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Health care and poor relief in Portugal. An historical perspective

Laurinda Abreu*

Abstract:

This contribution has two main objectives. First, it seeks to describe the policies that governed the provision, regulation and distribution of poor-relief and healthcare resources in Portugal in the sixteenth to eighteenth centuries. Secondly, it attempts to account for the persistence of the poor-relief system established at the turn of the sixteenth century, together with its financial underpinning. The main features of this system are discussed on the basis of its primary components – hospitals, *misericórdias* (charitable institutions) and officially accredited health professionals. This article draws on previously published works (especially Abreu, 2018a, 2018b, 2018c), where the reader will find further details and references.

Keywords: poor-relief policies, early modern Portugal, healthcare funding

Early reforms: Hospitals and *misericórdias*

In Portugal as in the rest of Europe, the social disarray and serious public health problems resulting from the socioeconomic upheavals and virulent epidemics – especially plague – of the latter half of the fourteenth century prompted the civil and religious authorities to adopt systematic and continual measures to support the poorest and most vulnerable members of the community. In contrast to other states, however, most notably in Italy, where the cities took charge of this process, in Portugal it was the crown that played the leading role, and it continued to do so in the following centuries. In the long-term view, the reign of Dom Manuel I (1495-1521) stands out as the time when welfare issues became a regular matter of political governance enshrined in law. The pressing need to increase the country's population at a time when Portugal was building its overseas empire and the clear perception that poor relief could play an important role in strengthening central government power and influence are likely to have been among the main reasons for the crown's considerable investment in this area (Abreu, 2016: 9-24).

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One of the sectors that best reveals the dynamics of politics and welfare in those distant times is the hospitals. It was a crown decision, for instance, that gave rise to *medical* hospitals, regarded as places for treating the sick and progressively less as hostels for pilgrims, travellers or poor people in search of some kind of relief. In most of the late-medieval establishments that called themselves 'hospitals', lodgers were given 'hearth and water and victuals' (Paiva, 2003: 199 [doc. 76: 1266, July 5, Benfica]) and often spiritual help as well. Few offered the services of a bloodletter or surgeon, and even fewer a doctor. Only leper hospitals catered for a restricted clientele, but their aims were more to segregate lepers than to provide them with medical care. In those days, sickness was the antechamber to death (Abreu, 2018a), a path of no return to be assuaged by the company of one's brothers belonging to the same confraternity ('and if one of the brothers be sick, let him be visited by all the brothers and kept and watched over by four brothers every night until his death. And let all the brothers be called to watch over him at night and to bury him'[1]) and, more broadly, by all those whose faith made them brothers. As one of the seven corporal works of mercy, visiting the sick appeared in contemporary texts in a form very close to that set down by Saint Thomas Aquinas in his *Summa Theologiae* (1265-1273), based on the words of Jesus: 'I was sick, and ye visited me' (Matthew 25, 36) (Aquino, 1990: III, Part II-II(a), Treatise on Charity, Alms C.32.a.2).

In hospital provision, Portugal lagged behind countries like England and France and even Italian cities such as Rome and Florence, where there had long been places devoted to patients considered curable. It was only in the second half of the fifteenth century that hospital reform started to take off in the country, culminating in the founding of Todos os Santos Hospital in Lisbon – building work started in 1492 (Pina, 1950, p. 148) and the hospital opened at the beginning of the following century. This was the first large early modern hospital in Portugal to adopt the medical, organisational and functional precepts of the most important hospitals in Europe, particularly Santa Maria Nuova in Florence. Todos os Santos was not an isolated case, however. The essential features of a *medical* hospital were laid down in 1495 in the statute (*Regimento*) of a small hospital in Montemor-o-Novo, a town south-east of Lisbon. They stated that the purpose of this hospital was to shelter and treat the sick, implying that the sick would be physically separated from those who did not need medical care; there were separate wards for men and women; patients with the financial means to do so had to pay the expenses incurred

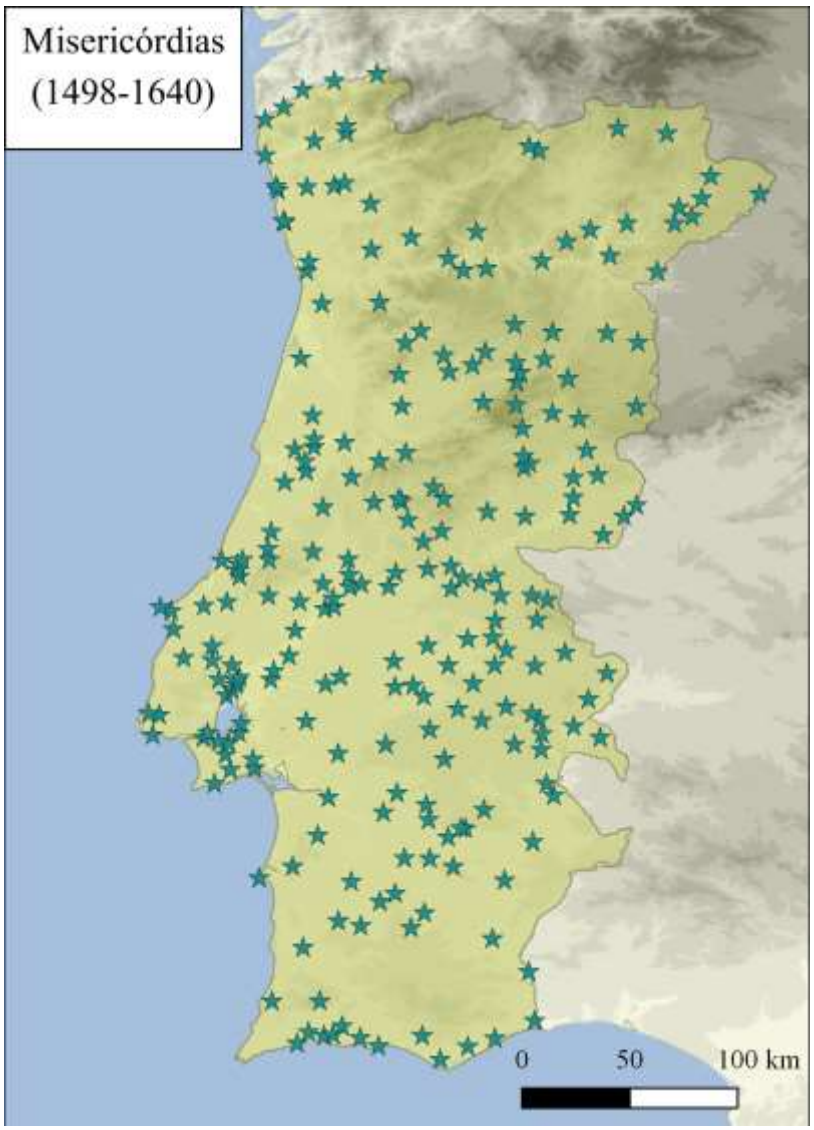
[1] From the by-laws (*compromissos*) of confraternities in Torres Vedras (Paiva et al., 2003: 287 [doc. 164: 1212, February 1, no place]).

during their stay; the hospital had its own apothecary's shop, a salaried (but not permanent) doctor, and couple of hospitallers who lived on the premises; and the doctor's duties included prescribing remedies and diet, overseeing the hospitallers and, together with the hospital governors, deciding on patient admissions (Abreu, 2018a).

All the provisions of the Montemor hospital statutes were transposed into the statutes of Todos os Santos Hospital in 1504, but expanded and further developed as befitted its status as the principal hospital in the country and a place of innovation, not least in the training it provided for surgeons in its 'School of Surgery'. Under Dom Manuel I this change in the hospital landscape became established and spread beyond the capital, and the Todos os Santos model was soon reproduced, to some degree at least, in the larger cities from Beja to Coimbra. Porto, however, remained aloof: its municipal council rejected the king's proposal to found a new hospital there for fear that it would lead to higher taxes.

At the same time as he was investing in hospitals, Dom Manuel also launched a nation-wide campaign to persuade communities to found *misericórdias*. These lay confraternities rooted in religious values (their full name means 'holy houses of mercy') marked a new era in Portugal for the organisation and distribution of welfare resources. The first *misericórdia* was officially created in Lisbon on 15 August 1498 under royal auspices. By the time of Dom Manuel's death in December 1521 there were 77 of these institutions in the kingdom and empire, increasing to over 300 by the early 1600s.

Figure 1 - *Misericórdias* founded between the reigns of Dom Manuel I and Filipe IV



Source: Data from the Medical Professions Database, 1430–1826[2]

[2] The Medical Professions Database, 1430–1826 originated in a research project funded by the Fundação para a Ciência e a Tecnologia (FCT) (PTDC/HIS-HIS/ 113416/2009). It is composed of the data on medical professionals found in five major documentary sources stored in the Portuguese central archives (Arquivo Nacional da Torre do Tombo): *Chancelarias Régias*, *Ementas da Casa Real*, *Desembargo do Paço*, *Registo Geral de Mercês* and *Santo Ofício*. New records are being added from sources kept in the Arquivo Histórico Ultramarino (the historical archive of the Portuguese Empire).

Although they continued the fraternal tradition that had long existed in the West, one difference between the *misericórdias* and the confraternities that had preceded them lay in their royal patronage, a prerogative recognised by the Church at the Council of Trent (1546-1563).[3] A *misericórdia* could only operate with the king's assent, a condition made explicit in its by-laws (*compromisso*), which acted both as a rule book and as confirmation of its legal status. The king's signature on the *misericórdias*' by-laws allowed them access to a wide range of benefits and privileges, both financial and legal, to help them carry out the works of mercy, above all assisting the poor when imprisoned or sick. The sick were visited either at home or in hospital, where they were sent if they required more specialist attention.

The fact that the first *misericórdia* by-laws already referred to the curative role of hospitals not only demonstrates the paradigm shift in the function and role of hospitals but also shows that the crown was acting in a systematic, concerted fashion. In the hand-written by-laws of 1498, the work of mercy relating to the sick had been expanded to read 'visit and heal the sick' (Paiva, 2004: 386 [doc. 246: 1498, August, Lisbon]); in the printed version of 1516, the text had been changed again to 'the second [work of mercy] is to heal the sick'. By that time, the crown was beginning to hand over the administration of some hospitals to the *misericórdias* on the grounds that the confraternities' welfare resources and efforts needed enhancing. The document transferring the Espírito Santo Hospital in Montemor-o-Novo to the local *misericórdia* in 1518 made this causative connection explicit, and it was repeated in subsequent deeds annexing hospitals to *misericórdias* (Paiva, 2004: 321 [doc. 206: 1518, January 6, Montemor-o-Novo]): hospitals were for curing the sick; curing the sick was a work of mercy; the *raison d'être* of the *misericórdia* confraternities was to carry out these works; and therefore transferring hospitals to these institutions would avoid having 'so many people not occupied in a service' (Abreu, 2018a). Even though the transfer of hospitals to the *misericórdias* had really only made progress after the Council of Trent, by the end of the century few hospitals were still outside their control.

Accrediting healthcare workers: empirical training or university degree?

The last corner of the triangle is occupied by the healthcare workers themselves. The crown initially focused its attention on 'empirics', that multiform category of healers who

[3] There is a vast literature on the *misericórdias* in Portugal. For further details see in particular the works by Isabel dos Guimarães Sá (1997), Maria Marta Lobo de Araújo (2000) and Maria Antónia Lopes (2000).

had no university training but whose experience could be formally recognised if they could demonstrate that they knew enough to practise the occupation they were applying for.[4] These occupations were overseen by the chief surgeon (*Cirurgião-mor*) and the chief physician (*Físico-mor*), positions usually held by the monarch's primary surgeon and physician, respectively. They were ultimately responsible for the health of the general public, in accordance with the metaphor of the king as the father of all his subjects.[5] The occupations in the chief surgeon's charge included midwives, dentists, bloodletters and especially surgeons, among others. Dom Manuel I strengthened the control measures over surgeons brought in by his predecessor, Dom João II, by requiring all surgeons to renew their licences, but without altering the legal framework that governed the chief surgeon's activities.

The situation of the chief physician was different. He was responsible for issuing licences to apothecaries and individuals who wished to practise medicine without having graduated from university. Although the field was open to others, it was mostly surgeons and a few medical students who applied to the chief physician to be examined for a licence. The importance that the crown attached to this task was confirmed in the Chief Physician's Statute of 1515 and its amendment of 1521, which also included earlier procedures together with new inspection measures (targeting apothecaries in particular) and the power to recognise medical degrees obtained abroad.

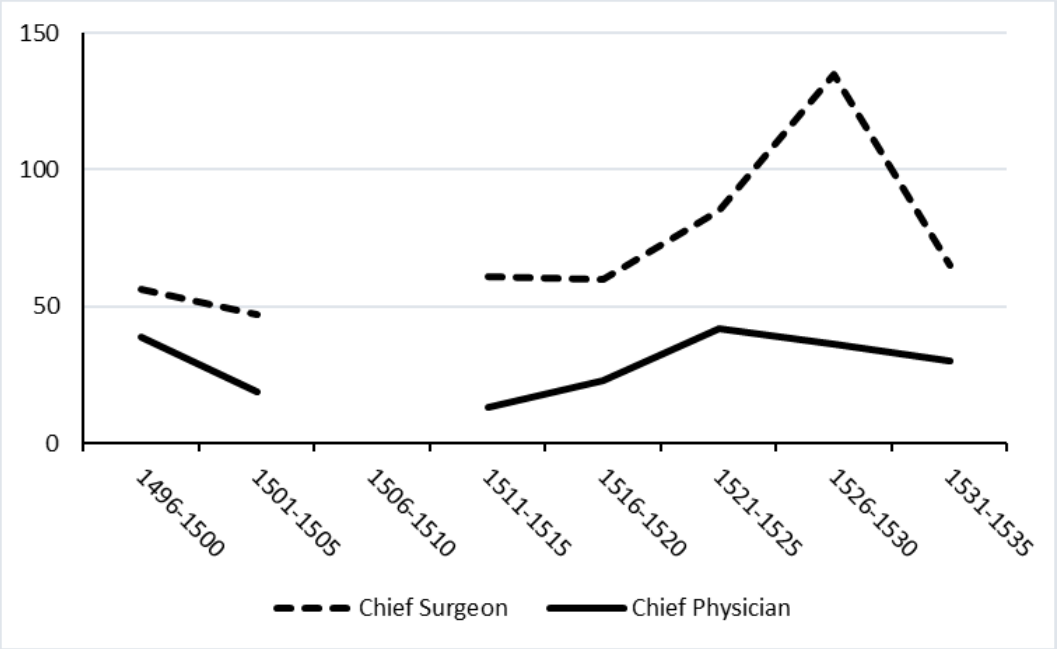
Alongside increasing central control, therefore, there was also an incentive to expand the number of healthcare workers to respond to the growing demand for medical care from hospitals, town councils, *misericórdias*, the royal court and wealthy individuals. In this context, the crown's officers conferred many hundreds of licences on doctors and surgeons, a particularly striking number when compared with the previous period. In the 62 years between 1434 and 1495, 111 physicians and 183 surgeons had been examined (Gonçalves, 1965), whereas in 35 years between 1496, the date of the first licence under Dom Manuel I, and 1535,[6] the chief surgeon issued 509 licences to practise surgery and the chief physician 220 to practise medicine (Figure 1).

[4] Information on the European setting for this process may be found in Brockliss and Jones, 1997; Pelling and Webster, 1979; Slack, 1985; Gentilcore, 2006; Pomata, 1998; and Cavallo, 2007. See references in Abreu, 2018b, for further relevant works.

[5] Portugal closely followed the French model in this respect (Lunel, 2008).

[6] No data have been found for the five-year period 1506-1510; the reasons for this hiatus in the Chancellery records of licences issued have not been determined, but the massacre of New Christians (converted Jews) in Lisbon in 1506 is unlikely to have been a mere coincidence. The initial rise in licences issued may have been part of Dom Manuel's strategy for dealing with the Spanish Catholic Monarchs' demand that he expel all Jews from Portugal as a condition of his marriage to their daughter, Princess Isabella of Aragon. Since many Jews worked in the 'curative arts', by forcing all surgeons (and potentially physicians as well) to renew their

Figure 2 - Licences issued by the chief surgeon and chief physician (1496-1535)



Source: adapted from Abreu, 2018a, p. 48

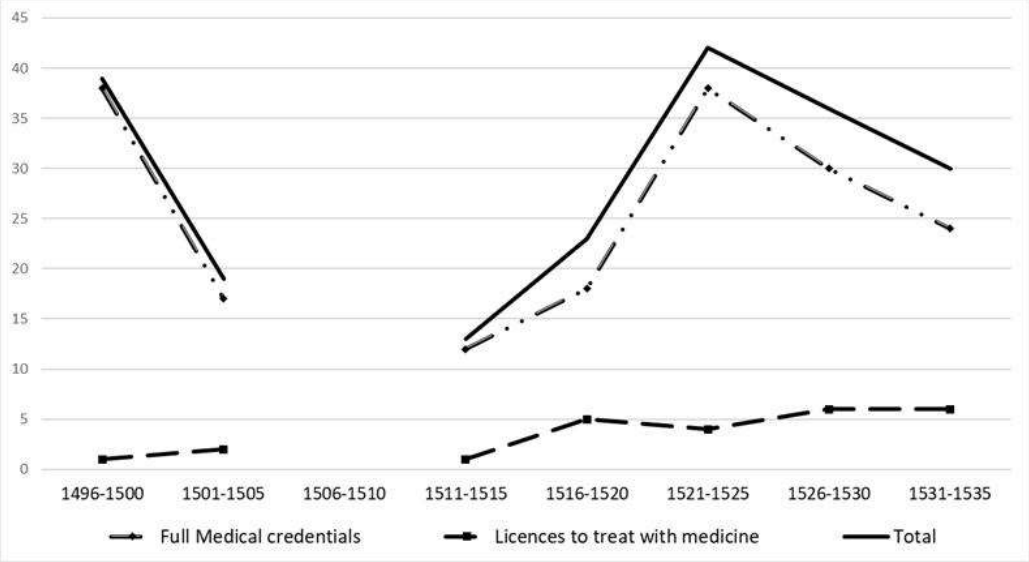
It should be noted that 61 of the 509 credentials for surgery were 'licences to treat with surgery' (*licenças para curar de cirurgia*) and 25 of the 220 for medicine were 'licences to treat with medicine' (*licenças para curar de medicina*). In practical terms, a full physician's or surgeon's licence effectively gave the same rights as a university degree (although, by law, licence holders could only practise medicine in locations were there were no Coimbra graduates), whereas a licence to treat was temporary and geographically restricted, and only allowed the bearer to perform a limited number of medical or surgical procedures, and even then only if there were no graduate professionals available. As Figures 2 and 3 show, it was not common practice for the chief surgeon and chief physician to recognise practitioners who did not have the required skills, at least in theory, by awarding them licences to treat; this helped to raise the official credibility of the full medical and surgical credentials.

licences Dom Manuel may have been seeking to avoid identifying New Christians to prevent them from being stigmatised.

Figure 3 - Licences issued by the chief surgeon (1496-1535)

Source: adapted from Abreu, 2018a, p. 49

Figure 4 - Licences issued by the chief physician (1496-1535)



Source: adapted from Abreu, 2018a, p. 49

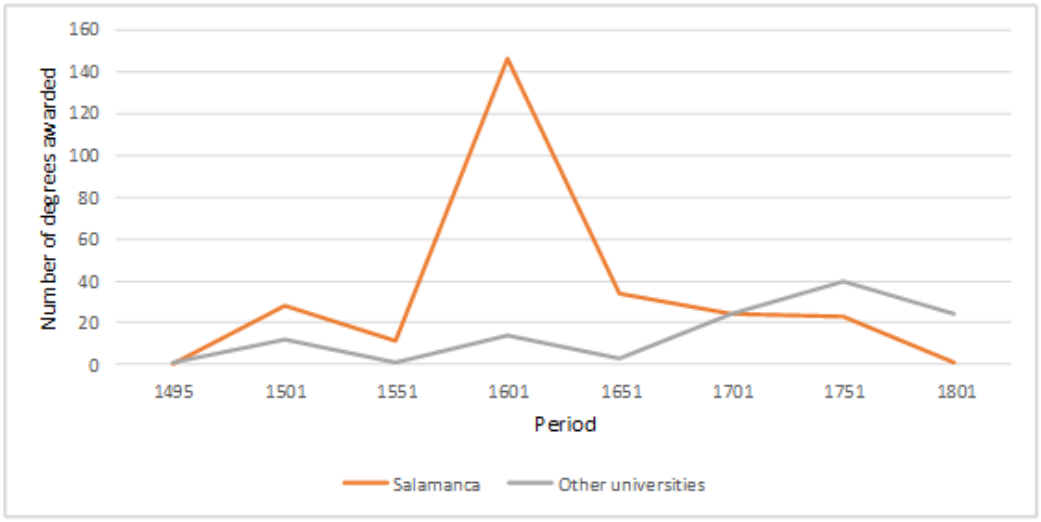
These numbers do not include the doctors who graduated from Portugal's university, which was going through a turbulent period at that time, resulting in its transfer from Lisbon to Coimbra in 1537. Two years previously, at the *Cortes* (assembly of the estates of the realm) held in Évora in 1535 (the end date of the graphs above), the people's representatives complained, apparently at the university's urging, that the chief physician and chief surgeon seemed to be concerned more about selling their licences – that is, receiving the fees for every diploma issued or examination conducted – than about assessing the skills of the professionals they were licensing, thus endangering the public's health. There is no way to prove or disprove this catastrophist scenario, but the complainants were right in at least one respect: the university medical course was unable to attract students as long as the chief physician and chief surgeon held sway over the field of medicine in Portugal. In 1535, for instance, only seven medical doctors graduated from the university.

In these circumstances, the king, Dom João III, initiated a thorough reform of the university medical course to modernise it and promote excellence in medical training. To do so he hired professors of repute who were teaching in foreign universities and introduced a programme of studies incorporating the latest advances in anatomy. In his pursuit of excellence, Dom João III issued a decree on 4 November 1545 increasing the length of the medical course to eight years (six years of theoretical studies followed by two years of practical training under a doctor practising in the city). That made it one of the longest, if not the longest, medical course in Europe. Although partially corrected the following year by dropping the requirement for two years of practical training (Braga, 1892–1902: II, 791-98), this decision exacerbated the Faculty of Medicine's difficulty in enrolling students, who preferred to take shorter degree courses abroad, especially in Salamanca,[7] which would be recognised by the chief physician on their return to Portugal despite fierce opposition from the University of Coimbra. Salamanca University's importance in training Portuguese doctors is clearly shown in Figure 5. While it is impossible to dissociate the peak period of attraction from contemporary political events – the union of the Iberian crowns under Philip II of Spain (Filipe I of Portugal),[8] at a time when Salamanca had lost some of its prestige and may have been keen to recruit Portuguese students to make up for a reduced home intake – the trends in Figure 5

[7] On the complexity of studying in Salamanca and the conditions that students faced, see Cubas Martín, 2014; Marcos de Dios, 2010; Abreu, 2018b.
[8] The union of the Spanish and Portuguese crowns lasted from 1580 to 1640.

primarily reflect the vicissitudes of the relations between the University of Coimbra and the chief physician.

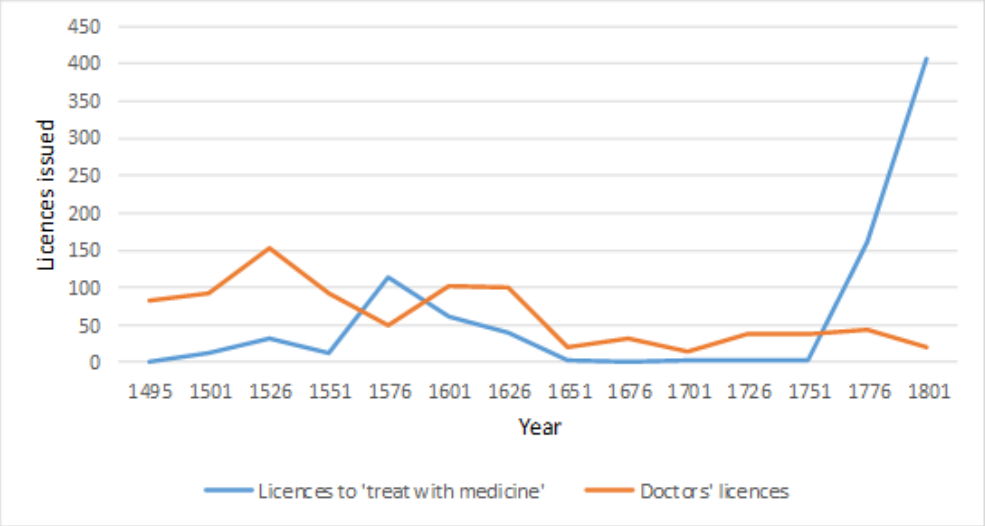
Figure 5 - Medical degrees awarded to Portuguese students by universities abroad



Source: Abreu, 2018b, p. 246

The open warfare between the university and the chief physician was to have an adverse effect on the field of medicine in Portugal throughout the early modern period, albeit punctuated by moments of dialogue and agreement. One such moment occurred in the late sixteenth century, following the royal proposal of 1568 to promote the training of doctors and apothecaries at the University of Coimbra (or under its supervision in the case of apothecaries) by creating 30 scholarships a year for medical students and 20 for apothecaries. Heartened by the crown's support, the university persuaded the chief physician to give up recognising foreign degrees in exchange for a sum in compensation for loss of income. This agreement lasted until the crown put an end to it in 1608, raising tensions between the two sides to unprecedented levels. The results of the complex rivalry between the university and the chief physician for control of the field of medicine may be seen in Figure 6.

Figure 6 - Medical licences issued by the chief physician



Source: Abreu, 2018b, p. 242

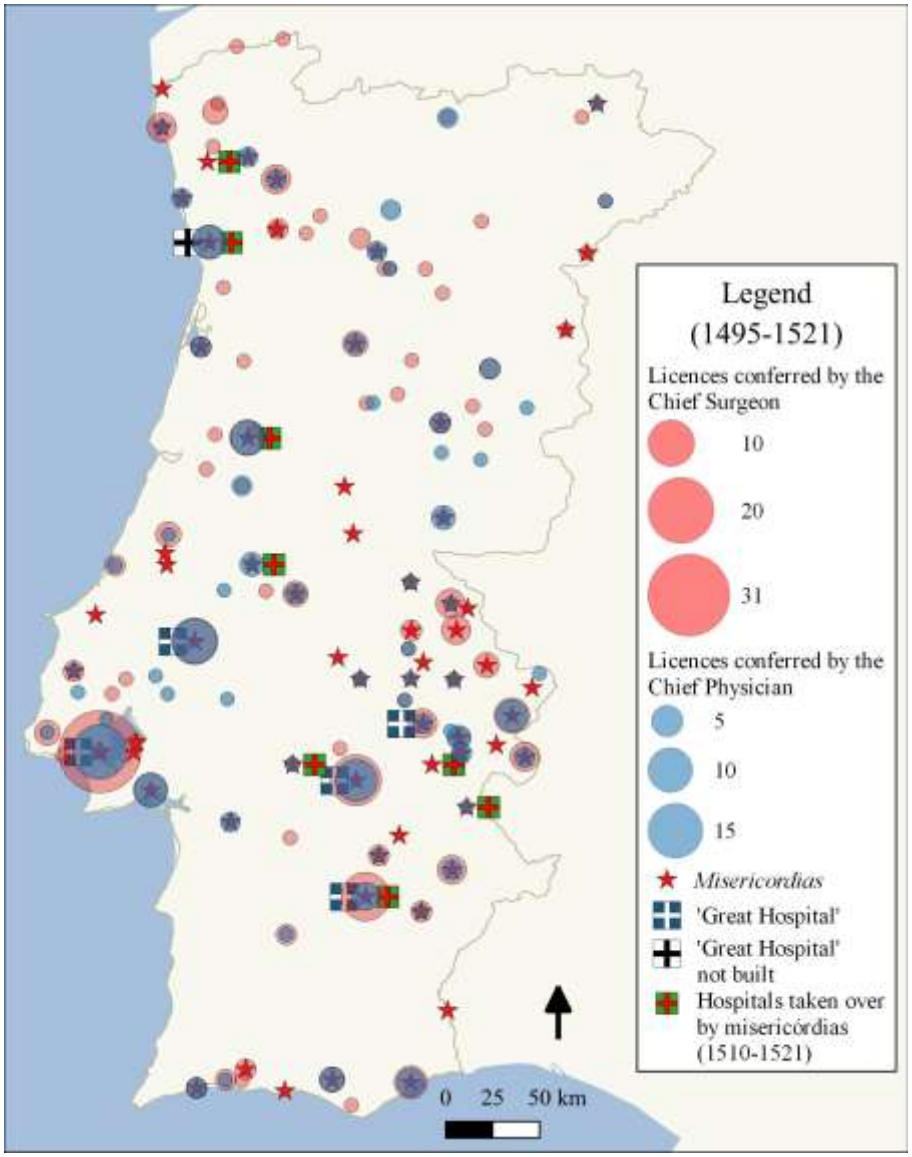
In practice, the chief physician had started to issue fewer medical licences after the university's move to Coimbra, and especially after 1550. The average number fell from over 6.6 per year between 1495 and 1550 to 5 per year from 1550 to 1826, even though the latter period included the surge in licences issued when the Protomedicato took over the work of both chief physician and chief surgeon in 1782 and clamped down on unregulated practice. The sharp fall in the number of full medical credentials issued in the late 1560s-70s may reflect the above-mentioned agreement between the chief physician and the university, supported by the king, under which he received 200 *cruzados* a year from the university instead of one silver mark from every doctor he licensed. When the crown in Madrid refused to maintain the agreement, the chief physician resumed his activity of accrediting medical degrees from foreign universities. Another point to note is the rise in licences to 'treat with medicine' issued in the same period. As the chief physician was not allowed to award full doctors' licences at the time, he may have been issuing these lesser licences to applicants with university training. With the breakdown of the agreement in the early years of the seventeenth century, the number of licences issued to 'treat with medicine' fell again while full medical credentials rose (Abreu, 2018b).[9]

[9] The relationship between the issuing of medical licences and the New Christian question is discussed especially by Marcos de Dios (2010) and Abreu (2018b). The latter work also discusses the trends seen in the following years. See also Gonçalves (in preparation).

Healthcare coverage in early modern Portugal

Several questions are prompted by the effects of the royal healthcare and poor-relief policy that began to take shape in the late fifteenth century. I will focus here primarily on the structure established under Dom Manuel I, since it persisted throughout the following centuries, and on two points in particular (Figure 7): firstly, how the crown's decisions were put into practice so swiftly and, secondly, how all the healthcare facilities and health workers mobilised at the time were funded. In the first case, given the crown's known logistical and administrative difficulties in making its presence felt outside the capital, the answer must be sought in the people's reasons for accepting the king's proposals so promptly. This is a particularly relevant issue here because this expansion of *misericórdias* and hospitals to the provinces was part of the royal move to establish regulations that would harmonise procedures throughout the country (although adaptation to local circumstances was still possible), in this case based on two documents originating in Lisbon: the statute of Todos os Santos Hospital and the by-laws of the Lisbon *misericórdia*, which served as a model for the by-laws of all other *misericórdias*.

Figure 7 - Formal healthcare and poor-relief facilities during the reign of Dom Manuel I



Source: Translated from Abreu, 2018a, p. 52

The *misericórdias* were the keystone of the system created at that time. Their rapid spread was driven to a great extent by their social appeal. The attraction was not so much their statutory obligation to be representative of society, with a balance of members from the nobility and from the people, but primarily the fact that in areas where there were not enough nobles to fill all the seats allotted to them, the crown allowed the vacant positions to be occupied by commoners from the lower echelons of society who held some kind of social capital acknowledged by the community. Once confirmed as 'noble brothers of the

misericórdias' and therefore members of the local elite, with seats in these high-prestige confraternities linked to the crown, these individuals found the way clear to joining their local municipal councils, which by law had to be made up of the best in the land. This possibility was immediately seized on by a number of small towns, which rushed to found *misericórdias*. In practice, charitable institutions came to be seen as routes for social mobility, albeit on a very local scale, while the people began to accept a new type of welfare arrangement and local councils underwent a certain degree of social renewal.

One reason for the concentration of facilities in the inland region of Alentejo in southern Portugal, as seen in Figure 7, may be the fact that these were royal lands, where Dom Manuel's policies could be implemented more rapidly.[10] Moreover, the pattern very roughly matches the distribution of the population: sparse in the far south in the depopulated Algarve (except for the coastal towns) and also in the north in the areas of Bragança and Vila Real.

The number and diversity of the facilities shown on the map begs the question of how the crown arranged their financial support. The answer again lies with the *misericórdias*, which the king immediately endowed with benefits and exemptions to enable them to be self-sufficient. In other words, the crown organised the country's welfare system but left its funding to be provided by the people. This strategy was given a double boost after the Council of Trent, when the running of hospitals was transferred more systematically to the *misericórdias*. The hospitals brought with them not only their own assets but also the chance of benefiting from the growing cult of Purgatory encouraged by the Council, since endowments for salvific purposes generally specified that the endowed income be split between masses for the souls of the dead and charitable works, often the care of the sick in hospitals. Very soon, however, most *misericórdias* stopped saying masses and diverted the corresponding income to their hospitals on the grounds that inpatient numbers were soaring. This argument suited the crown perfectly, as it meant there was still no reason for it to fund welfare itself.

A somewhat similar situation occurred in 1568, when the crown set up the above-mentioned scholarship scheme to expand the numbers of doctors and apothecaries. Once again, the costs had to be covered by the local communities, this time from the incomes of 74 local councils that were required to bear the entire burden of the scheme, which was organised and managed by the University of Coimbra under the auspices of central government. In return, these towns enjoyed a wider choice when hiring healthcare

[10] Another possible explanation is that these areas had a high proportion of New Christians, a group that had always included many doctors and surgeons (Gonçalves, in preparation).

professionals to serve their communities and, in some cases, being allowed to divert part of the tax they owed to the crown towards paying their salaries.

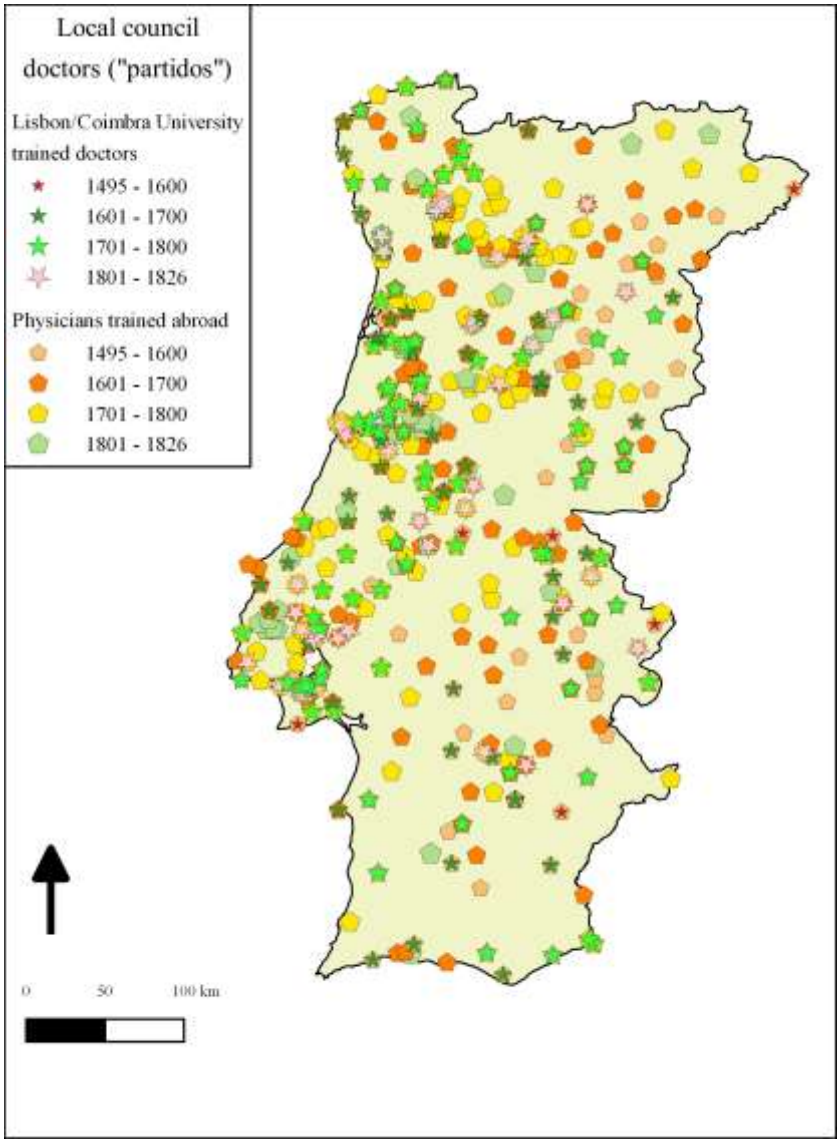
The fact that poor relief and health care were not directly state-funded led future governments to accept no financial responsibility in this area. This is apparent in the moves by the Marquis of Pombal in the mid-eighteenth century. While his government attacked the wealth of the Church and religious institutions (or institutions with religious aims, such as the confraternities), he protected the assets of the *misericórdias* and hospitals because he knew full well that otherwise the state would have to fund their activities. This attitude proved detrimental, because not only did the *misericórdias* have enormous outgoings, especially on hospitals and abandoned children, but their incomes were not keeping up with rising costs. This was due both to the natural depreciation of their assets and to mismanagement, which in many cases benefited the brothers instead of the poor. In fact, since the mid-sixteenth century this question of property had given rise to mutual mistrust between central government and the local elites that ran the *misericórdias*. While the crown blamed them for the *misericórdias*' financial troubles, the local elites suspected the government and its courts of wanting to interfere in their affairs and seize their property without giving anything in return.

The underfunding of poor relief and health care was to become a structural problem for Portuguese society, resulting in a minimalist, charity-based system of support catering for just a few poor people. Despite all the problems and weaknesses known to afflict early modern Portuguese hospitals, they were the main distributors of support for the poor. In urban areas, labourers formed a large – in some cases the largest – contingent of hospital users, including at Todos os Santos Hospital in Lisbon. Without going into the unstable working conditions of many wage earners, who were often migrant workers, or the complexity and plasticity of the concept of 'poor', or even the kind of care provided by the hospitals, the fact is that most poor people never set foot in a hospital. Some of them benefited from the outdoor poor relief dispensed by the *misericórdias* or institutions linked to the Church, but they almost always had to meet certain eligibility requirements, particularly the need to have a fixed abode and to comply with various moral and behavioural standards, conditions that not everyone could satisfy. Less restrictive access was available to the health care provided by doctors, surgeons and apothecaries (the trio of professionals often found in wealthier areas[11]) holding local council appointments

[11] To place this in its European context, see for example the works by Margaret Pelling, especially Pelling, 1982.

(*partidos*). Yet throughout the early modern period there was a scarcity of university-trained *partido* doctors serving local communities (Figure 8).

Figure 8 - Distribution of doctors holding local council appointments (*partidos*) (1495-1826)

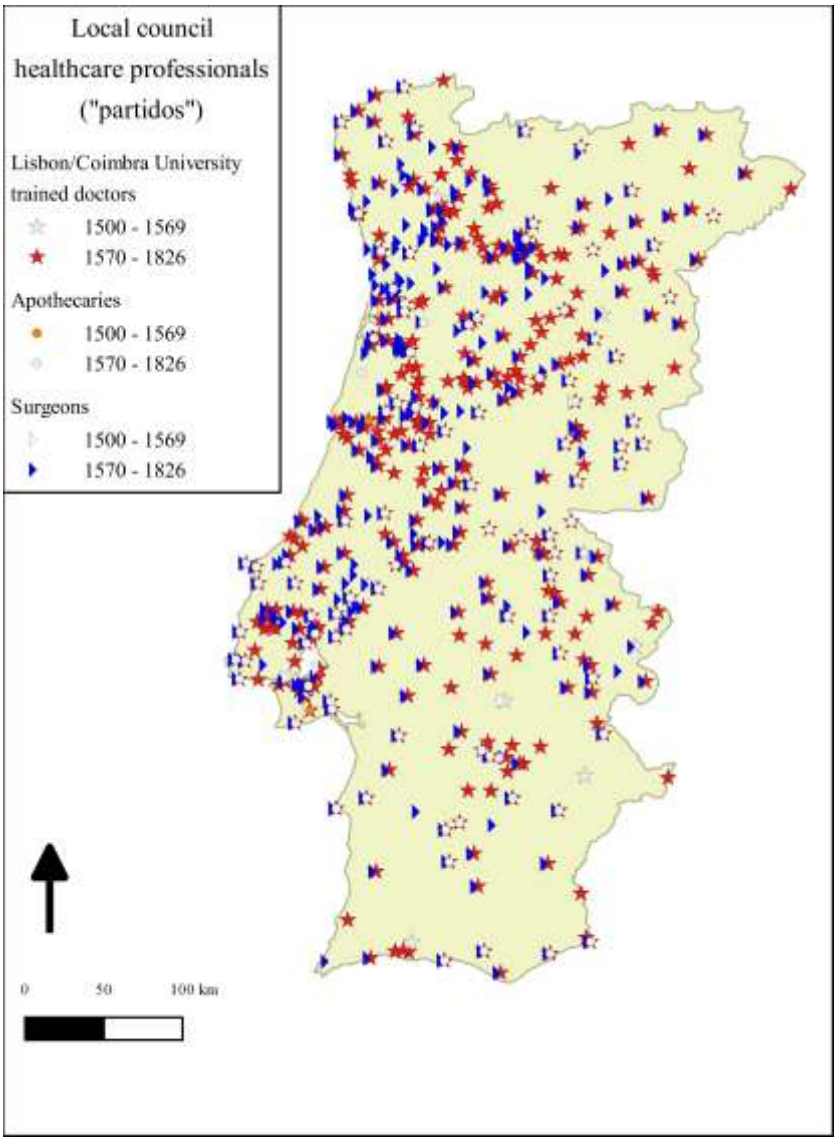


Source: Abreu, 2018b, p. 253

In addition, most doctors shared their time with hospital work and private practice for the wealthier groups, leaving little time for poor patients. The situation looks a little better when surgeons and apothecaries are included in the equation (Figure 9), but the uneven distribution of resources around the country is still obvious, with a greater concentration in the larger towns and cities. Social reformers unsuccessfully attempted to challenge this

situation – in relation to doctors, at least – in the second half of the eighteenth century by calling on the state to take action and require doctors to practise outside Lisbon.

Figure 9 - Local council healthcare appointments (*partidos*)

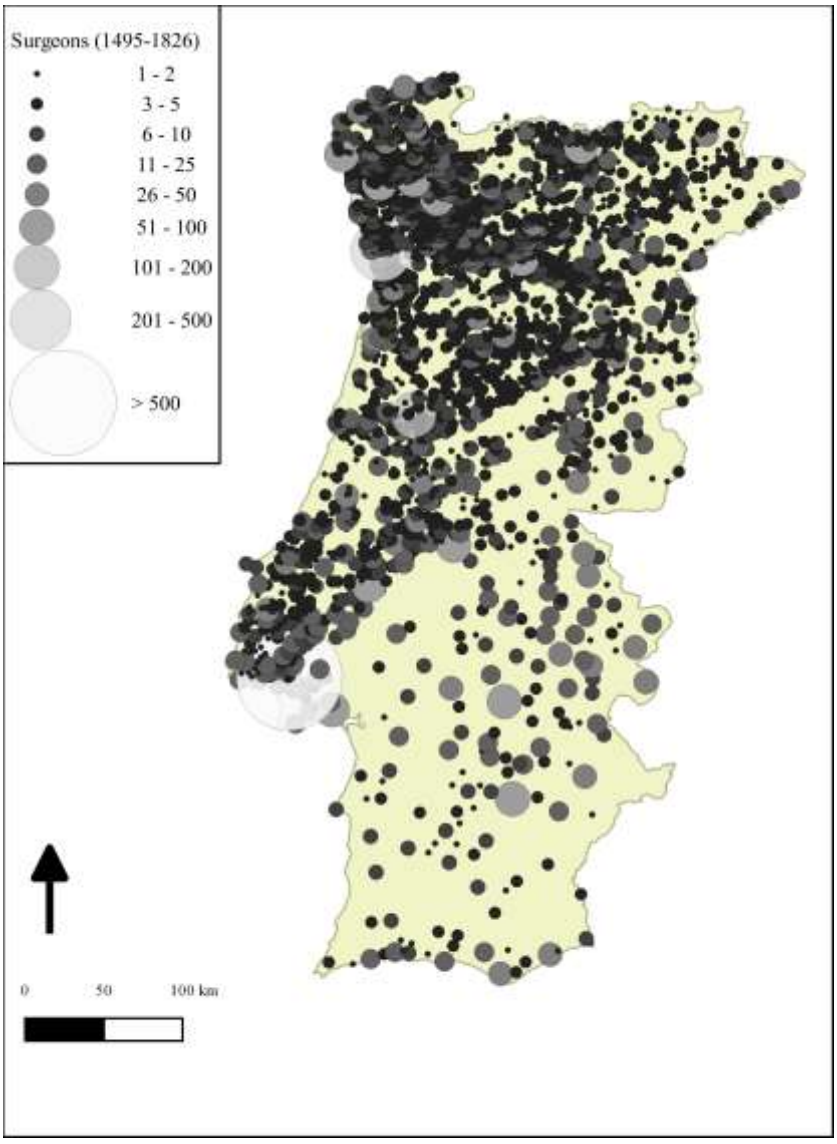


Source: Abreu, 2018b, p. 250

Although no studies on this subject have yet been conducted that are sufficiently representative of the Portuguese situation, previous calculations suggest that less than 10% of the population was covered by formal healthcare mechanisms in the early modern period, which is not very different from the average for other European countries. Several indicators, however, point to extremely high levels of poverty in Portugal. That does not

mean to say there was no health care at all for ordinary people. Those who had a little money could turn to a wide range of healers offering all kinds of health-related services. Some were officially recognised, the most important being surgeons. Trained by other surgeons in private practice or, more rarely, in hospitals and bearing a deplorable reputation among doctors, who ostracised them for the manual nature of their work, surgeons were by far the most numerous healthcare workers in early modern Portugal, as they were elsewhere in Europe and its colonies (Figure 10). Their critics accused them of causing more problems than they solved, but they were the ones who were most accessible to the people.

Figure 10 - Distribution of locally appointed surgeons (1495-1826)



Source: Abreu, 2018b, p. 254

Despite the political and legislative changes of the early nineteenth century, underfunding and the charitable basis of healthcare provision remained the primary features of the Portuguese system long after the triumph of liberalism in the 1820s. The constitutional monarchy invested more substantially in health and welfare but was politically and financially unable to fully implement the new laws it passed, including the first public health act of 3 January 1837, which outlined a relatively dense system of medical support for the whole country,[12] supervised by the Ministério do Reino (Interior Ministry). Most of the population continued to swing between poverty and destitution, attacked by many diseases that were still endemic in Portugal although coming under control in other European countries. As the French Enlightenment had recognised a century earlier, poverty was the most important issue of public health, and palliative measures by themselves did not make a revolution (Abreu, 2018c).

Portugal's health system entered the twentieth century still with its *misericórdias* and a multiplicity of other welfare institutions, such as mutual societies, most of which had few resources and only limited objectives. The much-trumpeted liberal principle of wealth distribution had not been realised. And so it remained, dependent on local, charitable and self-funded measures, despite the reforming *Regimento Geral dos Serviços de Saúde e de Beneficência Pública* (General Health Service and Public Welfare Statute) of 1901 and the ensuing republican legislation that followed the 1911 Constitution. The 1933 Constitution and the 1936 Administrative Code prompted the founding of a new wave of corporate welfare institutions, as well as the appearance of Social Security in 1935. The role of the state and its public services was still merely supplementary, although it continued to regulate private and social initiatives, especially the *misericórdias*. The Estado Novo recognised the central part these played in welfare provision, including hospital administration. Despite the ever-increasing number of beneficiaries of the services provided, the system remained socially restricted and identified with poverty. It was only in the 1980s, after Law No 56/79 of 15 November 1979 established the Portuguese national health service, funded by the taxpayer, that the state finally took responsibility for the health and well-being of all its people (Abreu, 2018c).

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[12] See, for example, Lopes, 2000.

References:

Abreu, L. (2018a). Oferta e regulação em saúde: o legado de D. Manuel I (1495-1521). In M. M. Lobo de Araújo (Ed.), *As sete obras de misericórdia corporais. Santas Casas de Misericórdia, sécs. XVI-XVIII* (pp. 35-57). Braga: Santa Casa da Misericórdia de Braga.

Abreu, L. (2018b). Tensions between the *Físico-Mor* and the University of Coimbra: The Accreditation of Medical Practitioners in Ancien-Regime Portugal. *Social History of Medicine*, 31(2), 231-257.

Abreu, L. (2018c). Pensar historicamente os cuidados de saúde em Portugal. *O Referencial*. *Revista da Associação 25 de Abril*, 130 (Julho-Setembro), 12-17.

Aquino, Tomás de. (1990). *Suma de Teología*, III, Parte II-II (a). Madrid: Biblioteca de Autores Cristianos.

Araújo, M. M. L. de (2000). *Dar aos pobres e emprestar a Deus: as Misericórdias de Vila Viçosa e Ponte de Lima (Séculos XVI-XVIII)*. Barcelos: SCMVV, SCMPL.

Braga, T. (1892-1902). *Historia da Universidade de Coimbra nas suas relações com a instrucção publica portugueza*, 4 vols. Lisbon: Typographia da Academia Real das Sciencias.

Brockliss, L. and Jones, C. (1997). *The Medical World of Early Modern France*. Oxford: Clarendon.

Cavallo, S. (2007). *Artisans of the Body in Early Modern Italy: Identities, Families and Masculinities*. Manchester: Manchester University Press.

Cubas Martín, N. (2014). *Salamanca y Coímbra: Universidades peninsulares del Renacimiento. Análisis de la población universitaria através de los grados académicos* (unpublished PhD thesis). Salamanca: Universidad de Salamanca.

Gentilcore, D. (2006). *Medical Charlatanism in Early Modern Italy*. Oxford: Oxford Univ. Press.

Gonçalves, I. (1965). Físicos e Cirurgiões Quatrocentistas: as Cartas de Exame, *Do Tempo e da História*, *1*, 69-112.

Gonçalves, L. R. (in preparation). *Prática médica e controlo profissional no Portugal quinhentista* (PhD thesis in preparation for the Universidade de Évora).

Lopes, M. A. da S. F. (2000). *Pobreza, assistência e controlo social em Coimbra (1750-1850)*. Viseu: Palimage.

Lunel, A. (2008). *La maison médicale du roi. XVI*e*–XVIII*e *siècles. Le pouvoir royal et les professions de santé*. Seyssel: Champ Vallon.

Marcos de Dios, A. (2010). A Universidade de Salamanca e Portugal no Período Barroco. In M. Teixeira Anacleto, S. Augusto and Z. C. Santos (Eds), *D. Francisco Manuel de Melo e o Barroco peninsular* (pp. 79-94). Coimbra: Imprensa da Universidade de Coimbra.

Paiva, J. P. (Ed.). (2003). *Portugaliae Monumenta Misericordiarum*. Vol. 2: *Antes da fundação das misericórdias*. Lisboa: União das Misericórdias Portuguesas.

Paiva, J. P. (Ed.). (2004). *Portugaliae Monumenta Misericordiarum*. Vol. 3: *A Fundação das Misericórdias: o Reinado de D. Manuel I*. Lisboa: União das Misericórdias Portuguesas.

Pelling, M. (1982). Occupational Diversity: Barber Surgeons and the Trades of Norwich, 1550-1640. *Bulletin of the History of Medicine*, 56, 484-511.

Pelling, M. and Webster, C. (1979). Medical Practitioners. In C. Webster (Ed.), *Health, Medicine, and Mortality in the Sixteenth Century* (pp. 165-235). Cambridge: Cambridge University Press.

Pina, R. (1950). *Crónica de El-Rei D. João II* (ed., pref. and notes by Alberto Martins de Carvalho). Coimbra: Atlântida.

Pomata, G. (1998). *Contracting a Cure: Patients, Healers, and the Law in Early Modern Bologna*. Baltimore and London: Johns Hopkins University Press.

Sá, I. dos G. (1997). *Quando o rico se faz pobre: Misericórdias, caridade e poder no império português, 1500-1800*. Lisboa: CNCDP.

Slack, P. (1985). *The Impact of Plague in Tudor and Stuart England*. London: Clarendon Press.