Vaccinazione* held at the *Archivio di Stato di Palermo*, this paper presents a case study of how medicine and issues of public health and institutionalisation entwined with different beliefs, ideologies and political agendas, and were utilised by different social and political groups in specific power struggles. It immediately emerges that in the Sicilian case vaccination came to be operated as a tool by the state in its erratic attempts at the 'modernisation' of a pre-modern society in transition during the pre-Italian unification period. Nonetheless, the central commission of vaccination faced great difficulties to start and maintain the process of spreading vaccination throughout the territory of this largest of the Mediterranean islands; these included geographical factors – issues of distance and proximity – as well as aspects of culture and religion, but also the mixed responses it had in the form of reception as well as resistance from various institutions and social classes, not excluding the medical sector itself.

From Warfare to Welfare: wartime scenarios of homelessness, dislocation and the birth of the postwar European Welfare State (case of Berlin 1945-1949)

Dr. Clara Oberle — University of San Diego

This paper presents the immeduate aftermath of World War II (1945-1947) and the challenge of housing and providing for millions of Europeans as a key turning point in the history of health and welfare policy of Europe. Were there indeed shared motivations and common actors? If so, what and who were they?

Following a brief overview of existing scholarly literature on living standards and welfare debates in the immediate postwar period across Europe, the paper will employ the methods of discourse analysis to examine the debates in which professionals of different governmental and non-governmental entities in Berlin and elsewhere were seeking for answers to this crisis.

Sources include records of the International Red Cross, the United Nations Refugee Relief Organization, as well as a wealth of records from Allied and municipal offices concerned with housing and public health in Berlin 1945-1949, now held at Military Archives of Britain, the United States, Russia, and France. Among the documents are weekly meeting minutes, decrees, law drafts, as well internal and international correspondence with peers in Britain, Poland, Russia, Belgium, and elsewhere by the members of the occupying forces working in Departments of Health, Housing, and Public Safety in Berlin. In addition, correspondence between Berlin municipal welfare, health, and housing offices, their Allied counterparts, and individuals in France, Britain, Germany, and elsewhere— now held at Landesarchiv Berlin, Staatsbibliothek, and in several district archives— will be examined.

Preliminary research suggests that across the board, political, police, and architectural experts were involved just as much as medical or social services personnel. The paper will argue that common professional assumptions, experiences, and concerns indeed contributed to the creation of jointly written welfare and housing policies in the years 1945-1947 for Berlin and Germany, despite Cold War differences. Moreover, the new policies resembled welfare and housing policies elsewhere in Europe as they were based on shared considerations. Among these, the paper suggests, were not just common fears of epidemics, but also an increasingly affected middle class as well as concerns about control and governability in a visibly unsettled Europe.

BARBERS, DOCTORS AND HEALERS. THE COMMUNITY WELFARE AND HEALTH CARE SYSTEM IN THE SPANISH NORTHWEST. THE PROVINCE OF LEON DURING THE 17th AND 18th CENTURIES.

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The primary aim of this study was to analyse the issue of health and illness in traditional rural society throughout the Middle Ages, an area which has received very little attention in the literature. The level of administrative autonomy and the total lack of intervention on the part of State or territorial bodies at the time left rural communities with no recourse but to directly confront the social and demographical problems arising as a consequence of recurrent common or epidemiological illnesses on an individual basis. At the same time, the weight of tradition and the lack of rational, scientific health care led to a deep-rooted, traditional "thaumaturgic" approach to health care. Three aspects of this situation will be analysed: the effect on health, through a study of illness; health care professionals; and the connection between health care provision and the local community-based councils.

The methodology employed for this study, and indeed the historical context, were dictated by documentary evidence and more especially, by typology. Consequently, information concerning quantitative and qualitative aspects, changes and continuities, was gleaned from local legal and parochial documents. Likewise, information from the 18th century property register, and local council records of accounts facilitated a quantitative assessment of certain aspects related to the kind of assistance available, the salaries of health care professionals, and the extent to which local council bodies were involved in health care provision in their communities.

Medical staff, diseases and mortality in Athens, 20th century

Eugenia Bournova (University of Athens)

The purpose of this text is to study the changes observed in an urban Mediterranean society as it moves, during the 20th century, towards the elaboration of a «modern» health system. Our analysis of the case study of Athens attempts to shed new light on the emergence of contemporary Greece.

During the first half of the 20th century, the modernization of the public health system in Greece was meant to positively contribute to the improvement of public health and consequently significantly reduce the high mortality rates.

Hence, the gradual adjustment of the Greek public health system to the needs and demands of the modern Greek society took place within the much broader framework of the massive transformation of the medical profession. During the 20th century Athens is characterized by a great increase of population due to the arrival of almost a half of million immigrants of Asia Minor in the 1920s' but also to a strong and continues internal immigration until the 1980s'.With the use of two sources, the national statistics on public health and the Guide of the city published until the 1950s', I will be able to compare Athenian infracture and mortality with the rest of the european capitals and point out that the real improvement in public health is a fact after the Second War World and not before. Until the 1980's and the great socialist reform in public health system, it was the private sector and the philanthropic organisations and initiatives that mostly tried to cover the needs of this urban society.

First professional social worker's in Bulgaria and their predecessors (1910 – 1940)

Kristina Popova, Southwest University Neofit Rilsky/Blagoevgrad Bulgaria

In 1910 the first female preparation courses for voluntary social work were organized in Bulgaria in which young middle class women took part. More than 1000 women were prepared during the war time were prepared for social and sanitary work. Most of them took part in the women's movement after the First world war.

In 1926 the first training courses for visiting nurses started. In 1932 the Bulgarian Women Union started the first School for social work – the High Female Social School (following the model of the Female social Academy of Alice Salomon in Berlin).

The first trained professional social workers graduated their education in 1934 and some of them were hired in the social care system. In the same time the municipality social assistance service in Sofia was reorganized , following models of European municipality practices. A central family card index system of poor population were introduced ordered by numbers and names. Female professional social worker replaced the previous social committees which included only male members of the municipality counsel. Quantitative measures of poverty were introduced parallel to a quantitative evaluation made by female social workers. Every female municipality social workers was in charge to the poor population in a certain part of the city. They had to visit the family homes of the poor population, to describe the family situation, to fill in the card indexes and to report single cases.

The regular visits brought the female social worker (most of them young women) close to the poor population. But did it mean also an emotional closeness, empathy or distance?

My paper analyses the curricula, the education as well as the municipality prescriptions (in Sofia) for the visiting nurses as well as for the female social workers. It is based also on the social reports in the late 30-es in order to see their relationship to the poor population, the professional procedures and the rhetoric of the reports as well. I will try to see the influence of social maternity ideology which motivated some young women to join this profession and to help the people as well as the ideas of keeping the social order which were spread by the authoritarian regime in Bulgaria in that time.

Using client's complains and letters, left in the municipality archives I try to see the images of the first generation of female social workers as well as the reception of their work by their clients.

Making room for humanitarian intervention at a civil conflict in 19th-century Europe: the Spanish Red Cross and the Second Carlist War, 1869-1875

Jon Arrizabalaga (CSIC-IMF, Barcelona, Spain)

The Red Cross was settled at Geneva in 1863 as an international humanitarian association to look after the wounded soldiers in international wars. Spain officially joined the Red Cross on the occasion of its first convention, signed at Geneva in August 1864. The military doctor Nicasio Landa and the Count of Ripalda as the representative of the military order of Saint John of Jerusalem that had been commissioned to organise the Spanish Red Cross, were the most outstanding early promoters of this association in Spain.

This paper will explore the ways through which the Spanish Red Cross managed to secure its humanitarian intervention during the Second Carlist War (1872-1876), a bloody civil conflict that appears to have been the earliest civil war where any national section of the Red Cross significantly deployed, and not without controversies, its activities. Attention will be particularly paid to the issues as follows,

1) The parliamentary reform of the Spanish Public Order Law on the eve of the civil war (23 April 1870) that declared as neutral those individuals of philanthropic associations for relief of wounded during wars, no matter they were international or civil.
2) Landa's and Ripalda's persuading efforts close the Geneva Committee (as from 1876, International Committee of the Red Cross, ICRC) to overcome its diplomatic cautions and to support the Red Cross's intervention in that civil war.
3) The activities of a special Spanish relief committee chaired by Ripalda and settled at Paris during the Carlist war to fairly distribute among war contenders the international humanitarian aid promoted by the Geneva Committee and by the central committees of other Red Cross national sections.

The main sources that will be resorted to in order to write this paper are archival material from the ICRC and Spanish Red Cross, mostly correspondence between the Spanish and the Geneva Red Cross Committees, as well as printed sources both hemerographic and bibliographic ones. And the research methods will be those common in social and cultural history of medicine and health.

Health status and health care provision in the rural area of North-Western Romania

Livia Popescu and Cristina Rat, Babes-Bolyai University

The present paper analyses the socio-economic predictors of subjective health status and satisfaction with health care provision in the rural area. We seek to answer two research questions. First, to what extent is the probability of reporting bad health influenced by the socio-economic variables (income, education, age and gender) ? Second, does satisfaction with health care services relate to subjective health status? Satisfaction with primary health care services, interactions with the medical personnel, informal payments and “out-of-pocket” expenditures on private health care services were used to assess the provision of health care.

The survey was carried in 2007 on three representative clustered stratified-random samples for the Romanians, Hungarians and Roma living in the North-West region of Romania. Households were selected with the method of random walk and within the household respondents were selected based on pre-established quotas.

Estimated household income per equivalent adult has a strong effect on decreasing the likelihood of reporting bad health among rural inhabitants. Moreover, subjective economic strain increases the probability of reporting bad health significantly. Gender holds statistically significant influence, males being less likely to report bad health than females. Education has only small effects on decreasing the probability of reporting bad health. As one might expect, age has a statistically significant effect on increasing the probability of reporting bad health. However, after controlling for other socio-economic predictors, the effect of age is rather limited.

Individual socio-economic variables play only a minor role in explaining the variance of satisfaction with health care services. At the same time, persons reporting bad health assign lower scores to the health care services.

Reporting bad health and dissatisfaction with health care services tend to have similar socio-economic determinants. Household income and belonging to discriminated groups have stronger effects than other determinants on reporting both bad health and dissatisfaction with health care provision.

PROGNOSIS AND LIFE QUALITY OF PATIENTS WITH CHRONIC DISEASE AS A FUNCTION OF PATIENTS' ORGANIZATION: HUNGARIAN EXPERIENCES

Sándor János, Brantmüller Éva, Szücs Mária, Bálint Lajos, Tigyi Zoltánné, Máté Orsolya, Bödecs Tamás (*University of Pécs)*

Background. The people affected by chronic diseases without causative therapy (definitive treatment), with only effective palliative treatment represent a special group of vulnerable people. Along with the improvement of medical care, this group has been growing continuously. The ability of these ill people to maintain their functional ability highly depends on the quality of their co-operation with health care providers.

Objective. Our study aimed to demonstrate that the patients' self-help organizations can improve this co-operation, and can contribute to ensuring the fair quality of life.

Methods. The investigation focused on cystic fibrosis and on myasthaenia gravis. The prevalence of treated patients had been calculated for every districts of Hungary using the hospitals' and outpatient centers' discharge records. The quality of collaboration had been indicated of the district specific prevalence of acute exacerbation of the underlying chronic diseases: need for respiratory therapy for mysthaenia gravis adults, and the need for hospital admission for cystic fibrosis children. All the 168 Hungarian districts could be characterized by an empirical Bayes adjusted age and gender standardized relative exacerbation frequency. The patient organizations prepared datasets on their members containing the appropriate age, sex, and residency data. Combining the prevalence and membership data, district specific coverage ratios (member of civil organization / treated patients) were calculated.

Results. There was significant inverse correlation between coverage ratio and relative exacerbation frequency. The association was stronger for myasthaenia gravis. The correlations remained significant after controlling for districts' socio-economic status (indicated by average level of education, unemployment ratio, urbanization, average income).

Discussion. Our study could demonstrate that the civil organizations have ability to improve the efficacy of the care of people with chronic diseases. The governmental support for these groups is not simple belong to charity but it is a rational investment in terms of utilization public resources.

Nutritional Status in Elderly People Living in Retirement Homes in the Czech Republic

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Background: Nutritional status of the elderly is basic determinant of the health and disease. Based on our experiences majority patients 75 years of age or older admitted to the hospital are undernourished. There is lack of studies about nutritional status of frail elderly in the Czech Republic. The goal of our study was to evaluate nutritional status of elderly people addmitted to the hospital and to compare two groups of them: people coming from home and people coming from senior housing facilities. ***Methods:*** 281 patients (101 men and 180 women) older than 75 years who were hospitalised at the II Department of Internal Medicine, University Hospital, Královské Vinohrady in 2006 took part in our study. We compared between patients living in facilities for seniors (retirement homes) and elderly patients who lived at home. ***Results:*** BMI doesn't differ patiens comming from home and retirement homes. 30% of patients admitted to the hospital have had biochemical signs of decreased proteosynthesis. Low albumin level have had 34% of patients from retirement homes and 20% of patients coming from home. The findings demonstrated a better heath/nutritional status and health perspective in patients who were living at home than in patients from the retirement homes. ***Conclusions:*** There is evidence of poor nutritional status in institutionalized elderly home residents. There were no studies which compared the nutritional status according to population size in certain regions and cities. It is precisely the absence of these studies which differentiates the Czech Republic from many other developed or developing countries. For these reasons, we would like to focus in our future studies on defining the nutritional status of elderly patients who have been institutionalised in social facilities.

The Constant Patient: Public Health Mediating Life and Death, the Case of the Port City of Patras, 1900-1940.

Panagiotis Eliopoulos (University of Athens)

Patras, the fourth largest city in Greece, underwent a great deal of change during the first half of the twentieth century. While actively trying to fight off the unhealthy factors of its urban environment, its continuous and spontaneous expansion meant that these efforts could bear little fruit, especially to the ones living at its outskirts. Up to the 1940's epidemics and disease will repeatedly carve their own print on the city map and disease will decimate the young populations. The medical institutions still, at that period, supported by philanthropic effort and local authorities, will not be able to provide healthcare to the extent of the city's needs. The arrival of thousands of Asia Minor Refugees, and the following frequent epidemic outbreaks, made it clear that new initiatives should be undertaken regarding the public health sector, from local authorities and central government alike. With the use of the Civil Registry archives, I will be able to show the frequency and course of epidemics and disease, such as tuberculosis- a scourge of Patran society- and syphilis, with the exhaustive indexing of more than 46.000 death records for the full period 1900-1940. The local press provides the useful information needed regarding housing, water supply and sewerage for the peripheral districts and slums of the city. Combining these two sources, we will be able to point out the correlation between urban infrastructure and epidemics mortality per district, which in fact is a correlation between income and health for the various socioeconomic groups comprising the city's population.

The Formation of The Danish Association of the Blind as a Civil Rights Movement?

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The paper is related to an ongoing project about "The Blind in Danish Society and the History of the Danish Association of the Blind in the 20th Century". The project is a study of blind people's reaction to societal definitions of the blind as a group and the changes in the societal image of the blind.
The starting point is that the formation of Danish Association of the Blind in 1911 and the primary function of the organisation was not to form a social community but rather to form a base from which given definitions of the blind and the role of the blind could be changed. The thesis is that the ambitions of the Danish Association of the Blind encompass an intention to normalize, but from their own perspective, however, and, hence, in possible opposition to the pre-defined roles.
The image of the disabled has primarily focused on a top-down perspective - this project is thus a differentiated view of the passive recipient/victim role and an analysis of the processes leading up to the categorization and definitions of groups. The focus is thus on the interplay between identity discernment among individuals and groups based on the given changing historical context.
In the paper I will refer to how group-formations are a result of group-identification and hereby are a platform created in order to gain rights. The organization of blind people exemplifies exactly how a group is able to gain rights. It is not only the system which assigns rights in an on-going democratic process but given groups speed up the process by wining rights even if they are defined as week and in a role as recipients. Blind peoples fight for rights and privilege illustrate furthermore that establishing a position not only can be seen in a political optic but also in relation to an understanding of normality.
In the paper this will be concretized with historical examples from the first decades after the formation of The Danish association of the blind. It will be illustrated primarily by using of annual reports and magazines from The Danish association of the blind, debates from the parliament and newspaper articles.

Birth Attendance Organization, Midwifery Practices, Obstetrics and the Fate of Mothers and Infants in Denmark 1750-1950

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During the late eighteenth and early nineteenth centuries, great efforts were made to provide Denmark with trained, examined and licensed midwives. A School of Midwifery was established in Copenhagen in 1787 and in 1810 a Midwifery Act obliged all parishes to employ a trained midwife. This goal was reached in Denmark by the 1840s.

In this same period the national infant mortality rate in Denmark fell from 20-25 deaths in the first year of life per 100 live births to a level around 13 deaths. A level among the lowest in the world in the nineteenth century. The same goes for the maternal mortality and the stillborn rate.

I have in other studies discussed the multicasual patterns and mechanisms in the infant mortality decline. There are absolutely no doubt there were many reasons for the fall. In this paper, however, I am going to argue that the major campaign to produce trained midwives have played an important part.

This is based on a study comparing the Danish system of assistance in childbirth in the years around 1900 to the system in the late eighteenth century and the early nineteenth century. The organisation of the Danish system, as it appeared in 1900, was identical to that introduced around 1800. But how quickly was the policy implemented. And was the early nineteenth century midwife able to provide the same quality of care as her late nineteenth century counterpart. Or did the same organisation conceal important differences in both knowledge and procedures. In other words - is it possible to trace any positive effect of Danish policy on midwifery before the late nineteenth century when Irvine Loudon has demonstrated that the assistance in child birth in Scandinavia, was among the best in the western world, when measured in terms of maternal mortality.

Swedish public health policy: background and experiences of the 2003 policy reform

Bernt Lundgren, Public health policy expert, Swedish National Institute of Public Health

A comprehensive Swedish public health policy was adopted by the Swedish Parliament, the Riksdag, in 2003. It pushes health up on the political agenda and affords equity in health high priority. The overall aim of the policy is to *"create societal conditions for good health on equal terms for the whole population"*. The research questions are:
What is the background to and content of the 2003 public health policy reform?
What are the experiences of the first phase (2003-2005) of multi-sectoral implementation of the policy?
What conclusions have been drawn by the Swedish National Institute of Public Health (SNIPH) and the Government regarding the experiences?
The methods are analysis of official reports and articles in scientific journals. The sources are reports by the Swedish National Committee for Public Health, Governmental bills 2002 and 2008, minutes from debates in the Riksdag, the 2005 Public Health Policy Report by SNIPH, and articles in Scandinavian Journal of Public Health, and Promotion and Education.
The final report in 2000 by the Swedish National Committee for Public Health was the basis for the public health policy that was adopted by the Riksdag in 2003, though changes were made by the Government which reduced the political support for the policy. A positive experience from the implementation of the policy is that the determinants approach is in general well understood by actors. According to SNIPH, support to actors outside the health service sector and a continuous steering from political bodies is of vital importance for maintaining interest for the implementation. This is also the viewpoint of the Social Democratic Government in a communication submitted to the Riksdag in the spring of 2006.
A new centre-right wing Government elected in September 2006 made changes in the policy in 2008, re-formulating it from a focus on structural determinants and health related life habits to mainly life habits. This seems to have been done without acknowledging the suggestions by SNIPH or the former Government. Key words: *Health, health inequality, policy, multi-sectoral, implementation, evaluation cycle.*

CHILDHOOD AND POVERTY IN LEON DURING THE EARLY MODERN AGE. THE INSTITUTIONAL ANSWER.

Alfredo Martín García
University of Leon

This paper analyses the different forms of care provided for poor, abandoned children under the Old Order in the small provincial Spanish city of León. The aim is to ascertain the reality of care in a typical Spanish city of the period, that is, the extent to which political and religious institutions were involved in providing assistance to such children, how these assistance mechanisms functioned, the principal areas to which such activity was directed, and their ethical and religious aspects.

The study will focus on the three most important institutions in the city in the 16th, 17th and 18th century, comprising the "Arca de Misericordia de Nuestra Señora la Blanca", the "Colegio de Niños de la Doctrina" and the "Hospicio". Each of these was founded at a specific point in the city's history, and addressed particular deficiencies in the provision of child care and assistance. The Arca de Misericordia was founded in the early Middle Ages, and specialised in rescuing children found abandoned in the streets of León and the surrounding area. The children were then placed with wet nurses who received a stipend in return. It was a religious institution, administered directly by the León Cathedral chapter. The Colegio de Niños de la Doctrina was founded in the 16th century in response to the need to provide a cultural and religious education for orphans, in the context of significant religious and pastoral fervour. This charitable foundation was administered by the city council, although the scant resources which the latter invested in the institution resulted in its decline in the 18th century. Lastly, the Hospicio was founded towards the end of the 18th century as a response to the new utilitarian climate which characterised Enlightenment Europe. Through this institution, its founder, the Bishop Cayetano Cuadrillero, sought to offer underprivileged León children the possibility, first, to survive, and second, to receive a training that would fit them for the labour market. At the beginning of the 19th century, the Hospicio and the Arca were merged into a single institution.

Religion, ideology and the use of contraceptives.

Antonina Ostrowska

Pultusk Academy of Humanities

In Poland, socio – political transformation and the process of integration with European Union co – occur with significant cultural and economic changes. They are congruent with growing values of individual self – realization, personal freedom and autonomy, investments in education and professional career. All these changes are significant for the decisions of family forming, procreation and generally patterns of sexual life, and as such, they result in attitudes and behaviors related to the use of modern contraceptives. However, notwithstanding liberalization and secularization of social life in recent years, the influence of traditional, religious values on the patterns of sexual life and procreation is very strong, and the issues like an abortion or use of contraceptives often becomes a source of moral conflict for many individuals.

The controversy between religious and secular doctrines in Poland and its impact on family planning methods has also a political character. In communist times, the introduction of liberal policy towards contraceptives (including the approval of abortion for demand) was an element of ideological struggle with the Church. Starting from the end of the Second World War, for over fifty years, abortion and contraceptives - although primitive - were easily accessible and affordable.

This policy has been changed radically with the transformation in 1990, for the pro-life approach as the only legitimate and morally fair. The abortion has been legally banned, contraception (except for natural methods) disapproved, and even sexual education has been cancelled from the school programs. The Poland's access to European Union in 2004 and opening to the West stimulated again the rise of secular values. Still, a fusion of "traditional" and "modern" thinking about sex and contraceptives creates confusion and real problems for many. As a consequence, the knowledge and the use of new family planning methods in Poland are lower than in other European countries.

The empirical data from the European Study of Contraceptives Use, executed in 11 countries will be used to illustrate the differences in relevant attitudes and behaviors.

Juvenile delinquency – the indirect result of the transition process

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The social, political and economical transition from socialism to democracy and capitalism was a more difficult process for Romania as for other countries from East-Central Europe. One of the reasons is that at the end of the 1980s, the Romanian economy was in serious collapse as the result of inefficient central planning which favored the heavy industry and useless, huge infrastructure investments. The end of socialism was also the end of social equality and the beginning of the appearance of new social strata, many of them showing no linkage with meritocracy. Thus, social results of the transition were massive insecurity and loss of trust.

In such a context was expectable that the rate of delinquency in general, and that of juvenile delinquency in particular, will rise.

The general purpose of the research is to present the evolution of juvenile delinquency in Romania after 1989, with some of its social and psychological aspects. We use a comparative perspective: the general, Romanian framework will be compared with local situation occurred in Cluj county. To complete the research we used data from Police General Inspectorate, The National Committee for Statistics, Ministry of Justice, The Direction for Social Reinstate and Supervision, and Forensic Medicine. The presentation is based on an extensive study of 420 delinquent juveniles, whose data on family situation, education, age, etc were analyzed and the youngsters were also tested with psychological tests (Nowicki & Strickland's Internal-External Control Scale for Children, McGuire & Priestley's Testing Your Reaction, Zuckerman-Kuhlman's Personality Questionnaire and A. W. Tucker's Inmate Dilemma Test). The results were compared with previous research data on Romanian population.

Data confirmed that young delinquents are more impulsive and have a higher sensation seeking tendency, but their decision making capacity in risk situations is not significantly different compared to the control group. Looking at the data of the psychological tests and the descriptors of the social situation of juvenile delinquents, it looks like personality factors are associated with low school performance and school drop-out, as important determinants of delinquency. An integrative model was tested, in order to analyze the social and cognitive determinants of delinquency.

The different uses of the hospitals in the Early Modern Period: some Portuguese examples

Laurinda Abreu (Évora University)

Previous research has shown that in some Portuguese hospitals the workers were the most important patients or, at least, had a very significant presence. Their yearly cyclical attendance in times of harvests (wheat, grapes or salt), shows an intentional use of the hospitals' resources, allowed by their administrators, even if justified by their charitable, social and religious responsibilities. Belonged to the urban elites, represented in the local governance as well as in the confraternities in charge of the hospitals (Misericórdias), these administrators played an important role in the hospital patients' profile once their economic, and therefore, social position was dependent of the labour market. On the other hand, for the migrant workers to be able to use the hospital poor relief and health care resources between different tasks or medical care for free was a way to improve their low incomes, to save money to take back home or to compensate the absence of family support.

The purpose of this paper is not to reduce the early modern hospitals to a sort of intentional workers' shelter but to consider it as an important element of the official social welfare organization. The whole system was shaped by the central government with the Church support during the 16th century, and lasted up to the early 19th century. Reassessing the different uses of the hospitals will illuminate the different interests and motivations behind the actions of the actors involved.

Although we are aware of the hospital universe as a composite one, where the divergences go beyond the rural and urban ambiences, we intend to discuss the general picture, paving the way to the analysis of hospitals as institutions where many other interests apart from the health ones converge. For instance, when we analyze the main Portuguese hospital (Hospital de Todos os Santos) it is possible to verify the existence of a whole world of economic interests, family and clientele links that draw parallel entities to the hospital, with the obvious involvement of the central government. These particular uses of the hospitals that have not interested the historians so far also have an important relevance even in the ways they provide health care.

Our documental support will be the analysis of the primary sources of three urban hospitals (from Lisbon, Évora and Setúbal), complemented with the study of the patient databases of the last two hospitals.

Wellbeing and Work. Social Inclusion of Vulnerable Groups in Northern Spain.

Oscar Fernández

University of Leon.

The European Union considers employment to be the best protection against social exclusion. All the policies and actions that are on offer from the various bodies and organizations in this area are directed towards achieving this objective and concentrate on the people involved obtaining employment. Nonetheless, the great heterogeneity noticeable in these processes shows the necessity of providing responses, actions and programmes that are differentiated and specific. The work being described here was carried out in the urban district of Ponferrada in the Province of Leon in Spain through a case study on the employability of certain groups at risk of exclusion, developed since 2005.

The study had the participation of groups that are users of the services of the Social Action department of that municipal authority. Among them are women at risk, the disabled, immigrants, ethnic minorities, the population of drug addicts and former addicts, and other groups such as the homeless.

A qualitative methodological design was used. One feature investigated was the various factors that make people belonging to these groups liable to exclusion. These factors relate primarily to the personal, family, educational, training, social, cultural, and life experience circumstances of the different individuals involved. Another feature was the position adopted by employers with regard to such groups.

On the basis of this primary criterion, the objectives proposed for the investigation were:

I. To identify and analyse the factors restricting the employability of vulnerable groups.
II. To discover and define the competencies for employability of such groups.
III. To construct tools for inclusion and for evaluating employability.

The results show that the majority of the individuals suffered from a number of educational, work-related, attitudinal and social deficiencies that prevented them from reaching an adequate condition to get access to a job. The challenge is that, starting from the capabilities of each person and their efforts, there should be a two-way commitment. On the one side, it would be from individuals through projects or routes for inclusion that would be personal and guided. On the other, it would be from bodies, whether from the administration supporting them, or from the enterprises or institutions giving them work and receiving assistance for offering a contract to the individual concerned.

Having or not having health insurance – Romanian case study

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In order to benefit from public health insurance, Romanian citizens ought to register at a general practitioner or „family doctor" who has a contract with the National Office of Health Care Insurance and they ought to contribute monthly to the Health Care Fund through income-related payroll taxes. The cost burden of health care insurance is shared between the employer and employee; self-employed persons should pay whole contribution from their declared income. The contributions are covered from public funds in the case of registered unemployed receiving state benefits (first 6 months of unemployment or slightly longer period, depending on employment history), disabled persons and those receiving social security. The contributions of pensioners are subsidized up to a certain ceiling from the public pension fund. Children below the age of 18 benefit from universal coverage, while young people in formal full-time education up to the age of 26.

Citizens who do not earn incomes and pay taxes in Romania may have the status of co-insured persons of contributors: this is the case of housewives, for example. If they are not co-insured, they ought to pay a monthly contribution equal to the value of the contribution corresponding to the minimum national wage. In order to benefit from subsidized public health care services, the proof of the regular payment of contributions is necessary: in the case of those who did not have any earnings during the last five years, it is necessary to prove that the contribution has been paid for the last five months. After the 2007 EU integration, the contributory periods from any EU member states can be assimilated with contributing to the national health care fund; nevertheless, for the remaining months (before January 2007) contributions ought to be paid in addition to the Romanian state as well.

This paper tried to analyze the status of insured person from legal point of view (since 1997, moment of introducing the health insurance system). Also it will be present the physicians' opinion regarding the dilemma – to be or not to be insured. The status of insured person will be prove according with ECHISERV research data[1].

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[1] ECHISERV – research project carried out in the North West Region of Romania. "Disparities in the use of public health care services in the North-West Development Region of Romania. Socio-economic patterns and causes". The project benefits from financing of the Romanian Ministry of Education & Research, the VIASAN program, Grant CEEX 157/2006.

Charity and Expertise: aspects of institutionalisation of healthcare in 16th century German imperial cities

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The paper aims to highlight the development of two major institutions of European healthcare and welfare frameworks:

1) The hospital founded on behalf of medieval charity and in the course of the 15th and 16th centuries developing special treatments for those *temporarily* in need of *medical* help.

2) The town physician appointed and paid by the communal authorities in order to be an academically trained medical expert to advise the magistrate. In the course of the 16th century some imperial cities traced the pathway from one or several publicly financed doctors to an expert medical advisory board called *collegium medicum*.

Actual research is done on the situation in the imperial city of Nuremberg, relying on archival sources in the municipal archive ("Stadtarchiv Nürnberg") and the state archive ("Staatsarchiv Nürnberg") as well as on the archives of the "Germanisches Nationalmuseum Nürnberg". The results of this research will be evaluated by comparing them with findings on other (imperial) cities, especially in southern Germany.

Both processes have been closely merged. On the one hand, town physicians often acted as the first specialised medical personnel when hospitals established branches for the sick and ill before the hospitals themselves appointed doctors. On the other hand, the *collegia medicorum* acted as supervisory boards of the local hospitals. Finally, historical research has to be aware not to confuse the 19th and 20th centuries achievements of institutionalisation with the early modern activities. Thus institutionalisation and professionalisation is to be studied by its several failures and has to take into account resistance and alternative ways of development.

STATE'S MEDICAL EXPERTS IN LOCAL PRACTICE.
PROVINCE DOCTORS AS PUBLIC HEALTH PROMOTERS IN THE MEDICAL DISTRICT OF SVEG, 1880-1920.

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Even if the 1930's and 1940' were the hey days of the Swedish welfare state, the first steps were taken in the last decades of the 19th century. This early welfare strivings were mainly expressed through public health measures, and public health has since then been a prioritized part of the welfare state. From now on, a national system for public health and medical services was established, and at the same time, the rôle of medical knowledge in social planning grew important. Medical science developed, medical care conformed to governmental administration and medical services expanded quantitatively. From a history of professionalization perspective, this meant that educated experts, the professional medical agents, came to play an increasing part in the Swedish state's efforts to solve different social problems.

My paper is based upon a case study, part of a broader research project that focuses Swedish province doctors – local, state employed general practitioners – in sparsely populated Jämtland County, 1880 – 1970. The project aims to acknowledge how public health as policy and practice was implemented in smaller Swedish communities. By studying the province doctors as the state's medical experts in local practice, the project intends to produce knowledge about the part played by these individuals, the state's medical experts, in the development of the Swedish welfare state.

The study presented here is limited, in time and place to the medical district of Sveg during the period 1880-1920, and in choice of source material to the province doctors' yearly reports to the State Medical Board. The study is about conditions and prerequisites for the impact of public health reforms in the Swedish countryside. Did public health, represented by the province doctor, have competition at the marketplace? What factors affected the province doctors, the welfare state's medical experts, possibilities to promote public health care and win control over the marketplace? And in what ways, if at all, was public health care implemented in this area during the period 1880-1920?

The preliminary results are these: In the medical district of Sveg, there was no noticeable development of public health during the period 1880-1920, until the end of the period.

It seems as if lack of confidence in authorized medicine and its represents was the most important explanation to public health's deficient successes in this medical marketplace, and here the medical experts met seriuos competition from the local quack. The question of the importance of medical expertise to local implementation of public health can here only be answered from the province doctors' own perspective. It is obvious that the province doctors understood themselves as medical experts, representatives of medical science and the Swedish state. The question of the medical experts' real significance in the development of public health at the Swedish countryside remains here mostly unanswered, then, until new source materials can shed light over the issue.

Professions, politics and the people. A Scandinavian research community in the 19th century

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One of the crucial elements in the history of the modern welfare states is the professional's relation to politics. Politics is here viewed as something more than a simple political decision, but has to do with what was considered as problematic, when and why?

The democratic systems in Europe and the US developed alongside the establishments in professional groups of scientists and professionals in various sectors of society, mostly in public institutions as hospitals, schools, universities, and various advisory councils. The professionals were also citizens in the civil society and they soon in the middle of the 19th century constituted a new bourgeois strata in the Scandinavian societies with their own values and traditions – among them engagement in the political debate and the parliamentary system. Therefore their political values and views became extremely important for the definition of social and health politics in society. They acted as both experts and advocates for the poor people.

The first part of the paper will show how a certain group of especially Danish physicians influenced the political system and formed the attitudes towards a new concept of citizen and of marginalized groups in society. I will show how their changing values of the professionals were crucial in the definition of the rights of the citizens, what was considered as 'problematic behaviour', at how they decided that problematic citizens should be treated or controlled.

The second part of the paper will especially be focused upon the similarities and differences between various the research groups in the Scandinavian countries. The sources used are the minutes from the meetings between Scandinavian researchers in natural science and humanities. These minutes has not yet been studied by historians. The idea is that each national research group was deeply rooted in their national context. The minutes can both explain the national research context of each researcher, but it can also offer an opportunity to understand of the Scandinavian negotiations of and exchange of research results.

The results will be a contribution to the intellectual understanding of the roots to the Scandinavian welfare concept.

Between the guild and the state: emerging occupational practices in early modern Geneva (1550-1750).

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The guild structure adopted in Geneva in 1569 was inspired by contemporary occupational structures then prevalent in many European towns. Medical activities were clearly described and each occupation ascribed a set frontier. These boundaries did not resist practices which tended to evolve following circumstances and opportunities. What is more, medical occupations were ultimately and surprisingly closely controlled by the town aldermen and therefore lay interests played an important role when decisions were taken about medical practice. Taking off from an important survey of administrative sources, a first section of this paper shall offer an overview of the density of each group of practitioners before proceeding to describe and analyse the evolution of occupational practices and attitudes throughout the period. What variables brought about changes in a seemingly rigid situation? Exterior influences such as demographic reality, migrations and transformations in training were important and can each be associated with specific evolutions. Among the more interesting trends was an important increase in numbers of young citizens who decided to make physic their profession in the second half of the eighteenth century. Working on administrative documents, printed material and a wealth of private documents the main question which shall be discussed in the second part of this paper concerns the nature of the motivations expressed by these future professionals. Born to affluent families, physicians traditionally charged little and seem to have been active in more prestigious than lucrative fields until the middle of the eighteenth century. Concentrating on the generation of physicians which started their professional activities in the second half of the eighteenth century, this paper shall explore how these young doctors imagined the “medicalisation” of their environment and contrived to turn a prestigious occupation into a lucrative profession from which they could earn a decent living.

"The negotiating process of the health care system in France and Spain (1919-1944)"

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Introduction

The aim of this paper is to study the negotiating process which took place in France and in Spain in the inter-war period, leading to the first establishment of compulsory health insurance in both countries. The intention, trough an historical analyse and from a comparative viewpoint, is to highlight the differences and similarities between the two negotiating processes, and to point out the main characteristics of the French and Spanish systems, as well as to show the reactions and positions of the doctors of both country to compulsory health insurance. We also study the role played in this process by the political, social and economic factors that existed in both countries.

Material and method

As sources we have used legal and medical sources, data from the general and workers' press of France and Spain. We have also used the secondary bibliography published on the topic after a search in the main generic bibliographic resources of the history of medicine.

Results

At the end of the nineteenth and beginning of the twentieth centuries, there was a shift towards positions progressively more favourable to state intervention, and the establishment of compulsory health insurance in France and Spain. These factors would become more important at the end of the First World War, given the international and external circumstances of the time, and the backwardness of both countries (even worse in Spain) in social legislation. Hence it started in both cases the process of negotiation designed to set up a social security system, which would include compulsory health insurance. France and Spain's own systems were initially modelled on the German social insurance, but the final result was different due to the doctors' opposition. In France, the offensive of medical syndicalism led to the establishment in 1930 of a model of compulsory health insurance, which respected the principles of liberal medicine. Meanwhile in Spain, the doctors' opposition prevented it from being realised until the new circumstances after the Civil War acted as the driving force for the establishment of a model similar to the German system.

The Changes of Health Status of Hungarian Population after the Economic and Social Transition (1989-2005)

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Aim: Political, economic and social transition from central planning communist system to market economy was one of the most important process observed at the last decade of the XX century. In some countries transition process was quite successful, in some other effects of economic transformation were not really impressive. Nowadays we can experienced significant social inequalities among others in the field of health status.
The main object of this study is to examine the socio-cultural dimensions of health inequalities, because the general state of health of the Hungarian people is worse than justified by the level of economic development.
Method: In our follow-up survey the dataset came from the random sample of the household in Hungary in which 3408 adult respondents were interviewed in 1988/89, 2357 in 1997/98 and 2078 again in 2004. The results were analyzed by one-way ANOVA and chi-squared test and we also used a multiple logistical regression model.
Results: In the past 15 years we have found that considerable deterioration has occurred in the population's health status, which is clear from both self-assessments of respondents and the appearance of new chronic diseases and which cannot be explained solely by ageing. We found high numbers of new cases of different disorders not only in the groups of elderly people but also among 30-40 year-old respondents. Gender and education determine the relatively protected and the endangered strata, too. The gravest life threatening diseases are more common amongst males, starting at an early age and their progression is more severe than in females. Our theoretical model has proved that work and financial conditions, psycho-social factors, lifestyle and health behavioural patterns determine considerably the change of health.
During 15 years found that 358 people died from the 3408 persons. 10.2% of the men, and 4.7% of the women died prematurely; whereas 28.3% and 17.2%, respectively, died at an old age. Apart from age, the level of knowledge of health and diseases and self-rated health have given marked indication of the risk of death. Different psychosocial factors were found to be dominant in the gender groups and in the various age groups.

Continuity and change in excess urban mortality from a gender perspective. Sweden 1750-2000.

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Ever since the birth of Swedish population statistics in mid-18th century a significant excess mortality could be observed for urban areas, particularly for adult men. In older times did factors such as overcrowding and unsanitary conditions play an important role for the general "urban penalty". The present urban excess mortality is connected to life style factors, such as alcohol consumption and smoking habits. In a historical perspective the marked excess male mortality in urban areas has often been associated with high alcohol consumption.

Regarding age- and gender-specific groups the mortality differentials between urban and rural areas have changed over time. In early 20th century we can even observe a "rural penalty" among younger age groups and women. Among middle aged men the "urban penalty" has, however, persisted. Generally the excess mortality is most pronounced for the biggest cities (Stockholm, Göteborg, Malmö), although, there are very large variations among municipalities within the metropolitan areas.

The general aim with this study is to analyse continuity and change in the urban excess mortality from a gender perspective in Sweden 1750-2000. The main sources are vital and other relevant statistics. The causes of the gender specific mortality differentials between urban and rural areas are primarily analysed in terms of life style factors and environmental health risks. Other questions discussed are the role of social change and change of gender roles, the role of selection contra contextual effects.

The long term perspective offers a unique possibility to capture important changes and general characteristics of the urban-rural mortality pattern in different historical contexts and to link them to possible factors.

Regional Dynamics and Social Diversity, Portugal in the 21st century

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Portugal has showed along its history regional differences in what concerns population distribution, as well as fertility and mortality behaviours. All these differences reflect not only different local socioeconomic conditions, but we believe they are also are markers of health outcomes.

Today Portugal faces some moderation on demographic growth, accompanied by the ageing phenomenon. Simultaneously, there were movements of decline of fertility and meaningful numbers of internal migrations, namely to the coast and urban centres. Those realities are only meaningful when analysed at a regional level and when related to non demographic indicators.

The main objectives of this study are:

1. to become aware and discuss the existence of demographic and socioeconomic regional differences, in order to verify if there is an association between modernization and homogeneity of the levels of social wellbeing;
2. to make a local analysis of the Portuguese reality in what concerns wellbeing levels and acknowledge: a) the existence of regional contrasts and possible causes; b) the complex relationship between social change and social wellbeing and health. For this purpose we created a statistical indicator that could sum up and allow stratification of what we named "*global indicator of demographic, economic and social wellbeing*" (1993-2004). This indicator includes 54 different variables (demographic indicators, offer of health resources /services, economic and social variables).

We will present the final results of a research financed by FCT (Science and Technology Foundation - POCI/DEM/58366/2004 *Regionalidade Demográfica e Diversidade Social,* The project was classified with Very Good (2005-2008). They will be published in 2009

A Century of the Social and Economic Change - its Impact on the Health and Welfare (Poland between 1830 and 1930)

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Paper's question is to summarize the main conclusions of the researches accomplished in Poland, concerning above mentioned problems.
The method consists in the regular historical analysis of the sources and the presentation of the conclusions in recent historiography.
The sources: the paper - with its aim to summarize our knowledge about mentioned problems - is based on the literature (and the sources analyzed in my own studies during the last ten years), and do not present new sources (in Poland there are lack of the sources - one can say that nearly all possible were analyzed).
The results of the survey are presented in some points: 1) the hundred years since about 1850 one can describe as a period of the capitalists modernisation and development of some new institutions in the social insurance and health care. The modernisation was retarded, not complete; 2) the comparatively rapid amelioration in the level of the life concerns fast whole population, but the development is visible rather in the individual, than in collective consumption; 3) the care of public health and hygiene, institutionalized by State, remained to be insufficient and slowly introduced; 4) the health care, social aid etc. until the end of the first world war a domain of the benevolent action; 5) the important role played the action of the entrepreneurs of the big factories - partly obligatory (according to the regulations of 1885 - 1992), partly benevolent. After 1920 the system of *Krankenkassen* (with its changing character) started to be implanted, with the relatively big success; 6) there was visible the amelioration of the standard of the life in the cities (the investments in the sewage system, sanitation, water filtration, petrol - and from the beginning of the 20th Century - electric illumination); 7) starting the 80-ties of 19th Century the discussions about the health, morbidity and mortality were more and more frequent. For the "intelligentsia" - especially the doctors - the activity at the field of the medicine and hygiene was the substitute of the political activity, impossible in existing regime; 8) all the amelioration had quite big impact in to the mortality and health indices.

Environmental changes and social vulnerability in an ageing society

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(Instituto Politécnico de Castelo Branco)

One of the main structural changes human societies are actually facing relies on demographic ageing process, with strong impacts on health system and quality of life. Dependence and disability do not constitute an inevitable consequence of human ageing, but situations of fragility and vulnerability increase with age. In this scenario, the need of help emerges as one of the most urgent problems, when regarding the future of sanitarian and social policies in all developed countries. Most of the variations observed on ageing individual process were due to social and environmental factors. The functional and cognitive deterioration that comes with age is a consequence of getting old, but depends on individual life style and environmental characteristics. Interferences in one of them will provide a major global benefit, guarantying a major level of independence, a higher quality of life and a better health status. Social and environmental factors can be used as predictors for health conditions, functional and cognitive autonomy, wellbeing and satisfaction on older ages. Reduced incomes, low educational level, situation of loneliness, can also be pointed as predictive factors of a major and premature deterioration of health. A better knowledge of the effect of environmental and social changes will allow us to better understand the process of vulnerability and situations of multiple dependencies. The adaptation of social structures must be a priority for all ageing societies. Portugal will also have to find answers to these challenges, in a context of disadvantage, due to a health system with major debilities. On other hand, the ageing process is due to dissimilar situations that reflect socio-economics and environmental disparities - it will constitute our case study.
The main objective of this study is understand the process of vulnerability and situations of multiple dependency caused by changes in Portuguese demographic structure, manly regarding old people, as concerns the following aspects: a) levels of well-being on the more age regions using a statistical indicator that could sum up and allow stratification of what we named "*global indicator of demographic, economic and social wellbeing*", in every region of Portugal (continent) among 1993 and 2004 (this indicator includes different variables such as demographic indicators, the offer of health resources /services and economic and social characteristics; b) different regional levels using the *National Health Survey* (mainly 1995/1996, 2005/2006); c) specific offer of health care and long-term care (health statistics, National Network of Palliative and Long-Term Care).
Discussion of results: on the different analysis check the various levels regarding the regional differences in what concern vulnerability and dependencies of elderly people.To sum up these differences could be essential to underline the need of new health policies, involving the commitment of political sectors, economic leaders and common citizens, in order to follow changes in social structures.

Wrong Time, Wrong Places: Environmental Pollution and Poor Health in Poland in the Second Half of the Last Century

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Objectives:

The paper aims to verify the hypothesis on the direct relationship between environmental pollution and the incidence of cancer and congenital defects in some regions (“voivodships”) of Poland in the second half of the twentieth century. The study also attempts to profile a territorial construction of cancer morbidity and congenital defects in Poland.

The system of planned economy, implemented in Poland after World War II, had been resulted in some efforts to build an economically independent state by intensification of the production in factories. Because little sewage plants were built, most Polish factories had polluted the air, the water, and the soil, but the detailed data on environmental pollution in the particular regions of Poland were disclosed only in 1988.

Methods:

This is a quantitative study in which the data on cancer mortality and development of congenital defects are compared with the data on environmental pollution in particular regions of Poland.

Sources:

Statistical Yearbooks of Poland, Demographic Yearbooks of Poland.

Results:

Despite shortage of data, the incidence of cancer and congenital defects in industrialized areas can be linked with environmental pollution. The historical and geographical analyse of the development of cancer and congenital defects in Poland shows some connection between them and the areas of polluted air, soil, and water. This connection was clearer at the end of the 1980. and at the early 1990. People who were born and/or are living in the polluted areas would have poor health. The increased risk of cancer and congenital defects should influence the health care and social care system.

HEALTH PROMOTION PROGRAMS FOR THE ELDERLY IN GREECE–THE “HEALTH PRO ELDERLY” PROJECT

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Aim: The ageing of the population and the increase of chronic diseases’ incidence, combined with limited resources for health care, led researchers and policy makers to search for health promotion alternatives. In most EU countries, many health promotion activities for seniors take place, but are not always properly evaluated or sustainable. The “Health Pro Elderly” project aims to identify criteria that make health promotion programs successful and provide evidence for sustainability.

Method: The project was realised within the Public Health Program of the European Commission and 19 partners from 11 EU countries are involved in identifying criteria for sustainable implementation of health promoting projects for seniors. Each country investigates the current situation and summarises literature findings on existing health promotion programs to contribute to a database.

Results: The synopsis of literature findings in all countries has been realized (www.healthproelderly.com). Relevant terms have formed an English glossary. Criteria have been set for the collection and selection of health promotion programs. A database with 33 examples of good practice has been compiled, including three from Greece. The first is *“Action Programme for older people”* focusing on maintenance and improvement of mobility, autonomy and self-care, via an exercise program. The second is *“The involvement and the role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases”* which promotes the Senior Health Mentoring concept as a model for spreading out health promotion issues through Day Care Centres. The third one is *“The Role of Health Education in Improving Compliance for the Prevention of Cardiovascular Diseases”* that focuses on access to preventive activities and healthier lifestyles. All three have been properly evaluated and widely disseminated.

Conclusions: The lack of resources and personnel could be balanced by promoting policies that will advance Healthy Ageing. “Health Pro Elderly” as part of a EU-wide health promotion policy contributes to that direction.

Social Diseases and Public Health. Society for Fight against Tuberculosis in Bulgaria until 1939

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This paper deals with social policies and public health practices with respect to the so called "social diseases" and in particular to tuberculosis in Bulgaria from the turn of 19th up to the 1930s.

In Bulgaria tuberculosis considerably began to be viewed as a social problem at the end of the 19th century; at that time all the experts were on the same opinion: the fight against tuberculosis had to be preventive, that meant: improvement of hygiene and labor conditions, overall information about the disease aimed to reach widest circles of the population and last not least, medical treatment.

Throughout the 1930s and in the course of finding the balance between state and public initiatives state institutions, media and societies succeeded in discovering new forms of collaboration. After 1934, the state started to introduce standards and common bureaucratic rules of social work and centralized the public health care.

The questions, which are supposed to be analysed, refer to the following themes:

-Conceptions and constructions of health and disease and the origins of modern public health in Bulgaria; The development of the basic political, legal and ideological conditions of public health and social medicine in Bulgaria in this period;

-To reconstruct and analyse institutional nets, built and supported in the relation with their overcoming as a social problem; the role of government in the organization and financing of health services; The responsibilities of the state, the NGO-s and of the individual in preserving health; The organizations which were responsible for initiating initiatives in the field of the fight against tuberculosis.

-The role of international institutions and international control policies – International Association for Fight against Tuberculosis, Rockefeller Foundation etc.

-The persons that shaped efforts for fight against tuberculosis in Bulgaria in this periods of time.

Research methods

-Archive work (Central State Archives, Local archives, Scientific archive – Bulgarian Scientific Academy): The available archival sources, among other funds of central state institutions and different societies which operated through the whole period of interest untill 1939 - ministries, regional and local administration, Society for Fight against tuberculosis, Rockefeller Foundation,

-analysis of the periodical press (specialized and not) give the opportunity to reconstruct the general institutional frames (and key figures of these institutions), and the interactions (as balances and misbalances) between state engagements and societies initiatives in the social politics toward social diseases.

-Comparative research: to compare this picture of Bulgarian history of social medicine through a comparative approach with the currently existing assumptions on the European history in this field; to relate the specific features of historical development in Bulgaria and to investigate the reasons for common characteristics and differences in Eastern Europe.

DISEASE AND HEALTH CARE IN THE NORTH-WEST OF SPAIN IN THE EARLY MODERN PERIOD. THE BIERZO REGION

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University of Leon

Up to eight hospitals were functioning in the town of Ponferrada (Spain) during the Middle Ages, but only that known as the "Hospital de la reina" survived into the 18th and 19th centuries. From the outset, it was managed by the local council. In addition to providing medical attention and health care to hospitalised patients, the hospital offered alms to the poor, provided accommodation for pilgrims and travellers, and transported patients. It was a modest centre with limited assets.

The aim of this present paper is to analyse the functioning and evolution of this centre throughout the Modern Period. Several aspects will be considered:
Internal organisation and the kind of personnel working there. This analysis is based on the regulations drawn up in the 1790s, and the accounts referring to several years in the 17th century, which provide detailed information on the salaries to be paid.
Hospital economy: the accounts books still extant refer mainly to the 17th century. A reconstruction of income and expenses has yielded information concerning the source of the hospital's scant income, and the use to which this was put. The principal source of income was rural land and loans, and the two biggest expenses comprised food for the patients and salaries for the personnel.
An analysis of the facilities and of the patients' diet. In this case, the relevant material was gleaned from the hospital book of statutes, and other books detailing expenses, especially with reference to building works and food.
Hospital care, in terms of evolution and seasonal variations. In the absence of an admissions register or, failing that, of deaths, indirect sources – the number of meals served - have been used to calculate hospital bed occupation at the "Hospital de la Reina".

In conclusion, this study of the "Hospital de la Reina" has contributed to an understanding of the functioning of a typical hospital in the Province of León under the Old Order. Its sphere of action was considerably restricted by its small size and limited assets, but for a geographically isolated area with limited urban development, it was nevertheless important.

Cholera in the Portuguese region of Alto Minho in the second half of the nineteenth century: epidemic outbreaks, treatment and behaviours.

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Universidade do Minho

Key-words: cholera, assistance, public health.

The aim of our work is to analyse the impact of cholera outbreaks that took place in Alto Minho, a region in the North of Portugal, in a century in which, due to several developments, distances became shorter and people from different parts of the globe became closer, and thus explaining the spreading of a disease that manifests itself quickly and evolves rapidly.

We also intend to evaluate the effect of the measures undertaken by administrative and sanitary authorities and to verify the alterations in the daily life of the affected communities as far as economic activities, organization, cleanness and hygiene in the public venue are concerned, emphasizing on the temporary suspension of the relations with the neighbouring region of Galiza equally affected by numerous cholera outbreaks. On the other hand and under a more restricted point of view, we have tried to evaluate the impact of the measures enforced by authorities concerning individual hygiene and the daily hygiene of the population in general, as a way to stop the spreading of a highly contagious disease associated with the lack of control and inspection over food and public and individual hygiene. The lack of cleanness, the illnesses and the filth in the public venue as well as in private places favoured the incidence of a highly contagious disease such as cholera.

Despite people's resistance and incomprehension, the control of the sanitary situation in the district of Viana do Castelo was achieved through the enforcement of measures which reduced the fatal effects of the several epidemic outbreaks in Alto Minho, the control of the number of victims by creating hospitals for cholera patients, the establishment of support commissions, the formation of districts and sanitary cordons, and finally through the close cooperation between sanitary, administrative and police authorities.

Our work had, as primary sources, documents from the Governo Civil of Viana do Castelo, because one of its main concerns was the public health. Also used articles taken from newspapers of that time, all related to cholera, in order to know the full impact of the disease in this region.

WOMAN, FAMILY AND SOCIAL WELFARE IN SPAIN FROM THE 18th CENTURY TO THE PRESENT

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The intention is to make a contribution from the field of Cultural History to the recent historiographical debate on the slow and complex formation of Public Social Welfare in Spain.
Essentially, printed sources of information have been used (government decrees, parliamentary laws, the writings of reformers and specialists in social problems, official statistics...). A critical re-reading, as exhaustive as possible, has been made of historiographical publications of the last decade. At the methodological level, we have sought not to radically counterpose the models of classical Social History and those of Cultural History. Emphasis is placed on the importance of factors that are often marginalized, such as the educational formation of women for their task of responsibility for welfare and care within the families; this, for example, made possible improvements in public health. We note that the relevance of women in the charitable activities of the public sphere grew through reactionary movements (although they were always considered subordinate to men). Emphasis is placed on the importance of women in Social Welfare during the Catholic Renaissance from the end of the XIX century onwards: as receivers of charity (in Christian trade unions, in catholic mutual aid societies), as intermediaries for poor families (facing priests, nuns and charitable ladies), as assistants (nuns who were teachers in religious schools and nurses in hospitals) and as leaders (Catholic ladies of the high bourgeoisie). Also, in a way that is only apparently paradoxical, there was an increase during the Francoist dictatorship in the participation of women in the reception, intermediation and offer of charity; both in groups closer to the initial fascism and in the Catholic organisations.

The social and economic effects of deterioration in health: Direct evidence from a European panel survey

Antigone Lyberaki (Panteion University) and Platon Tinios (Pireus University)

The advent of Sickness is a situation which calls forth all reserves, whether these are of a familial, wider social or economic nature. As such it may serve as a test case of the responsiveness and efficacy of social and economic solidarity mechanisms. These may be the response (and precautionary measures taken) by the individual directed affected, family support networks, the local and national health care infrastructure, the welfare state as a whole.
The most common approach to analysis suffers from four drawbacks; by analyzing data from a new panel survey of Europeans 50+ (The Survey of Health and Retirement in Europe, SHARE), we hope to overcome some at least of the effects of these drawbacks: First, the response of social systems is most often inferred *indirectly* through *macro* indicators measuring cost, inputs, or outputs at a system-wide level; illness is usually only inferred and what can be examined is its effect on observable variables.
Second, the social response mechanisms call forth reserves from formal and informal support networks. It is thus imperative that a multidisciplinary approach is used, bringing forth insights from economics, sociology, psychology and medicine.
Third, most surveys are of a cross-sectional nature, where individuals are studied at a point in time; in such surveys the effects of illness have to be inferred and lines of causation are often blurred.
Fourth, the comparisons between countries are very frequently highly problematic. The researcher is often reduced to comparing independent national surveys whose comparability is open to question.
Our paper utilizes the longitudinal (panel) data of the SHARE Survey to approach the complex questions of the effects of illness and how that calls forth economic, social, family and societal reserves. The SHARE wave 2 data has only become available in the end of 2008 and covers information from 11 countries for 2004 and 2007. One of the strengths of SHARE is the explicitly multidisciplinary focus of the questionnaire. It allows us to identify broadly comparable serious health episodes that have befallen members of the panel in the period between the two waves. The way individuals, their families and the welfare state apparatus responded to the health emergency across the 11 SHARE countries should reveal important features of the social support networks. Our approach at this early stage eschews a full statistical analysis, in favour of a more impressionistic methodology relying on diagrammatic and other tools. Focusing on a small number of health emergencies (chosen in order to guarantee adequate sample sizes), differences in response, as well as the immediate effects of the illness, will be characterized and related to key economic, social and systemic determinants. Particular emphasis will be placed on identifying the separate mechanisms and interrelationships between formal and informal support systems.
The paper will thus attempt to provide an overview of a very complex issue grounded on empirical observations, and in this way will hope to identify broader themes underlying social support networks.

The shaping of a collective memory in the history of medicine and health

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Background:

Experiences from museums and teaching programmes in the history of medicine and health show that certain discoveries, events, and mainly spectacular topics are repeatedly selected, driven by assumptions on the interests of the visitors, listeners or readers. E.g. bloody amputation or trepanation scenes are used to represent 18th century medical practices, regardless of how frequent such operations really were in the day-to-day health care. Ravaging and dramatic epidemics are selected to illustrate infectious diseases, even for periods when the incidence and prevalence of endemic infections were high and constituted the real scourges for the population.

Items preserved for display are often misleading because their representativity is limited. Presentations may be biased by the reasons why the items have been preserved: E.g. frequently used instruments are not found, because they were worn out and thrown away, while equipment which is in good shape because it showed to be less useful is on display.

In general, the relationship between medical science, practice and effects on the health conditions of the population seems to be weakly communicated.

Question:

A collective memory of medicine and health has been shaped. However, to what extent represent the images of medicine and health which are conveyed especially to lay or undergraduate audiences and readerships the real world?

Material and methods:

Material from visits in medical museums is discussed in light of relevant literature and teaching material.

Results:

Very often the general impressions which are presented seem to be skewed. Topics have been taken out of context or have been selected from other principles than those leaning on historical reflections.

The presence of medical staff in the Spain of the eighteenth and nineteenth centuries: was there, or was there not medicalization?

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María Isabel Porras-Gallo, University of Castile-La Mancha

Enrique Perdiguero-Gil, Miguel Hernández University

Introduction

The aim of this paper is to assess the level of medicalization of Spanish society during the eighteenth and the first part of the nineteenth centuries. We understand here medicalization in the sense used by Pierre Goubert, that is, the presence of health staff (including medical doctors, surgeons, barber-surgeons, blood-letters and other health pratitioners such as nurses and midwives) in cities and towns, and especially in the rural milieu. Our point of departure is the arrival of the new Bourbon dynasty at the beginning of the eighteenth century. Our end point is the Act of Medical Districts passed in 1854 and the General Health Act of 1855. The main aim of the two acts, regarding health care was to guarantee medical and pharmaceutical care for Spanish society.

Methodology

As sources we have used the secondary bibliography published on the topic after a search in the main bibliographic resources of the Spanish history of medicine. We have also used generic bibliographic resources. The result of theses searches is that we have information for Andalusia, Aragon, Castile-Leon, Catalonia, Extremadura, Murcia and in some cases for the Valencian Kingdom, though for different periods of time. We have, in other words, only an approximation to the level of medicalization of these regions in different epochs.

Results

In general terms, we can state that, notwithstanding important regional differences, the Spanish society of the eighteenth and the first part of the nineteenth centuries was indeed medicalized. There was health staff in most cities, towns and villages. It is true that medical doctors were concentrated in most cases, in those cities or towns with the highest numbers of inhabitants, frequently working as liberal professionals. Nevertheless, the rural areas were not lacking health staff. During the eighteenth century, surgeons (without university training) barber-surgeons and blood-letters were widely distributed among the small towns and the villages. In the first part of the nineteenth century, with the increase in the categories of medical doctors and other health staff, the rural milieu also had a remarkable number of health professionals, hired by the local authorities to care either for the underprivileged sick or for all the inhabitants of the towns and villages.

The Patrimonial Power and Development of Public Health in Modern Iran

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Modern medicine and public health is deemed to have been developed with the emergence of modern state in most non-Western countries. Modern hospitals, for instance, were created first and foremost to serve the modern army, with its regular troops that were more than previously subject to gunshot injuries, or to epidemic diseases occurred more than formerly. Likewise, the newly established nation-states required a nationwide public health system, with a standard medical knowledge practised by a recognised medical profession. In this paper, however, I argue that the development of modern public health system and modern medical institution, characterised by its uniformity of organisation in countries such as Iran, finds its organisational and institutional framework in the patrimonial structure of power, which remained in force through into the nineteenth century. Although the focus of the study is on the nineteenth and early twentieth centuries in Iran, the paper will refer to the history of medicine in Islam across time and space with a cross-cultural and comparative approach due to the conceptual and socio-political continuity. The bibliography covers thus a wide range of secondary and primary sources dealing with medieval and modern history of medicine in the Islamic lands.

In early Islam, the state support for the translation of Greek medicine set the latter as the normative knowledge, which remained the criteria for professional medical status until modern period. Likewise, within the boundaries of the standard medical knowledge, the practical means of professional distinction was of institutional order that, in the history of Islam, fell within the remit of the state. This sociological principle, also at work in modern societies, was well entrenched in the societies of patrimonial structure, such as nineteenth-century Iran. The state sponsorship of medicine featured, even before the effective modernization, a medical organisation that became the foundation of modern medicine and public health.

Far from claiming that modern medicine originated in medieval system, this paper explores historical and traditional grounds that could, or did, frame the development of modern public health. This approach leads us to review the current narrative of medical modernization that is predicated on the presumed antagonism of modernity and tradition.

Curing the body and saving the soul in the Portuguese hospitals in the Early Modern Period

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Alexandra Esteves
(Universidade do Minho)

Taking care of the body and healing the soul became one of the touchstones of the Portuguese Misericórdias during the Modern Age. Proprietors of the large majority of existing hospitals, these brotherhoods either helped the sick people in their hospitals or sent health professionals to their homes, paying for the medicines or even giving those alms so that they could treat themselves.

In this article it will be my purpose to analyse the reform of assistance at the beginning of the Modern Age, as well as to caracterize its consequences in the hospital system.

At the same time, I will pay attention to the clientèle of hospitals, diseases, treatments and religious assistance to the interns.

Hospitals in Modern Age provided a wide set of services to those sick people, thereby covering body cares and soul assistance.

In this work I will try to analyse and discuss the Portuguese Misericórdias' health services thoughtout the Modern Age, either at the Misericórdias' hospitals and by their provision of home care services. I will pay attention to their hospital facilities, to the range of health care services provided, to those in charge of health care and to the sick benefiting from these services

The primary sources used included livros de actas (register books of proceedings), livros de entradas e saídas de doentes (registers of entry and exit of the sick) and livros de receita e despesa (account books).

In this article I intend to outline the ways in which hospitals did work, the kinds of services provided to the sick, focusing in particular to those concerning body and soul.

Socio-Economic Determinants of Population Health: to what extent can the rise in educational attainment mitigate the health burden associated with aging phenomena in Portugal?

Maria Rosário F. O. Martins (ISEGI-Universidade Nova e Lisboa)

The purpose of this study is to describe the extent to which the expected rise in the educational attainment of the Portuguese population can compensate the increases in the prevalence of ill-health based on the aging of the population for the period 2004-2021. We used national representative data obtained from the 1998/99 and 2005/06 health survey, provided by the National Health Institute Dr. Ricardo Jorge and the National Institute of Statistics (INE). To estimate the current differences in health by age and educational level we used logistic regression models. In the model considered in our framework, the dependent variable is health status (Y=1 if the individual declares that it is in bad or very bad health and Y=0 if it is in good or very good health). The explanatory variables are the following: age, educational level and the existence of certain disease typology. As usual we fit two separate models for men and women and we considered two distinct periods: 1998/99 and 2005/06. Our results suggested that, as expected, people with higher educational level have lower probability of declaring themselves in bad or very bad health. These conclusions are similar to those obtained in other studies on this subject. Moreover, the estimated impact of education on health status is significantly higher for men than for women. As anticipated, older people have a higher probability of being declared in bad health than younger ones. With regard to this variable, the results between women and men are not as different as those regarding the educational level. Comparing the results for the two periods, preliminary findings suggest that possibly the coefficients relating socioeconomic characteristics and health status did not change significantly over time. Consequently, projections of ill-health population can be estimated based on this stable scenario. We conclude that, to some extent, the expected rise in the educational level will relieve the future health care burden associated to population aging in Portugal.

Tried and Disapproved: Local Authorities and the Issue of Internal Migration from the Countryside to the Town of Linköping, Sweden during the First Half of the 19th Century.

Victoria Nygren
Linkoping University

The aim of this paper is to demonstrate how local authorities and town dwellers in a small, pre industrialized town during the early 19th century viewed and handled the issue of new prospective settlers, especially proletarians and others among the lower social strata. *The method* used for this purpose is qualitative, investigating different *sources* from the town and parish administration, mainly records of the poor relief committee and parish assembly, but also announcements in the local newspapers and from the county governor.

This research topic can be seen in connection with the wider "social issue" during this time, concerning a society in dramatic change, struggling with new demographic and socio- economic conditions. The migration to town increased while medieval paternalistic regulations still let the burghers decide who to allow living in town and, hence, be entitled to poor relief. This traditional system was rigidly bound to a certain local place and to certain fixed labour markets.

The results from the local context of Linköping, show how the old system clashed against the new, upcoming. If the migrants without means were incapable of doing servant work, i.e. had passed their forties, had a family to provide for or had any kind of problems with the law or their health, they were not wanted in town. This group had to apply for a special permission to stay in town. If they were to be let in, the committee for poor relief needed a guarantee that someone took responsibility for them in case of their misfortune. In fact, there was a stigma around all the proletarians as a group. The local authorities noticed them as *potential* paupers if they stayed in town, after being servants, and started a family. To live as an unskilled worker in town with a family to support was not formally approved or in line with the old system since it required the family to live outside a master's household. This unconventional situation was believed to ultimately make them beggars and thieves because the salary was only intended for one person and not a whole family. The moral standard regarding new settlers was embedded in the paternalistic, place bound society.

Impoverishment, life –cycle and social nets: exploratory study (Évora 17th -18th centuries)

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Charity, poor relief and health-care are usually concepts and practices related to the *poor*. However, studying the outdoor relief provided by the Misericórdia of Évora between the 17th-18th centuries, we realized that the main group that benefited more from the different forms of institutionalized care belonged to the local *elites*.

My presentation has three different aims: to analyse the presence of some members of this group, either in family or personal terms, in the institutional poor relief system (archbishopric and Misericórdia); to identify the social uses they did of it; and to understand the uses of these resources as social and economic strategies in order to maintain their social statutes or even increase it.

So as to reach those goals, we will reconstruct the social/economic and family structure of the poor relief recipients, identifying key-points in their life-cycle – such as widowhood, births, illness, aging – as well as their social capital and how they used it.

My main sources are primary ones (records of outdoor relief, parish documents and the payment of taxes) and the methodology is based on a combination of the prosopography method with the sociology concept of life-course.

Following these life-courses and life-cycles we will conclude that impoverishment could be a transversal phenomenon in the early modern Évora society, as everywhere, but the poor relief resources could take part in a variable set of social strategies of specific groups, where poverty was not the most important.

Diversity and Convergence in practice: the Mutual Benefit Societies' Responses to the 1918-19 Influenza Pandemic in Pamplona

Pilar Leon Sanz
University of Navarra

This paper discusses the responses of the Mutual Benefit Societies to the 1918 epidemic in Pamplona, a town in the North of Spain, a point which has barely been studied to date, perhaps due to the difficulty in finding information on these institutions, which looked after one third of population who resided in Pamplona at the time. The documental sources complement the data of the Town Archives and the newspaper reports of the time.

The presentation shows the major importance of the data from these institutions in the follow-up of the epidemic. We have seen an increase in the morbimortality from influenza and other respiratory diseases in the years before the pandemic, particularly since 1915. We have also noticed that there is no coincidence between the number of victims of the epidemic and the measures adopted by the government, as, according to the Societies' data, the epidemic continued relentlessly in the first three weeks of February 1918, while the exceptional measures were shelved at the beginning of the month.

Secondly, we study how the epidemic was fought by diverse assistance institutions in Pamplona. The arrival of the flu, in the same form as in other cities, brought about a critical situation. There was also a lack of basic food and medicine in the city at the time. The Mutual Benefit Societies joined together with the committees organised by the City Council and the Government to acquire basic foodstuffs and medical attention.

The epidemic alarmed these institutions and forced them to carry out economic campaigns to obtain monetary help from members and multiple donations in order to fulfil their commitments to the ill members and still remain solvent. The number of contributions illustrates the social support that these entities had. It is also proof of the support the Mutual Benefit Societies received from the provincial and municipal governments.

In addition, the conduct of the health professionals contracted by these institutions during this period will be analysed.

The effects of measles and other epidemics in virgin soil populations. The case of Iceland and the Faroe islands during the 19th century

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University of Iceland

In most European societies during the 19th century, measles were an endemic disease with epidemic fluctuations. Under such conditions measles are predominantly a children's disease. This paper examines measles epidemics in two island-societies in the North Atlantic, Iceland and the Faroe Islands. Mortality rates in those islands situated at periphery of the European continent were prone to considerable fluctuations during the 19th century. Due to the geographical isolation, many lethal diseases that had already transformed into childhood diseases in more densely populated European societies affected all age groups and had wide-ranging consequences for the infrastructure of relatively poor societies.

The paper focuses mainly on the measles epidemic in 1846 and in part on the epidemic in Iceland 1882. The epidemic 1846 was widely analyzed by the well known physician Peter Panum who was appointed to the Faroe Islands by the Danish Health Board (*Collegium Medicum*) when the epidemic broke out in the islands in April 1846. Panum and his colleague A.H. Manicus showed that the measles epidemic affected almost the entire population of the Faroese with the exception of the very old, i.e. those born prior to the preceding epidemic in 1781. Similar observations on measles in Iceland were made by Icelandic physicians and the Danish physician Peter Schleisner who was in Iceland in 1846. However, Schleisner did not make a study on measles comparable to the one of Panum and Manicus. This paper uses the empirical studies of those physicians to shed light on measles epidemics in societies where the majority of the population was immune. Church registers and medical records are used to assess incidence rate and case fatality rate from measles in Iceland and the Faroe islands. Special attention will be paid to infants and young children. Another objective is to shed light on the human implications of mortality crises in sparsely populated isolated societies where the care of the sick was entirely the responsibility of family, kin and neighbours.