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Marginal and Obsolete? Rural Hospitals in Early Modern Europe: A Case Study of Catalonia

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Summary. Small local hospitals have been neglected by historians, and frequently assumed to have been marginal to their communities and largely obsolete by the eighteenth century. This paper questions such assumptions via a case study of Catalonia. It provides the first comprehensive estimates for the number of hospitals over the course of the eighteenth century, and then examines a sample of surviving accounts and other documentation to analyse the extent and nature of care provided. While the quality of care varied and most hospitals were restricted by their income, particularly against a background of war and rising prices, many nevertheless provided considerable care both to transient populations of foundlings and migrants and to their local communities. The paper calls for a re-evaluation of these forms of care in line with the re-evaluation of women's caring work.

Keywords: hospitals; rural; Europe; Catalonia; care work; finances

From the late Middle Ages onwards, hospitals proliferated across the landscape of Europe.[1] Towns of any size and even villages had a building, however small, with the designated function of taking in the sick poor and passing travellers or pilgrims. Frequently, historians have given these smaller hospitals a bad press. They have been described as 'marginal to community activities' by the early seventeenth century and as 'obsolete and in ruins' by the later eighteenth century.[2] Overall, however, what is most striking is how little attention these hospitals have received, especially compared with the larger urban hospitals. What work has been done tends to take the form of single case studies. With some notable exceptions, such as the work of Daniel Hickey, there is a lack of systematic work that attempts to look at rural hospitals in a wider setting. Larger hospitals have attracted more attention as either having a clearer medical function or as being central to attempts to confine the poor. The records of larger urban institutions are also easier to access, explaining in part why they remain the key focus of studies of welfare and poor relief outside of England and, to a lesser extent, the Low Countries. Even those few broader studies of poor relief and welfare that exist for rural as opposed to urban

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[1]Joanna Innes, 'The regulation of charity and the rise of the state' in David Hitchcock and Julia McClure, eds, *The Routledge History of Poverty, c.1450–1800* (Abingdon: Routledge, 2021), 3–20, here 6; Robert Jütte, *Poverty and Deviance in Early Modern Europe* (Cambridge: Cambridge University Press, 1994), 127–8.

[2]For the first quote, Daniel Hickey, *Local Hospitals in Ancien Régime France. Rationalization, Resistance, Renewal, 1530–1789* (Montreal: McGill-Queen's University Press, 1997), 36; for the second, Pedro Carasa Soto, *El sistema hospitalario español en el siglo XIX. De la asistencia benéfica al modelo sanitario actual* (Valladolid: Universidad de Valladolid/Caja de Ahorros y Monte de Piedad de Salamanca, 1985), 46. All translations are my own unless otherwise stated.

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areas of continental Europe give little attention to hospitals, often precisely because they appeared to be obsolete in welfare terms.[3] The survival of such institutions at the end of the *ancien régime* is seen either as an anomaly that liberal reforms would sweep away, or as a curious relic of a medieval past.[4]

Such views reflect a tendency in some older accounts by historians of France and Spain in particular to focus on poor relief and welfare precisely at the end of the *ancien régime*, when arguably both countries were experiencing what many have described as a 'crisis' of traditional charity.[5] Historians have here tended to confirm the pessimism of contemporaries, particularly in France, where the dire state of poor relief on the eve of the Revolution and in the reports of the 1790 Comité de Mendicité is taken as indicative of longer-term trends. Work on Spain has similarly focused on the end of the *ancien régime* and gradual emergence of a welfare state over the nineteenth and twentieth centuries.[6] As in France, what discussion there is of smaller hospitals has concentrated on the end of the eighteenth century, when government enquiries such as the 1787 Spanish census of Floridablanca provide a handy overview but also make it easy for the historian to dismiss such institutions as obsolete.

More recent studies, particularly those looking back to the earlier eighteenth and seventeenth centuries, have proposed a more dynamic role for traditional charity in France, Spain, Italy and Portugal, including hospitals, a role which was given renewed vigour post-Trent.[7] As this paper will show, hospitals were often struggling financially by the end of the eighteenth century, and many buildings at least were in a state of disrepair. Dismissing smaller hospitals as 'obsolete' in whatever context is nevertheless hazardous. It runs the risk of adopting a narrowly teleological focus in which perceptions of the *ancien régime* hospital are coloured by the eventual 'birth of the clinic'.[8] A particular failure of this approach is that it tends to emphasise medical care (often narrowly defined)

[3]Olwen Hufton, *The Poor of Eighteenth-Century France, 1750–1789* (Oxford: Clarendon Press, 1974); Jean-Pierre Gutton, *La société et les pauvres. L'exemple de la généralité de Lyon 1534–1789* (Paris: Les Belles Lettres, 1978).

[4]For the first view, Carasa Soto, *El sistema*, 44–8, 83–4; for the second, Gutton, *La société*, 479–82.

[5]Hufton, *Poor*, 201; Colin Jones, *Charity and Bienfaisance: The Treatment of the Poor in the Montpellier Region 1740–1815* (Cambridge: Cambridge University Press, 1982), 76–94.

[6]Carasa Soto, *El sistema*; idem, *Pauperismo y revolución burguesa (Burgos, 1750–1900)* (Valladolid: Universidad de Valladolid, 1987); idem, *Historia de la beneficiencia en Castilla y León. Poder y pobreza en la sociedad castellana* (Valladolid: Universidad de Valladolid, 1991); Elena Maza Zorrilla, *Pobreza y asistencia social en España, siglos XVI al XX. Aproximación histórica* (Valladolid: Universidad de Valladolid, 1987); Montserrat Carbonell, *Sobreviure a Barcelona. Dones, pobresa i assistència al segle XVIII* (Vic: Eumo, 1997). See also the special number of *Dynamis*, 41,1 (2021): *La configuración histórica del sistema hospitalario en España*.

[7]Ole Peter Grell, Andrew Cunningham and Jon Arrizabalaga, eds, *Health Care and Poor Relief in Counter-Reformation Europe* (London and New York: Routledge, 1999); Tim McHugh, *Hospital Politics in Seventeenth-Century France* (Aldershot: Ashgate, 2007); Hickey, *Local Hospitals*, 100–33; David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester and New York: Manchester University Press, 1998).

[8]M. Sonenscher and C. Jones, 'The Social Functions of the Hospital in Eighteenth-Century France: The Case of the Hôtel-Dieu of Nîmes', *French Historical Studies*, 13,2 (1983), 172–214; Jonathan Israel, 'Counter-Reformation, Economic Decline and the Delayed Impact of the Medical Revolution in Catholic Europe, 1550–1750' in Grell, Cunningham and Arrizabalaga, eds, *Health Care and Poor Relief*, 39–54; Jon Arrizabalaga, 'Poor Relief in Counter-Reformation Castile: An Overview' in Grell, Cunningham and Arrizabalaga, eds, *Health Care and Poor Relief*, 151–76; Carasa Soto, *El sistema*, 117; J.M. Comelles, A. Daura, M. Arnau and E. Martín, *L'hospital de Valls. Assaig sobre l'estructura i les transformacions de les institucions d'assistència* (Valls: Institut d'Estudis Vallencs, 1991).

and the extent to which such care was becoming 'professionalised' as the criteria for judging the usefulness of hospitals. Other functions, such as that of providing shelter, are accorded less importance, inevitably relegating hospitals to a marginal role within communities. In fact, as Hickey's comparative study of eight French hospitals and Joseph Verley's case study of Vic-en-Bigorre in the French Pyrenees show, rural hospitals could perform a range of functions within a community, including outdoor relief as well as care for the sick poor, and also going beyond relief provision to offering credit and labour market opportunities.[9]

This paper explores the role and functioning of smaller hospitals, those outside the large cities, where the number of beds was only in double, more usually single figures. It takes its inspiration from French studies, but looks instead at Spain. Historians have recently stressed the importance of Counter-Reformation reforms here as in France, though how far the seventeenth-century economic decline and crisis may have limited such reforms is not yet clear.[10] Many of the contemporary criticisms of eighteenth-century hospitals were the same both sides of the Pyrenees, and there were similar attempts at centralisation and reform from above, though with less success in the Spanish case. To look at the whole of Spain is beyond the scope of a single article. This article thus focuses on one region, Catalonia. Whereas the role of the local hospital in Castile has received some attention, that in early modern Catalonia has received little attention beyond case studies of single institutions, in marked contrast to the medieval period.[11] Catalan hospitals (and those within the Crown of Aragon more generally) had a distinctive political and legal status.[12] Administration was a mixture of secular (municipal) and religious, as was often the case in France, but rarely involved confraternities, unlike in Castile. Catalonia was distinctive within Spain in other ways: sharing to a great extent in the crisis of the seventeenth century, but then experiencing an early transition to capitalism over the eighteenth century, based on commercial viticulture, colonial trade and the expansion of the textile industry.[13] Such changes made an impact on hospital provision, as will be seen.

After a discussion of the sources, the paper begins by estimating the number of hospitals and their capacity in Catalonia at the end of the eighteenth century and beginning of the nineteenth, before successive liberal reforms abolished many smaller institutions.[14]

[9]Hickey, *Local hospitals*; Joseph Verley, *Mendiants et bourgeois à l'hôpital de Vic-en-Bigorre, 1568–1861* (Tarbes: Société Académique des Hautes-Pyrénées, 1987).

[10]Colin Jones, 'Perspectives on Poor Relief, Health Care and the Counter-Reformation in France' and Ole Peter Grell and Andrew Cunningham, 'The Counter-Reformation and Welfare Provision in Southern Europe', both in Grell, Cunningham and Arrizabalaga, *Health Care and Poor Relief*.

[11]María Luz López Terrada, 'Health care and poor relief in the Crown of Aragon', in Grell, Cunningham and Arrizabalaga, eds, *Health Care*, 177–200. An exception for the early modern period, though still heavily urban and eighteenth-century in focus, is Miquel Borrell Sabater, *Pobresa i marginació a la Catalunya il.lustrada* (Santa Coloma de Farners: Centre d'Estudis Selvatans, 2002). For the medieval period, see James Brodman, *Charity and Welfare: Hospitals and the Poor in Medieval Catalonia* (Philadelphia: University of Pennsylvania Press, 1998).

[12]Josep M. Comelles, 'Hospitals, Political Economy and Catalan Cultural Identity' in C. Bonfield, J. Reinarz and T. Huguet-Termes, eds, *Hospitals and Communities, 1100–1960* (Oxford: Peter Lang, 2013), 183–207.

[13]The classic account of these transformations is Pierre Vilar, *La Catalogne dans l'Espagne moderne* (Paris: S.E.V.P.E.N, 1966). See also Julie Marfany, *Land, Proto-Industry and Population in Catalonia, c.1680–1829. An Alternative Transition to Capitalism?* (Farnham: Ashgate, 2012).

[14]Josep Puy Juanico, *Pobres, desvalguts i asilats. Caritat i beneficència a la Catalunya del segle XIX* (Barcelona: Abadia de Montserrat, 2009).

The paper then examines the finances of some hospitals in depth, and the extent to which their activities were constrained by their income. It then moves on to assess the nature of welfare provision in terms of medical care and diet, but also emphasising the importance of shelter and other types of provision, drawing on evidence for as wide a range of hospitals as possible. While many hospitals were struggling financially by the end of the eighteenth century, usually for reasons beyond their control, Hickey's emphasis on 'renewal' also applies in the Catalan case, as evidenced both by new foundations and by the continuing important role played within communities by established hospitals.

Sources

The first difficulty in assessing the function of hospitals is ascertaining how many hospitals there were, since none of the sources available provides complete geographical coverage. There are two main sources that offer a count of hospitals across the region. The first is the published returns of the 1787 census of Floridablanca, the first census carried out for Spain.[15] This census asked the authorities in each locality to include the numbers resident in convents, schools, hospitals, prisons, barracks and other similar institutions. In the case of hospitals, staff are distinguished from patients. For Catalonia, the surviving returns are incomplete. Those for the districts (*corregimientos*) of Barcelona and Tortosa are missing, except for totals for the two cities, which do include hospitals. The 1787 census counted 93 hospitals across all Catalan locations. As discussed below, however, many hospitals known to have existed do not appear.

The second source is an unpublished survey carried out in response to an order of 16 April 1813, circulated round the region in August, requesting all localities to supply details of schools, charitable institutions, correctional facilities and welfare organisations in existence.[16] The printed forms asked for details of the original purpose of the foundation, its patrons, its income per quinquennium, the source of that income, the current state, what improvements or misfortunes it had suffered and what improvements could be made to it in future. Replies were sent back over several months during the autumn and winter of 1813–14. In most cases, the authorities sent back the laconic declaration that there was nothing of that sort in their locality. Others simply sent back the completed forms, but a handful supplied descriptions with more detail than was required.

The survey provides more information than Floridablanca, but its chief weakness is that it was taken in wartime. Parts of Catalonia were still under French occupation and, unsurprisingly, sent back no returns, notably the district of Figueres and large parts of Girona to the north, Tarragona to the south and Barcelona, occupied right up until the end. The returns for Tortosa and Cervera are incomplete, while for other districts, some important towns failed to send back returns, possibly also the result of continued occupation, since the French troops maintained control over towns more effectively than over rural areas. A total of 85 hospitals are listed. Aside from its incompleteness, the main

[15]I have used the published Catalan Returns: *El cens del compte de Floridablanca (part de Catalunya)* ed. J. Iglésies, 2 vols (Barcelona: Fundació Salvador Vives Casajuana, 1969–70).

[16]Returns are in the Arxiu General de la Diputació de Barcelona (AGDB), lligalls 12 and 13.

problem caused by the timing of the survey is that the current state of most institutions reflected the effects of the war, whether from interruptions to usual income or from the frequent acts of theft and vandalism by troops.

In addition to the census and survey, further information is supplied by the travel diary of Francisco de Zamora, a government official who travelled round Catalonia during the years 1785–90 taking notes on agriculture, industry, local customs, schools, hospitals and other features of interest.[17] Again, his different trips did not cover the entire region, omitting the south and far west. Another source exists only for the diocese of Girona. In 1772, the bishop, Tomás de Lorenzana, asked all parishes to provide information about hospitals and other forms of poor relief, with a view to appropriating their funds for a new poorhouse in the town of Girona. The letter asked for details of the foundation of hospitals, where known, what their capacity and income were and who administered them, but the replies vary as to the level of detail.[18] Some additional information can be gleaned from ecclesiastical visitations, since hospitals were subject to periodic inspection by bishops. Alongside these cross-sectional sources, this paper uses accounts, regulations and correspondence for a number of hospitals, chosen for ease of access to their archives. Finally, the primary sources have been supplemented by secondary sources, such as published case studies of particular hospitals.

Numbers and Capacity

Combining these sources yields a count of 209 hospitals for Catalonia for the period 1737–1814. Arriving at this figure is not straightforward. The incompleteness of the 1787 census and 1813–14 survey is highlighted by the fact that only 38 hospitals were recorded in both. A further 101 are documented in neither. It would be tempting to assume that these 101 were obsolete by 1787. In a few instances, this was the case. According to Zamora, the hospital at Sant Llorenç de la Muga had been abandoned, though clearly recently enough that the building remained.[19] Conversely, Zamora notes the existence of 14 hospitals not recorded in either 1787 or 1813–14. Another 86 hospitals are recorded in pastoral visits for the dioceses of Barcelona, Girona and Tarragona.[20] Again, where a hospital appears in seventeenth-century visits but not later ones, it might be a sign it had ceased to exist. However, this cannot be assumed: Valls appears only in 1614 and 1656, but continued to function throughout the early modern period and into the nineteenth century.[21] Some hospitals were new foundations in the late eighteenth century, as discussed in the final section.

Table 1 therefore includes only those hospitals that can be documented for 1737–1814. The first date allows for the inclusion of hospitals recorded in ecclesiastical visitations, provided they are not subsequently described as obsolete. It excludes seven

[17]Francisco de Zamora, *Diario de los viajes hechos en Cataluña*, ed. Ramon Boixareu (Barcelona: Curial, 1973).

[18]Arxiu Històric de Girona (AHG), 676, 677, 2363.

[19]Zamora, *Diario*, 327.

[20]The visitations for Barcelona are all in Arxiu Diocesà de Barcelona (ADB), vol 74 (1726), vol 82 (1756–8), vol 84 (1771–2), vol 86 (1776), vol 87 (1778), vol 88 (1781–5) and unbound visitation for 1804. Details of hospitals from the visitations for the diocese of Girona between 1727 and 1777 are summarised in Borrell, *Pobresa*, appendix II. Those for Tarragona are all available online at www.ahat.cat.

[21]AHAT, Arquebisbe, Visites Pastorals, 'Santa Visita del Il.lustríssim Senyor Moncada 1614 a 1615', 7–34; 'Llibre de visites pastorals' (1647–1662), 80–8; Comelles, 'Hospitals'; Comelles *et al.*, *L'hospital de Valls*, 138–45.

Table 1. Hospitals c.1737–1814 according to population size of location in 1787

Population size in 1787	% population of Catalonia	Number hospitals	% hospitals
<1,000	42	85	41
1,000–1,999	18	69	33
2,000–4,999	16	40	19
5,000–9,999	9	10	5
>10,000	14	5	2
		209	

Source: for hospitals, see text. Population figures taken from Josep Iglésies (ed.), *El cens del comte de Floridablanca 1787 (part de Catalunya)* (Barcelona, 1969–70), 2 vols.
Notes: Tortosa estimated as >10,000 population; Batea between 1,000 and 2,000; La Pobla de Massaluca <1,000.

hospitals that are so far documented only in seventeenth-century ecclesiastical visitations for the diocese of Tarragona. Doing so may exclude some institutions that were still in existence, given the gaps in the sources, but may include some others documented in the mid eighteenth century that had ceased to function by the end.[22] A further issue arises with the definition of 'hospital'.[23] By the late eighteenth century, institutions for the poor in larger urban areas were becoming more specialised. A key distinction that emerged, given sharper focus by a renewed crackdown on vagrancy and begging, was between workhouses or *hospicios*, which aimed to take in the able-bodied poor, and hospitals, which were for the sick poor. A further reforming impulse saw the establishment of various foundling hospitals, sometimes separate from existing hospitals or workhouses, sometimes attached to them.[24] In the largest cities, institutions might be specialised still further, with workhouses specifically for girls and young women (often known as *misericordias*), orphanages for children up to 12, and workhouses for prostitutes and other female criminals (*galeras* or *casas de reclusión*). Barcelona, as is to be expected, had the most specialised provision. The biggest institution, catering for the sick poor and foundlings, was the Hospital de Santa Creu, with 1,755 patients in 1787, including foundlings at nurse. Second was the workhouse for the able-bodied poor, which operated across two sites, one for men and one for women, with 1,341 inmates between them.[25] Alongside these two main institutions were an orphanage, the Casa dels Infants Orfes, with just 21 orphans; the Casa del Retir, for penitent prostitutes, with only 24 inmates, and a *galera* with 111 prisoners. Elsewhere, specialisation was less marked. Girona, Cervera, Vic, Tarragona, Tortosa, Seu d'Urgell, Manresa and Olot all had workhouses or orphanages alongside hospitals for the sick poor by the end of the eighteenth century. Seu d'Urgell established a separate institution for foundlings in 1798, and Tarragona also had a *galera*. Cervera, which had a peculiar status of being a university town, also had a hospital just for sick students. Elsewhere, the norm was for there to be just one hospital, usually described as catering for the sick poor, sometimes for pilgrims. This paper takes a slightly stricter definition than Muriel Jeorger in counting as a hospital any institution described as such with evidence of a building, but excluding

[22]Carasa Soto, *El Sistema*, 44 notes similar problems for Spain as a whole.
[23]Ibid, 30–4.
[24]Ibid, 64–5.
[25]See Montserrat Carbonell-Esteller and Julie Marfany, 'Gender, Life Cycle and Family "Strategies" Among the Poor: The Barcelona Workhouse, 1762–1805', *Economic History Review* (2017), 70,3, 810–36.

institutions of the kind just described.[26] So, for example, for Barcelona, only the Hospital de Santa Creu is included, not the workhouse or other institutions.

Hospitals certainly proliferated in rural areas. Table 1 provides the breakdown of the 209 hospitals according to population size of their locations in 1787. As expected, the four towns with populations of over 10,000 (Barcelona, Lleida with two, Reus and Tortosa) all had hospitals for the sick poor, as well as other charitable institutions.[27] Almost three-quarters of hospitals, however, were in places of under 2,000 inhabitants in 1787, higher than for France, where 1,034 (53%) of the 1,961 hospitals counted in 1791 were in settlements with populations of fewer than 2,000.[28] For Spain, there is no comparable breakdown for the 938 hospitals recorded in 1787, but as late as 1840, one investigation still claimed rural hospitals were 72–86% of provision.[29] The smallest place in Catalonia with a documented hospital was the village of Siurana in the north-east, which only had 76 inhabitants in 1787. Its hospital was described as only for those passing through. A further 32 places with hospitals had populations under 500 in 1787. Also striking is the high proportion of hospitals in places of between 1,000 and 2,000 inhabitants, even though these locations accounted for only 18% of the Catalan population.

Estimates of capacity are impossible to calculate, since no source records this systematically. Some idea of size is provided by the figures for patients resident at the time of the 1787 census. These record only patients present in the hospital at that point, not the number of beds available. That beds might well be empty is illustrated by the hospital in Reus, which had between 20 and 25 beds, but in 1787 recorded only seven patients.[30] Similarly, Castelló d'Empúries recorded only four patients on the census, but stated in the reply to Lorenzana in 1776 that the usual number was six.[31] Nonetheless, the figures for 1787 at least give minimum estimates. Table 2 shows the breakdown for the 91 hospitals recorded in the 1787 census. As can be seen, just under a third of hospitals had no patients at all on the census date, while just under 43% had between one and nine.

At first blush, these figures suggest a rather minimal role for hospitals. However, the picture is more complex. It is possible that hospitals failed to record patients because these were only temporary residents, especially if not from the parish. It is impossible to know how different localities interpreted the instructions they were given. Assuming that returns of zero were accurate, for some hospitals being empty on the day of the census was a reflection of an emphasis on temporary shelter rather than long-term care. At Tremp and Olot, patients could only stay a maximum of three nights.[32] To a considerable

[26]Muriel Jeorger, 'La structure hospitalière de la France sous l'Ancien Régime', *Annales HSS*, 32,5 (1977), 1025–51, here 1026. Some of the *hôpitaux générales* Jeorger includes may have been more akin to workhouses, though terminology is not precise.

[27]Tortosa is estimated at over 10,000 as the returns for Floridablanca are missing.

[28]Ibid, 1027–33. The proportion of hospitals in smaller places was undoubtedly higher than 53% in some regions, but Jeorger does not give figures.

[29]Carasa Soto, *El Sistema*, 44–8. What counts as 'rural' is not specified and different percentages for 1840 are given on 44, 48 and 82. It should be noted that 938 is much lower than the figures of 2,052 given for the Crown of Castile in 1750 and 2536 for all of Spain in 1797, though the last figure is almost certainly inflated, since it was motivated by the desire to expropriate land.

[30]Pere Anguera, *Hospital de Sant Joan de Reus, 1240–1990* (Reus: Hospital de Sant Joan de Reus SAM, 1990), 21.

[31]AHG, 677, Castelló d'Empúries.

[32]For Tremp, see Jacint Reventós (ed), *Història dels hospitals de Catalunya*, (Barcelona: Servei Català de Salut/Editorial Hacer, 1996), vol. III, 115–21. For Olot, see 'Estat del Hospital de Sant Jaume de la Vila de Olot, modo de administrarlo y resolucions de la Junta per son bon govern 1773–1778', reproduced in Miquel Borrell, *Hospicis i hospitals*, 52–3.

Table 2. Hospitals in 1787 according to number of patients

Number patients	Number hospitals	% hospitals
0	28	30.8
1–4	26	28.6
5–9	13	14.3
10–19	7	7.7
20–49	8	8.8
50–99	3	3.3
100+	6	6.6
	91	

Source: Josep Iglésies (ed.), *El cens del comte de Floridablanca 1787 (part de Catalunya)* (Barcelona, 1969–70), 2 vols.

extent, unsurprisingly, the number of patients was positively correlated with the size of the location. There were exceptions, such as the specialised institutions described above for Barcelona, but in general, larger places had larger hospitals.

Finances: Incomes at the End of the Ancien Régime

Any assessment of hospital provision needs to recognise that most were severely circumscribed by their income. Income took various forms, as illustrated by Table 3, which provides a breakdown of income for a sample of hospitals for which the information is available. Three hospitals, Figueres, Cadaqués and Castelló d'Empúries, provided a breakdown of figures in their replies to the Girona enquiry in 1772, based on an average of the previous five years.[33] For the other hospitals, the information was calculated from surviving accounts, just for 1772 to keep the data comparable across the sample.[34] These other hospitals were Fulleda and Constantí, in southern Catalonia, Berga in the centre, and Puigcerdà in the Pyrenees.[35] The table suggests that hospitals derived most of their income from property and from *censals*, essentially disguised loans of indefinite duration, which paid out a fixed amount of 'interest' each year.[36] They were similar to annuities, but could be transferred or inherited, often over several generations. The capital invested in these came from the original endowment or subsequent bequests. *Censals* were a relatively risk-free means to guarantee a steady income stream each year, and one of the main forms of credit in Catalonia. Unfortunately, the interest rate was cut from 5% to 3% in 1750, meaning a drop of 40%. Some hospitals owned land or houses, which were either rented out, or used for self-provisioning, and a few also received income from tithes. Hospitals with land

[33]AHG, 676 (Cadaqués), 677 (Castelló d'Empúries and Figueres).

[34]1771 was used for Constantí, as 1772 appears to be incomplete (many payments from that decade are undated).

[35]AHAT, Parroquials, 7.64 Fulleda, 'Llibre de l'administració del hospital del present lloch de Fulleda'; 7.48 Constantí, 'Llibre de comptes del sant hospital de Constantí comensat en lo de 1765'; Arxiu Comarcal del Berguedà (ACBR), Fons Hospital, 'Llibre del hospital de la vila de Berga' (1677–1723), 'Ospital. Entradas y Eixidas' (1723–1796); Arxiu Comarcal de la Cerdenya (ACCE), Hospital de Puigcerdà, Comptes.

[36]See also Josep Barceló Prats and Josep M. Comelles Esteban, 'La economía política de los hospitales locales en la Cataluña moderna', *Asclepio*, 68,1 (2016), 127. The same was true for French hospitals in the eighteenth century. See Marie-Claude Dinet-Lecomte, 'Les hôpitaux sous l'Ancien Régime: des entreprises difficiles à gerer?', *Histoire, économie et société*, 18,3 (1999), 527–45, here 535–6. Her sample is heavily weighted towards larger urban institutions.

Table 3. Sources of income (%) for selected hospitals, c.1772

	Berga	Cadaqués	Castelló d'Empúries	Constantí	Figueres	Fulleda	Puigcerdà
Censals	94.6	16.2	37.0	22.7	37.2	56.7	4.5
Land and houses		6.5	22.8	76.6	3.5		5.1
Tithes		77.3			28.2		19.8
Grain sales							63.0
Livestock sales							
Total property and rents	94.6	100	59.7	99.3	69.0	56.7	92.5
Charitable endowments			30.3				
Alms	1.8		10.0				0.8
Bequests							2.1
Collections	3.5			0.7		43.3	0.6
Total charity	5.4		40.3			43.3	3.5
Soldiers					24.8		0.7
Other					6.2		3.2
Total other					31.0		3.9
Total (ll, s, d)	140 ll, 4 s, 6 d	600 ll, 10 s	703 ll	231 ll, 8 s, 5 d	4426 ll, 12 s	8 ll, 17 s, 7 d	807 ll, 15 s, 5 d
Population in 1787	3,259	1,598	2,911	2,047	5,398	428	1,634

Source: See text.
Note: Constantí figures are for 1771.

or income in kind fared better over the eighteenth century, since they either benefitted from rising food prices if selling or were insulated from them if self-provisioning. Some hospitals also recorded income from collections in church or door-to-door and charitable bequests in wills (if substantial, the latter were usually invested in *censals*). This kind of income may be underreported in the surveys compared to accounts, as many places clearly only declared regular income, or that to which they had a definite claim. In some cases, charitable income was substantial. Castelló d'Empúries received a regular income from three charitable funds or *causes píes*, endowments that paid out regular sums. The hospital also estimated that charitable donations averaged 70 *lliures* a year, so 10% of total income.[37] Fulleda had two collections each year: one in grain, which was given a cash value in the accounts, and one in church, which was in cash. It is not clear if these collections each took place on a single day, or if the figures simply record the total amounts collected over the course of the year. Bequests may also not show up in any given year, but were usually the source of any property hospitals owned. In the seventeenth and eighteenth centuries, some hospitals near garrisons were able to supplement their income stream by taking in soldiers as paying patients, though this then limited their capacity to take in civilian patients. It is not clear whether

[37]The Catalan money of account was the *lliura* (pound), divided into 20 *sous* (shillings). Each *sou* was in turn worth 12 *diners* (pence).

hospitals actually had much choice in the matter, either in theory or in practice.[38] A quarter of the income at Figueres came from soldiers and a further estimated annual amount of 87 *lliures*, 9 *sous*, 8 *diners* from an agreement to care for sick labourers engaged in the construction of the nearby fortress of San Fernando (subsumed under 'other' in the table above, along with profits from the apothecary). Some hospitals took in paying civilian patients as well.[39] Other attempts at diversifying income took the form of income from theatre tickets, dances, monopolies over games and sport, public baths and selling raffle tickets.[40] Reus, for example, was granted the right in 1769 to a monopoly over theatre and card games.[41]

How much income hospitals had in total varied also, as is evident from the wide range in total incomes given in Table 3. Table 4 compares declared income for two samples of hospitals: those from the Girona diocese that responded to the bishop's request for information in 1772, along with a handful of hospitals that had their income recorded in the ecclesiastical visitation of the diocese of Tarragona in 1776; and those surveyed in 1813–14. The two samples show different distributions, which may in part be a reflection of the different geographical spread (only seven hospitals appear in both), and the nature of the data. In 1813–14, information is missing for many of the larger, better-endowed hospitals, but the greater geographical spread means that more hospitals of medium size in terms of endowment and capacity are included than for a single diocese. In 1772, the richest hospitals included Figueres, with an annual income of 4,427 *lliures*, 5 *sous*, and Girona, with 3,000 *lliures* per annum, whereas in 1813–14, the richest was Manresa, with 700 *lliures* per annum. Moreover, many hospitals in the 1770s with income from land or tithe simply claimed that the value fluctuated too much from year to year to be able to offer a figure, whereas in 1813–14 hospitals in a similar situation made more of an effort to provide average figures or estimates.

The figures suggest that income was a constraint on the provision of care by hospitals. Some declared no income at all, though what this meant in practice was that they had no income from rents or *censals* and thus relied on charitable donations, as was the case in 1772 for Armentera, Lladó and Sant Jordi Desvalls. Similarly, other hospitals also supplemented their income with charitable collections, as at Llança, which had only 12 *lliures*, 3 *diners* regular annual income. The figures here therefore are likely to be on the conservative side, especially when we remember that it was in the interests of hospitals to downplay their wealth. In 1813–14, however, the situation is likely to have been bleak enough, given the impact of the most recent war. Indeed, many hospitals made clear that the income they declared was purely nominal, since much of it had been impossible to collect in recent years. On top of that, many had seen buildings destroyed and goods stolen by invading troops, as at Granollers, where the building had been 'entirely destroyed' and all the bedding and linen stolen by the French.

[38]Hospitals with royal patronage were required to take in soldiers, but other hospitals could be more or less commandeered in periods of war. For the difficulties this requirement posed, in particular recouping payments from the treasury, see the reports for Figueres, undated but c.1804, in ACAE, Hospital de Figueres, capsa 356 and the correspondence for 1795–8 in capsa 162.

[39]Arxiu Comarcal de l'Anoia (ACAN), Hospital Comarcal d'Igualada, Llibre de comptes, 1795, where the hospital notes being reimbursed for expenditure on two patients.

[40]Reventós, *Els hospitals*, 97–8.

[41]Anguera, *Hospital*, 21–6.

Table 4. Incomes declared by selected hospitals, c.1772–1776 and 1813–1814

Income per year	1772–1776		1813–1814	
(lliures)	N	%	N	%
None	4	8	8	12
<50	27	56	26	39
50–99	6	13	10	15
100–199	1	2	10	15
200–499	3	6	8	12
500+	7	15	4	6
Total	48		66	

Source: See text.

1813–14 thus represents a low point for hospital finances. The war of 1808–14 was only the most recent of a series of disasters to befall hospitals. The returns for Sitges, ostensibly the second wealthiest hospital in the 1813–14 sample, illustrate the cumulative effect of various changes on their financial situation. The hospital had 2,000 *lliures* worth of debt owing to it. Part of it was in the form of tithe paid on a house that was in ruins. Another part was in the form of *censals*, but those who should pay them had too many other debts. Roughly half was in government bonds, which had not been paid for years. Investment in government bonds had been forced upon hospitals and other charitable institutions by the 1798 disentailment law, which required the sale of their properties, supposedly compensated by investment in government funds at a rate of 3% interest.[42] Not all hospitals appear to have lost property by 1813: the law was applied only very slowly in the years before the French invasion of 1808, and many did not have fixed property to begin with.[43] However, the government's failure to pay interest on its bonds did have a serious impact on those hospitals that had experienced disentailment. Prior to 1798, hospitals had suffered the effects of war again in the 1790s with France and then England, and soaring prices. Even Figueres, one of the richest, went from being in credit by about 60 *lliures* a year in the 1770s, to struggling with debt by the end of the century.[44] In 1803, the hospital began a process of auditing the accounts and reimposing order after the chaos of the 1790s.[45]

[42]The 1798 law has received very little attention compared with later disentailment laws. The classic studies remain Richard Herr, 'Hacia el derrumbe del Antiguo Régimen: crisis fiscal y desamortización bajo Carlos IV', *Moneda y Crédito* 118 (1971), 37–100 and idem, *Rural change and royal finances in Spain at the end of the Old Regime* (Berkeley: University of California Press, 1989), 78–136. Barceló and Comelles claim that municipal ownership protected Catalan hospitals from disentailment, unlike Castilian ones, but Puigcerdà (see next note) was also a municipal hospital, as was Sant Hipòlit de Voltregà, which also claimed in 1813 to be owed interest on bonds following disentailment. Further work is needed to ascertain how many hospitals did lose property under the law. See Barceló Prats and Comelles Esteban, 'La economía política'.

[43]The authorities were still complaining in 1807 that the administrators of the Puigcerdà hospital had not provided them with details of the properties to be disentailed, despite requests going back to 1799. See the correspondence between the district governor, Rafel de Zúñiga, and the town council in ACCE, Hospital, Correspondència.

[44]J.M. Bernils, *Hospital de Figueres. 680 anys d'història* (Figueres: Hospital de Figueres, 1993), 38–9.

[45]Arxiu Comarcal de l'Alt Empordà (ACAE), 376 Lligall de comptes del procurador Josep Labrosa, 1794–1801; 1 Comptes (1791–99). Labrosa attributed the poor state of the hospital finances to the war.

Finances Over the Longer Term

The 1770s represent a better moment for hospital finances. Certainly the hospitals included in Table 4 above were at least breaking even. The situation prior to the 1770s is harder to judge, given a shortage of accounts, but seems to have been more volatile as Figure 1 shows for Berga and Puigcerdà, two hospitals for which accounts survive for a longer run, set against Fulleda, with only three decades of accounts and Constantí, with four. Particularly prior to 1750, the accounts were often not presented yearly, but after a run of two years or more, so it is easier to present total income and expenditure by decades, though not every decade is complete. In the case of Berga, the accounts are more or less complete from 1677 to 1796. The Puigcerdà accounts are patchier, with some decades missing entirely and others with only a couple of years prior to the 1730s. The lines for Puigcerdà should thus be read for the gap between income and expenditure, more than the trends.

Fulleda and Constantí were breaking even over the short period for which information is available, despite these being decades of rising prices. In the case of Fulleda, it is striking that income remained steady despite a much greater reliance on charitable collections than elsewhere. Constantí may have been matching expenditure to income, but also benefited from leasing some land on short-term rents, which could be adjusted more easily, and did indeed increase in the 1780s. Puigcerdà seems to have more or less broken even, with a slight deficit in some decades. Here, the picture is further complicated by the fact that some income and expenditure were in kind so not included. The hospital had income in grain, some of which was used for self-provisioning, some to pay rents and for other outgoings and the rest was sold. The sales appear on the income side, but otherwise it is hard to know to what extent income and expenditure in kind cancelled each other out. Berga seems to have operated in some decades with a healthy surplus and others with a deficit. The decades where expenditure outstripped income were sometimes ones with substantial building work, such as the 1720s. In 1788, the administrators borrowed 300 *lliures* to pay for building costs. Income took a dip in the 1740s and 50s as a result of failures to pay by those who owed rents or *censals*. The surplus income in the 1760s, despite that being a difficult decade with a serious harvest failure in 1764 and high prices overall, was down to persistent chasing of debtors, many of whom spent the 1760s and 1770s slowly paying off two or three decades of arrears. Failure to pay was often at the root of financial problems for hospitals and charitable funds. Most *censals* and rents were small annual payments. Hospitals were at the centre of networks of credit involving small loans to artisans and smallholders, usually within the local area. If one debtor failed to pay, it made little difference, but an accumulation of debts over time would have an impact. At the same time, chasing numerous debtors for small individual payments was costly. In 1787, Berga recorded a payment to someone hired to send reminders to debtors from outside the parish, an added administrative cost. Legal redress existed, but again, was costly. In 1737, the hospital of Bràfim acknowledged a refusal hitherto to take a debtor to court, arguing that the debt was too small to be worth the costs.[46] Moreover, administrators may have been reluctant to

[46]AHAT, Arquebisbe, Visites Pastorals, 'Llibre de decrets de visita pastoral, 1737', fols 119–20.

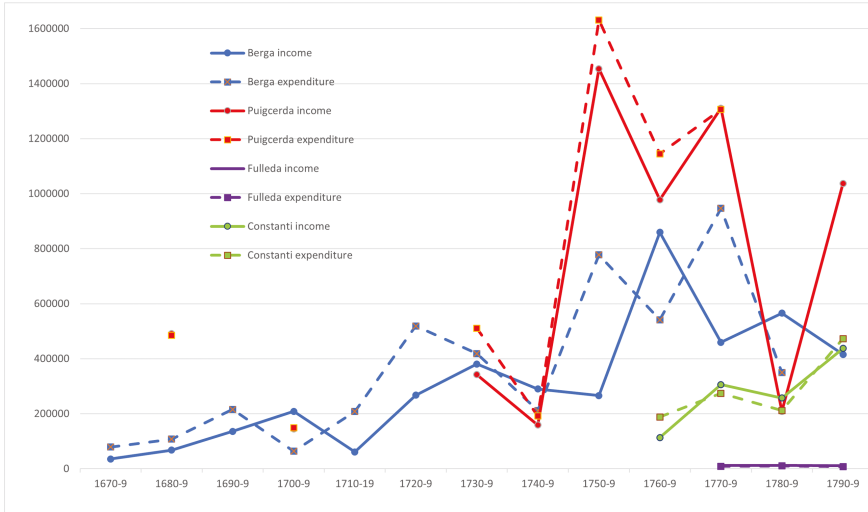

Fig. 1. Annual income and expenditure by decade, selected hospitals

press too hard for payment from neighbours when times were hard, although the Berga administrators clearly did to some extent.

Tables 5 and 6 show how the composition of income and expenditure changed over time for Berga and Puigcerdà, comparing the situation before mid-century with afterwards, with the caveat that the Puigcerdà accounts are patchy before the 1730s. For Puigcerdà, income and expenditure in kind have been excluded, except where a cash value was assigned in the accounts, as with grain sales. Surprisingly, income from rents and *censals* became more, not less, important in both absolute and relative terms at Berga despite the cut in interest rates in 1750, a reflection of the greater diligence in chasing debtors and also the creation of new loans. Berga also had fewer sources of income and thus fewer choices, but Comelles suggests this kind of income remained significant for other hospitals well into the nineteenth century.[47] Charitable income became less significant over time, unlike at Puigcerdà and at Fulleda and Castelló d'Empúries (see Table 3). While bequests and donations fell off, the main decline at Berga was from collections, many of which ceased to take place. In 1764, the administrators suspended collections on the grounds that the harvest had failed and thus it was unfair to ask for money. Lenten collections are not recorded again until 1786, though collections on St Barnabas's Day (the patron saint) appear again from 1769. The administrators seem to have decided to chase debts rather than request charity. At Puigcerdà, by contrast, charitable income increased over time. In relative terms, it remained a very minor income stream, but in absolute terms, the increase is striking. There is no mention of any deliberate effort to request charity. Puigcerdà had less need to do so, given the diversified sources of income. Absolute income from *censals* also rose, despite the interest rate cut, but in relative terms became much less important. The most striking rise, both absolute and relative, was income from grain sales. Here, the hospital could benefit from rising prices in a way

[47]Comelles, 'Hospitals', 192–3.

Table 5. Income over time, Berga and Puigcerdà

	Berga				Puigcerda			
	1677–1751		1752–1796		1685–1750		1751–1802	
	Total (d)	%	Total (d)	%	Total (d)	%	Total (d)	%
Censals	977,558	62.6	1,857,301	75.8	244,513	19.3	610,213	11.0
Land and houses					378,177	29.9	243,108	4.4
Tithes					96,356	7.6	715,961	12.9
Grain sales	9,594	0.6	1,350	0.1	481,890	38.1	2,992,013	53.7
Livestock sales					5,315	0.4	11,812	0.2
Total property and rents	987,152	63.2	1,858,651	75.8	1,206,251	95.3	4,573,107	82.1
Alms	72,457	4.6	66,219	2.7	9,586	0.8	6,534	0.1
Bequests	239,908	15.4	183,833	7.5	5,011	0.4	72,055	1.3
Collections	241,037	15.4	75,090	3.1	6,212	0.5	52,493	0.9
Total charity	553,402	35.4	325,142	13.3	20,809	1.6	131,082	2.4
Soldiers	2,208	0.1	132,395	5.4			281,774	5.1
Funerals	2,850	0.2	1,020	0.0	636	0.1	216	0.0
Paying patients	2,040	0.1	12,271	0.5	90	0.0	10,558	0.2
Other sales	4,102	0.3	32,080	1.3	5,371	0.4	8,526	0.2
Other	9,847	0.6	90,206	3.7	20,602	1.6	158,315	2.8
Unknown/unclear					11,886	0.9	406,876	7.3
Total other	21,047	1.3	267,972	10.9	38,585	3.0	866,265	15.6
Total	1,561,601		2,451,765		1,265,645		5,570,454	

Source: See text.

that institutions without land could not. The increase in the 'other' category reflects in part for Puigcerdà an increase in income that was recorded without any information as to source, other than sometimes the name of the payer, but for both hospitals it also reflects the growing importance of income from soldiers and to a lesser extent from other paying patients. 'Other sales' were usually items of clothing or other possessions of deceased patients, but Berga also made money from selling off surplus building materials.

Building work and repairs represented a significant outlay over time for both hospitals.[48] Differences reflect the timing of extensive building works: Berga seems to have more or less rebuilt the hospital in the 1720s, with the renovation of the chapel a significant but less expensive project in the 1780s. Puigcerdà does not seem to have carried out such extensive building, but had to pay for the upkeep of buildings besides the hospital itself. Otherwise, what is striking is the rise in expenditure on patient care. Unspecified care at Berga was mostly food allowances, and costs of transport on to other places, discussed in more detail below. Allowances were increased over time. Patient numbers may have gone up over time at Puigcerdà, though they were stable at Berga, as will be seen. We thus do not have per capita figures, but the rise in food expenditure is nonetheless likely to be a reflection of increasing prices. The same is probably true for fuel and lighting at Puigcerdà; why the same costs did not rise at Berga is a mystery. Legal and administrative costs rose in both places, as the result of greater efforts to chase debtors and claim outstanding or contested income. There are references to an ongoing lawsuit at Puigcerdà, which was also hit by the need to pay different taxes on properties owned

[48]The same was true for Pontorson and Caudebec in Hickey's study: see *Local hospitals*, 120.

Table 6. Expenditure over time, Berga and Puigcerdà

	Berga				Puigcerda			
	1677–1751		1752–1796		1685–1750		1751–1814	
	Total (d)	%	Total (d)	%	Total (d)	%	Total (d)	%
Food					444,159	31.3	1,715,674	57.6
Medicines	131,849	9.9	130,562	6.9	61,795	4.4	161,449	5.4
Laundry	22,773	1.7	42,526	2.3	1,254	0.1	21,793	0.7
Fuel and lighting	15,851	1.2	15,784	0.8	86,956	6.1	386,855	13.0
Bedding, furniture, clothing and utensils	91,480	6.9	44,272	2.3	119,144	8.4	365,575	12.3
Burials and baptisms						0.0	4,330	0.1
Apprenticeships and dowries					14,316	1.0	5,130	0.2
Unspecified patient care	309,210	23.2	642,312	34.1	7,533	0.5	13,477	0.5
Building and repairs	622,386	46.7	536,865	28.5	205,004	14.5	1,224,733	41.2
Agricultural labour					30,317	2.1	125,160	4.2
Legal and administrative costs	54,697	4.1	137,951	7.3	124,373	8.8	460,438	15.5
Salaries	67,727	5.1	151,151	8.0	287,779	20.3	234,785	7.9
Masses	360	0.0	114,126	6.1	1,260	0.1	8,121	0.3
Charity					54	0.0	124,061	4.2
Other	15,192	1.1	68,450	3.6			42,576	1.4
Unclear/not stated	210	0.0	120	0.0	34,470	2.4		0.0
Total	1,331,735		1,884,119		1,418,414		2,976,060	

Source: See text.

in French territory, involving separate administrative processes. Salaries paid to doctors, surgeons and to the hospital warden rose at Berga in the 1770s and 1780s. The much greater outlay here at Puigcerdà and its decline over time was because of payments to wetnurses. Before 1750, wetnursing accounted for around three-quarters of the wage bill. After 1750, the hospital employed fewer wetnurses, for reasons discussed below. Puigcerdà also had to pay wages for agricultural labour, including planting trees on some of its land. Diverse sources of income were a benefit, but not cost-free either.

There are two main points to take away from the preceding discussion. The first is that the end of the eighteenth century, despite the greater abundance of sources, may skew our perspective on the income and finances of hospitals (and indeed, charitable funds more widely). As these figures indicate, charity was indeed in 'crisis' to some extent (though not entirely) by the 1790s, as was the economy as a whole.[49] The experience of Berga and Puigcerdà in facing rising prices was shared by all hospitals. It is not surprising that more accounts survive for the late eighteenth century or that auditing took place, given the financial pressures. In earlier periods, by contrast, finances were more buoyant, and hospitals could do more, though they were always vulnerable to the effects of war and poor harvests. The second is that, even in good times, rural hospital incomes were

[49]J.M. Delgado, 'El impacto de las crisis coloniales en la economía catalana (1787–1807)' in Josep Fontana, ed, *La economía española al final del Antiguo Régimen*, vol. III (Madrid: Alianza, 1982), 99–169; Vilar, *Catalogne*, vol. II, 104–9, 384–418.

nevertheless modest compared with large urban institutions. This is hardly surprising. Modest incomes were in keeping with the size of their communities. To assume, however, from a lack of resources that hospitals did not provide meaningful care is to make the anachronistic assumption that care required large, centralised institutions with a wealth of expertise. Expertise, by the standards of the time, was not in fact lacking, but more importantly, the forms of care that hospitals had always provided continued to be important throughout the seventeenth and eighteenth centuries.

Care: The Transient Poor

The transient sick poor were often the most visible category served by rural hospitals. Accounts frequently record payments to the warden or someone else to transport patients to the next hospital along the road. The eventual destination was usually Barcelona, and the facilities offered by the Hospital de Santa Creu. The costs of transporting patients were thus spread out along the route. It is not clear whether temporary shelter was always restricted to the sick. Some hospitals retained their original remit of shelter for pilgrims. Coastal hospitals also took in sailors, as was noted by the authorities at Cadaqués.[50] Shelter of this kind may have allowed the poor to dodge accusations of vagrancy, especially when tramping in search of work.[51] The administrators of the hospital of Borges Blanques informed the bishop in 1776 that to prevent the hospital warden taking in the idle poor, they had given a room in the hospital to the schoolteacher. Significantly, the bishop approved this only provided there continued to be room for the poor of the village and 'those passing through'.[52] Many hospitals had been set up precisely to offer shelter along difficult and dangerous roads, especially at mountain passes and in relatively isolated spots, a valuable option for travellers in a region plagued by banditry. The hospital at Viella in the Val d'Aran was situated at an altitude of 1,620 metres at the end of a mountain pass described by Zamora as 'extremely dangerous in winter and in late autumn and early spring', making the hospital a useful refuge for travellers.[53] The village councillors of Crespià pointed out that, without 'the care and protection' offered by the hospital, many would die without receiving the sacraments.[54] Hospitals thus formed a network of support for the transient poor.

An important category of the poor served by this network were foundlings, who were sent from hospital to hospital until they reached one of the large foundling hospitals. Barcelona and Girona were the main ones, but Lleida, Cervera, Seu d'Urgell, Tremp and Tortosa also took in smaller numbers.[55] Although not mentioned in the historiography,

[50]AHG, 676, Cadaqués.

[51]Montserrat Carbonell-Esteller, Julie Marfany and Joana Maria Pujadas-Mora, 'Migration and the household economy of the poor in Catalonia, c.1762–1803' in Beatrice Zucca Micheletto (ed.), *Gender and Migration in Historical Perspective. Institutions, Labour and Social Networks, 16*th *to 20*th *Centuries* (Cham: Palgrave Macmillan, 2022), 323–53.

[52]AHAT, Arquebisbe, Visites Pastorals, 'Visita general hecha por el ilustrísimo y reverendísimo señor doctor don Juan Lario y Lancis, arzobispo de Tarragona, 1776', fol. 196v.

[53]Zamora, *Diario*, 201–2.

[54]AHG, 676, Crespià.

[55]Margarita López Antón and Céline Mutos Xicola, 'Nutriendo la economía familiar: nodrizas, inclusas y salarios en Cataluña y Baleares (1700–1900)' in Carmen Sarasúa (ed.), *Salarios que la ciudad paga al campo. Las nodrizas de las inclusas en los siglos XVIII y XIX* (Alacant: Universitat d'Alacant, 2021), 132–73. It is not clear how consistently the smaller hospitals took care of foundlings as opposed to passing them on to the larger institutions.

Puigcerdà seems to have looked after foundlings until 1774, when they were sent to Barcelona instead, despite the distance.[56] Foundlings were placed with wet nurses until weaned, then returned to the hospital and cared for until placed as apprentices in the case of boys or married for girls (hence expenditure on dowries and apprenticeships in Table 6). On marriage, girls received a dowry of 18 *lliures* and a dress.[57] From the larger hospitals, most foundlings were sent back to rural areas to be placed with wet-nurses. Some rural hospitals paid for wet-nurses on route, presumably local women with milk to spare. The hospital at Banyoles paid 1 *sous*, 6 *diners* a night to wetnurses from the start of the surviving accounts in 1737.[58] These payments represent a higher daily rate than that paid to long-term wet nurses. Olesa de Bonesvalls paid the even higher sum of 3 *sous*, 9 *diners* between 1776 and 1808.[59] Elsewhere payments may have been subsumed into the costs of transporting the foundlings, or women nursed for free.[60] Without such a network in place, it is hard to see how parishes could have ensured that foundlings were taken to the institutions set up to provide for them.

Care: Local Patients

The importance of hospitals in supporting the transient poor should not, however, obscure the care that was provided to local patients. Patient registers are rare before the nineteenth century for rural hospitals. An exception is the hospital in Berga, which consistently recorded the names of patients in the accounts from 1738 onwards, usually in the form of number of days paid for and the start and end date of payments.[61] In some cases, the end date is noted as being that of the patient's death, sometimes as the date on which they left, though in some instances, departure has to be assumed from the fact that payments cease. For some patients, there is additional information, such as place of origin or possibly residence in the case of nearby parishes, for women, marital status and for some children, details of parents' names.

Zamora claimed that the local poor preferred to die rather than go to the hospital, although he also describes it as 'good, though poor'.[62] The accounts contradict this view. During the 57 years for which we have information, there were some 1,041 stays by

[56]The recent survey in ibid does not mention Puigcerdà, perhaps because the focus is on institutions officially designated as foundling hospitals. Payments to wetnurses decline from the 1750s, though do not cease entirely until 1774. A cluster of payments were recorded again in 1812, probably the result of the Napoleonic war and perhaps French efforts to reinstate local wetnursing.

[57]ACCE, Hospital de Puigcerdà, Privilegis i ordinacions, Informe de 1726.

[58]Arxiu Comarcal del Pla de l'Estany (ACPE), Hospital 362 Llibre de aixidas del Sant Hospital de Banyolas 1737.

[59]Xavier Miret, 'Els expòsits. La seva visió a través d'un hospital de pas a les darreries del segle XVIII', *Actes del Primer Congrés d'Història Moderna de Catalunya* (Barcelona: Universitat de Barcelona, 1984), 2 vols., vol. 1, 119–23.

[60]The bishop of Solsona claimed that women sometimes nursed for free in his diocese, but otherwise were paid 1 s, 6 d per day and the same again per night. Cited in López and Mutos, 'Nutriendo', 142.

[61]ACBR, Fons Hospital, 'Ospital. Entradas y Eixidas' (1723–1796). Information on patients is recorded before 1738 but not consistently. Some background on the hospital is provided by Lluís Guerrero, *Aspectes sanitaris de la vila de Berga (1569–1760)* (PhD thesis, Universitat de Barcelona, 2006), vol. 1, 499–502. Patient registers have been found for the hospital at Igualada for the years 1795, 1796 and 1800, but by then the majority of patients were soldiers. ACAN, Hospital Comarcal d'Igualada, Altes I baixes.

[62]Zamora, *Diario*, 100.

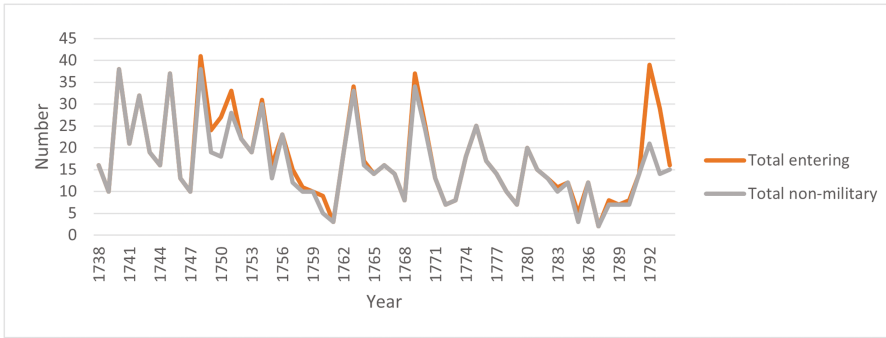

Fig. 2. Numbers of patients admitted to the Berga hospital, 1738–1795

755 patients, allowing for possible errors of identification.[63] Of these 755 patients, 370 were women, 377 were men, with a further 8 for whom sex could not be determined, usually patients listed only by surname. In some years, patients in transit may have been included, since there are various entries where no name is given, or a patient is described as 'a certain Maria from Montcalp who could not tell us her surname'. In other years, these patients were listed separately, as a total payment for their care, with no names or further information. The first point that stands out is the extent to which numbers of named patients fluctuated year on year, as illustrated in Figure 2. From 1749, the hospital admitted soldiers from the local barracks, a point to which I return later. In most years, these made little difference to the figures, but in the 1790s, the effect of the war with France is evident. Thirteen patients admitted between May to July 1794 were from local militia companies formed to fight against invading French troops.[64] Otherwise, spikes in numbers suggest outbreaks of disease or other hardship. The accounts do refer to *malalties* (illnesses) in the 1770s. 1764 was also an extremely poor harvest across Spain.[65] However, what may require explanation here are the low numbers in some years, which would seem to be more of a departure from the norm. Financial problems might be one explanation: as we have seen, the hospital was in debt in the 1750s. The 1780s could be explained by debt caused by building works, but possibly also a lack of space while building was in progress.

A second point is that entries show marked seasonal as well as annual fluctuations, with the summer months of May through August accounting for 40% of all entries. This seasonal pattern is in keeping with the patterns of disease and higher mortality associated with summer temperatures in Mediterranean areas, although the handful of institutions for which comparable data exist (all large urban hospitals) do not all

[63]With common names, it is impossible to be sure that only one patient is referred to, and there is also a risk of confusing, for example, fathers and sons with the same name. I took the arbitrary decision that a gap of 15 years or more between two stays meant the individuals in question were not the same person.

[64]These are listed separately under the heading 'malalts y ferits del cordó'. For a contemporary account of fighting against the French, see 'Memoria altra per lo venider' reproduced in Guerrero, *Aspectes sanitaris*, 1026–30.

[65]Vilar, *Catalogne*, vol. II, 104–9, 384–418; A. Simon Tarrés, 'Barcelona i Catalunya durant la crisi de subsistncies de 1763–4' in *idem*, *La població catalana a l'edat moderna. Deu estudis* (Bellaterra: UAB, 1996), 193–210.

follow this pattern.[66] It also fits with fatigue after the harvest months, as suggested by Dinet-Lecomte for Blois, who suggests hospital stays may have been as much about recuperation as treatment for illness.[67] Specific diseases and causes of death are rarely mentioned.[68] A son of Joan Ballus died in 1742 after being burned and Marianna Fortich died in 1782 after breaking her leg. A patient described only as 'a stranger' had smallpox in 1788 and Ursula Pujals came in with scabies in 1783, requiring all her clothes to be washed separately.[69]

Most striking, however, is the length of time and frequency with which many patients stayed, despite Zamora's claim. The longest stay was Mariangela Freixa, a spinster, who was in the hospital continuously from 1781 until her death on 3 July 1790, though she had had previous stays, including one of 318 days in 1780. Mariangela seems to have been an exception, as a note in 1786 recorded that the daily allowance for food was to be reduced in her case since 'she is not sick and in need, but is allowed to stay out of charity'. Exactly what this meant is not clear, but Mariangela obviously required care and shelter that could not be provided outside the hospital. Another patient, Maria Fortich, entered on 20th September 1764 and stayed until her death on 2 February 1770, though in her case, there is no explanation for why she stayed so long. These two stays were exceptionally long, although some other stays were for around a year at a time. Excluding the two exceptional stays, the average length of a single stay was 32 days.[70] Women stayed longer on average: for 36 days; while men stayed 30 days. Shorter stays of a week or less were less common than stays of one to two months, though after two months, the frequency of longer stays tails off sharply. There is very little comparable evidence on hospital stays before the nineteenth century. The Piedad hospital in Medina del Campo, in Castile, recorded average stays of 21 days for men, 27 for women in the years 1578–87.[71] In two sample years of 1787 and 1804, average stays in the women's Hospital de la Caridad y Refugio in Granada were shorter, 12 days and just under 11 days, although if a possible convalescence period is added, up to 20 days.[72] At Blois, most patients

[66]Carasa Soto, *El sistema*, 163–70 synthesises data for Palencia (1752–6), Valladolid (1752), Málaga (1845) and Madrid (1855). Summer and autumn do dominate but the highest month for entries for Palencia was January. On seasonal mortality in the Mediterranean, see N. Sánchez-Albornoz, 'La modernización demográfica. La transformación del ciclo vital anual, 1863–1960' in *idem*, *Jalones en la modernización de España* (Barcelona: Ariel, 1975), 147–80; M. Breschi and M. Livi-Bacci, 'Saison et climat comme contraintes de la survie des enfants. L'expérience italienne au XIXe siècle', *Population*, 1 (1986), 9–36; V. Pérez Moreda, *Las crisis de mortalidad en la España interior, siglos XVI-XIX* (Madrid: Siglo Veintiuno, 1980), 203–17; D.S. Reher, *Town and country in pre-industrial Spain: Cuenca, 1550–1700* (Cambridge: Cambridge University Press, 1990), 115–1; Julie Marfany 'Proto-industralisation and demographic change in Catalonia, c.1680–1829' (PhD thesis, University of Cambridge, 2003), 173–82.

[67]Marie-Claude Dinet-Lecomte, 'Recherche sur la clientele hospitalière aux XVIIe et XVIIIe siècles: l'exemple de Blois', *Revue d'histoire modern et contemporaine*, 33,3 (1986), 345–73.

[68]This is true in general: see Carasa Soto, *El sistema*, 183–209.

[69]ACBR, Fons Hospital, 'Ospital. Entradas y Eixidas', fols 24r, 133v, 168r, 135v.

[70]Length could not be calculated for 17 stays for which an exit date was missing.

[71]Alberto Marcos Martín, 'El sistema hospitalario en Medina del Campo en el siglo XVI', *Cuadernos de Investigación Histórica*, 2 (1978), 341–62, here 353.

[72]Inmaculada Arias de Saavedra Alías and Miguel Luis López-Guadalupe Muñoz, 'Hospitales de élite? El Hospital Femenino de la Caridad y el Refugio de Granada' in María José Pérez Álvarez and María Marta Lobo de Araujo, eds, *La respuesta social a la pobreza en la Península Ibérica durante la Edad Moderna* (León: Universidad de León, 2014), 55–88, here 82–3.

Table 7. Frequency of stays by patients at the Berga hospital, 1738–1795

Number of stays	Number of patients	% patients
1	604	80.2
2	92	12.2
3	32	4.2
4	12	1.6
5+	15	2.0
	753	

Source: See text.

stayed between 10 and 15 days, while at Nîmes around half stayed for fewer than 14 days.[73] There may have been more demand for beds in these larger towns than in Berga, however.

Table 7 shows the frequency with which patients entered the hospital. The majority of patients only recorded one stay during the period under analysis, but a small group stayed repeatedly. Again, Mariangela Freixa recorded the highest number of stays, entering the hospital some twelve times in total. She was not so exceptional in this regard. Tomasa Casals recorded 11 stays, beginning in 1744 with a stay of 14 days, and culminating with a stay of 205 days between 17 August 1756 and her death on 10 March 1757. Josep Aspachs was in and out 10 times between May 1740 and his death in November 1744, with his final two stays being considerably longer than the previous ones. Margarida Muchola recorded eight stays although she did not die in the hospital. Six patients recorded seven stays each, often with a pattern of repeated stays of greater length and/or at shorter intervals. The impression is one of increasingly severe illness, with the hospital serving almost as respite care for families. In that regard, families perhaps made use of the hospital for their sick members in a similar way to the uses made of workhouses for dependents who were either too young or too old to work: as temporary relief in times of hardship or when the burden of care was too great.[74] What is clear is that hospitals served local communities, not just the transient poor, and that care could be considerable.

The Nature and Quality of Care

Assessing the quality of care is difficult. Contemporary accounts point to variation in quality. Zamora condemned some hospitals and praised others. The hospital at Àger was 'miserable, with more coffins than beds'.[75] By contrast, Mataró was 'excellent', and Vic, where he spent some time looking round, notable for its 'good order'.[76] He waxed lyrical about the Manresa hospital, praising the separate quarters for the sick, including a room for tertian fevers, where the sick 'were assisted with great care', the pharmacy, the well for fresh water and the 'lovely' vegetable garden.[77] Similarly, Solsona, where

[73]Marie-Claude Dinet-Lecomte, 'L'assistance et les pauvres à Blois aux XVIIe et XVIIIe siècles', *Histoire, économie et société*, 8,1 (1989), 3–7; Colin Jones, *The charitable imperative: hospitals and nursing in ancien regime and Revolutionary France* (London and New York: Routledge, 1989), 64–5.

[74]See Carbonell-Esteller and Marfany, 'Gender, life-cycle and family "strategies"', 829–30.

[75]Zamora, *Diario*, 219.

[76]Ibid, 44 and 59.

[77]Ibid, 107.

patients had individual cubicles with windows, and dressing-gowns for when they were out of bed, was 'well-situated, well laid-out, well-assisted and well-endowed [...] it is a pleasure to see how it is maintained'.[78] Clearly, larger places had an advantage in terms of the care they could provide, at least as far as separate wards were concerned, but small places were not always miserable. Viella, despite being a small place and relatively poor, had a 'fairly spacious house' and 'useful' provision.[79] The new hospital at Tossa de Mar was only intended for twelve patients, but had a 'sufficient endowment' and was 'agreeable'.[80]

Aside from such comments, statutes and ordinances occasionally give details of what was at least expected in terms of day-to-day care. One example is those for Olot, which set out that each patient should have his or her own bed, be visited by the doctor twice a day and be given a pound of meat a day (usually in the form of a stew) with bread and 'a reasonable portion of wine'. Some patients in addition were to receive chicken broth, or chocolate, as decreed by the doctor, and if funds allowed, cool drinks in the afternoons. Patients were to be given a bed for as long as needed, unless they were rude to staff or refused to follow rules.[81]

Otherwise, some insights are provided by staffing, and expenditure on patient care. For staffing, we have a snapshot across all hospitals since the 1787 census asked places to provide numbers of staff as well as patients. The categories specified were vague: *capellanes* (priests), *empleados* (employees), *facultativos* (medical professionals) and *sirvientes* (servants). The difference between *empleados* and *sirvientes* is unclear. The former may have been intended to distinguish administrators from those providing day-to-day care, but hospitals seem to have been confused by the terminology, since many just provide a total under one heading, such as Vilarrodona, which claimed to have seven faculty and two servants, despite being only a small hospital. It is cases such as this that have led to the widespread claim among historians that staff outnumbered patients and thus hospitals were obsolete. Twenty-eight hospitals recorded staff, but no patients, while in others staff outnumbered patients. However, it is unlikely that all staff were resident, indeed, it seems to have been rare for anyone except the wardens and their families to have lived in. In the case of the 35 hospitals with *facultativos* in 1787, these were most likely doctors, surgeons and sometimes apothecaries paid a fixed salary to provide their services to the hospital. Similarly, some of the larger hospitals paid salaries to rent collectors and legal representatives (*procuradores*).[82]

Again, the 1787 census cannot be taken too literally here. It is reasonable to assume that hospitals that did not record a medical practitioner on the staff still called on the services of a surgeon, physician or apothecary as needed. Indeed, most localities since the medieval period had employed a medical practitioner on a fixed salary to provide medical services to the local population, paid for either out of municipal funds or by means of a tax on the inhabitants, a practice known as a *conducta*.[83] For the poor, in

[78]Ibid, 144–5.
[79]Ibid, p 202.
[80]Ibid, 381.
[81]'Estat del hospital de Sant Jaume…'.
[82]Notably Figueres, which had not only a local *procurador* but also paid for legal representation in Barcelona in 1772 and in both Barcelona and Madrid in 1799, though some of these payments were ad hoc rather than retainers.
[83]Alfons Zarzoso, *La pràctica mèdica a la Catalunya del segle XVIII* (PhD thesis, Universitat Pompeu Fabra, Barcelona, 2003), 292–323.

and out of hospitals, such services were often given free of charge, as at Llançà, where the local doctor and surgeon provided their services for free and the apothecary provided medicines at half the usual price. Medical care might have been more specialised in some places, but it was thus not solely the preserve of larger institutions. Cadaqués, despite only having 8 or 9 beds, paid fixed salaries of 14 and 6 *lliures* respectively to both a doctor and a surgeon. Similarly, Castelló d'Empúries, which had an average of 6 patients at any one time, paid salaries of 20 and 12 *lliures*. Physicians and surgeons visited patients regularly, on a daily basis seems to have been usual at least according to statutes and ordinances.[84] Medicines were provided according to direction, usually from a local apothecary, although in some places at least, remedies were also made up in house. As well as the pharmacy at Manresa, mentioned by Zamora, Figueres had its own apothecary shop, selling medicines for wider consumption as well as for the hospital patients. Medical care could thus be significant. Puigcerdà even paid for patients to take the waters.[85] Most importantly, it was free for the poor, as was the food and shelter provided, and thus even the most basic care would have been welcome.[86] The hospital at Llançà, despite having only around 12 *lliures* guaranteed income, tried to offer medical care to poor labourers, 'to prevent them from using up what little money they have, and their families from ending up on the streets'.[87] Similarly, hospitals usually paid the costs of burial and masses when patients died, taking on the burden of a cost that was far from negligible for poor families.[88] Many hospitals offered outdoor relief as well. The hospital at Constantí recorded numerous payments to 'the sick in their homes' (*als malalts a sas casas*).[89] Similar payments were common in Cadaqués.[90]

Who did most of the day-to-day care is harder to know. As a minimum, hospitals had a woman to look after any patients, as at Vidreres, where a woman was employed to look after the hospital and beg charity on behalf of any transient poor unable to beg for themselves.[91] More usual was for the day-to-day running to be in the hands of a married couple, who might also have their children living in with them. Salaries for wardens (*hospitalers*) varied considerably, and in some cases, they may simply have received bed and board, since accounts do not always record a salary. At Puigcerdà the hospital in the later eighteenth century was run by two married couples, an older and a younger, with two children, and two former foundlings, one male, one female, who presumably worked as servants. No mention is made of cash wages, but bed and board arrangements are given in detail, including a fuel allowance, the right to grow produce in the garden and to keep two pigs, since they would not be given a meat allowance except on feast days.[92] At Alcover in 1615 Pere and Magdalena Casselles received 10 *lliures* and 2 *cortans* of oil a year and the use of the hospital land.[93] At Verges, the *hospitaler* is described as occupying the hospital properties, namely a house, fruit and vegetable garden, and two

[84]Jones, *Charitable imperative*, 13 suggests daily visits were the norm in French hospitals.
[85]As did Vic-en-Bigorre: Verley, *Mendiants*, 145–53.
[86]Verley makes the point that medicines were beyond the reach of the poor. Ibid, 141.
[87]AHG, 676, Llançà.
[88]Guerrero, *Aspectes sanitaris*, vol. 1, 504.
[89]AHAT, Parroquials, 7.48 Constantí, 'Llibre de comptes del sant hospital de Constantí comensat en lo de 1765'.
[90]Josep Rahola Sastre, *Cadaquès. Noticias históricas de su hospital* (Girona: Bisbat de Girona, 1980), 36–7.
[91]AHG, 328.9, letter from councillors of Vidreres to Joseph Ignacio de Castellví, 5 April 1772.
[92]ACCE, Hospital de Puigcerdà, Personal, undated document originally included with papers from 1789.
[93]AHAT, Arquebisbe, Visites Pastorals, 'Santa Visita del Il.lustríssim Senyor Moncada 1614 a 1615', fols 142r-v, 144v. A cortà or quartà was about 0.26 litres.

small plots of land, the implication being that he kept the produce in return for caring for patients.[94] Variation may also be a reflection of the size of wardens' families.

While it is usually the male warden who is most visible in hospital accounts, it is clear that the preference if not the expectation, was for the role to be shared with his wife, since sources frequently refer to the female occupation of *hospitalera*. Indeed, the Berga accounts show that it was often the *hospitalera* doing the bulk of the caring work, since payments are recorded directly to her. This is most evident in the 1780s when the hospital was run by Ramon and Teresa Freixa. Ramon is described as a carpenter and paid as such for repair work, with the implication that this continued to be his main work, while for most hospital affairs, the administrators dealt with Teresa.[95] Similarly at Banyoles, various *hospitaleres* received payment (in November 1781, several payments were made to the daughter of the *hospitaler*) and from the end of that month until January 1791 Caterina Tarrus was named as *hospitalera*, with no mention of a male warden or of her marital status.[96] At Vila-seca, by the early nineteenth century, only women are mentioned in the running of the hospital, with payments first to a Maria Carreta and later to a Maleña Cantarera. Marital status is not mentioned for either. Both received a salary of 3 *sous*, 9 *diners* a day, though it is unclear if this was in addition to bed and board.

What this care consisted of is not specified but presumably covered a wide range of activities, from buying in and preparing food, cleaning, washing patients, nursing them and, in some cases, preparing at least some remedies. In addition, the work of laying out patients, keeping vigil and preparing them for burial presumably also fell to women. The narrow historiographical focus on 'modern medicine', combined with neglect of women's unpaid care work, has often overlooked the extent and value of such care, as several historians have compellingly pointed out.[97] How far such work fell entirely to the wardress is difficult to know. The Girona hospital employed several staff, including women as cook, cook's assistant, chamber maid, nurse, wetnurses, a matron for the babies and a woman to teach the older girls.[98] Such a range was exceptional and reflects the hospital's role in taking in foundlings and orphans, prior to the construction of a workhouse. As Table 6 shows, accounts frequently record payments for laundry, indicating that this often required additional labour. Nursing also required additional labour in some larger hospitals. Figueres and Girona recorded a male and a female nurse in addition to the hospital warden. At Figueres, Mariangela Sala, nurse, was paid 15 ll for four months

[94]AHG 328.9, letter from councillors of Verges, 4 April 1772.

[95]One entry in 1782 reads: 'Paid to the wardress for work done by her husband Ramon Freixa, carpenter, for repairs to the house, wood, nails and plaster…' ACBR, Fons Hospital, 'Ospital. Entradas y Eixidas', fol. 134v.

[96]ACPE, Hospital 362 'Llibre de aixidas…'.

[97]Margaret Pelling, *The Common Lot. Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London: Longman, 1998); Susan Broomhall, *Women's Medical Work in Early Modern France* (Manchester: Manchester University Press, 2004); Mary Fissell, 'Women, health and healing in early modern Europe', *Bulletin of the History of Medicine*, 82,1 (2008), 1–17; Sharon Stroccia, 'Women and healthcare in early modern Europe', *Renaissance Studies*, 28,4 (2014), 496–514; Jane Whittle, 'A critique of approaches to "domestic" work. Women, work and the pre-industrial economy', *Past and Present*, 243 (2019), 35–70; Alexandra Shepherd, 'Care' in Catriona Macleod, Alexandra Shepard and Maria Agren, eds, *The Whole Economy. Work and Gender in Early Modern Europe* (Cambridge: Cambridge University Press, 2023), 53–83; Erin Maglaque, 'Care work and the family in Catholic Reformation Tuscany', *Past and Present*, 253 (2021), 119–50.

[98]Borrell, *Pobresa*, 91.

between November 1796 and March 1797.[99] During severe outbreaks of disease, even smaller hospitals might employ other women as temporary carers. In 1737, the Berga administrators recorded a payment of 14 *lliures*, 11 *sous*, 4 *diners* to Magdalena Codina, for nursing the sick in 1735 'during the time of sickness'.[100] The town council had ordered she be paid 4 *sous* a day. Lleida recruited 25 men to help with nursing in 1763 when French troops were in the town.[101] Banyoles paid an unnamed woman in August and September 1790 to cover for the illness of the current *hospitalera*.[102]

The financial and legal administration was a male preserve. I have found only one reference to a woman described as an *administradora*, at Vila-seca, where Raymunda Saleses or Salecer was reimbursed for quite significant sums on two occasions, suggesting her role was above that of the *hospitalera* in charge of day-to-day expenditure. Women were involved in some cases to oversee the provision of linen and clothing, as at Solsona, Arbúcies, Olot and Figueres, but this seems to have been a charitable activity done by 'women of distinction', to quote a source from Figueres.[103] They also collected alms on behalf of the hospital, as at Berga, where the Lenten collections were carried out by women of some status in the town.

Central to care, and accounting for the bulk of expenditure was food. As many historians have noted, diet was not an addition to medical care in the early modern period, but an essential component of it.[104] The quantity patients received is rarely given. The statutes for Cervera in 1803 stipulated 6 ounces of meat and 12 ounces of white bread per day, along with wine, but patients may have been given additional food on top.[105] There are a few examples of expenditure per head. The hospital at Castelló d'Empuries claimed to be spending around 11 *sous* and 3 *diners* per day on food for six patients in the 1770s, coming in at 1 *sou*, 11 *diners* a day per head. The hospital in Vic was spending 9 *sous*, 6 *diners* per patient in the same decade, though it is not clear what that included.[106] Sustenance (*manutenció*) is specified in one payment in 1793 by the Banyoles hospital as 8 *sous*, 4 *diners* a day, but whether that was the going rate throughout the century or recent is unknown, and payments continued to be made alongside these for food and other items.[107] Sant Feliu de Codines paid 3 *sous* a day in the second half of the eighteenth century.[108] Tàrrega paid 3 *sous* a head in 1795–8, then 4 *sous*, but with some extra payments for hens, brandy and other goods.[109] Berga was spending 1 *sou*, 6 *diners* per head on food in the first half of the eighteenth century, with an increase to 1 *sou*, 9 *diners* in 1765 and 2 *sous*, 4 *diners* in 1780 as the result of a legacy. There are frequent

[99]ACAE, Hospital de Figueres, capsa 376.
[100]ACBR, Fons Hospital, 'Ospital. Entradas y eixidas', fol. 11v.
[101]Lorena Lourdes Tejero Vidal, *Las Hijas de la Caridad de San Vicente de Paúl en el Hospital de Santa María, la Casa de Maternidad y la Casa de Misericordia de Lleida (1792–1936). Aportaciones a la enfermería* (PhD thesis, Universitat de Lleida, 2016), 215.
[102]ACPE, Hospital 362, 'Llibre de axidas…', unfoliated.
[103]Zamora, *Diario*, 145–6; Borrell, *Pobresa*, 95.
[104]David Gentilcore, *Food and Health in Early Modern Europe: Diet, Medicine and Society, 1450–1800* (London: Bloomsbury, 2016); Broomhall, *Women's Medical Work*, 147; Fissell, 'Women', 14; Martin Dinges, 'L'hôpital Saint-André de Bordeaux au XVIIIe siècle: objectifs et réalisations de l'assistance municipale', *Annales du Midi*, 99 (1987), 303–30.
[105]Josep M. Llobet Portella, *L'hospital de Castelltort. Sis-cents anys d'assistència social a Cervera* (Lleida: Pagès, 1990), 53–4.
[106]Antoni Pladevall, Isidre Prades and Francesc de Rocafiguera, *Hospital de la Santa Creu de Vic. Història d'una institució assistencial* (Vic: Hospital de la Santa Creu, 2000), 68–9.
[107]ACPE, Hospital 362, 'Libre de axidas…', unfoliated.
[108]Reventós, *Història*, vol. IV, 155–9.
[109]Arxiu Comarcal d'Urgell (ACU), Hospital de Tàrrega, Comptes.

references, however, to *gastos extraordinaris* (extra spending) on patients, which may have included extra food. How adequate allowances were is harder to assess. Céline Mutos' recent calculation of a respectability basket of goods for textile workers in Girona in the 1780s equates to 59 *lliures*, 2 *sous* per person per year.[110] After deducting rent, respectability works out as just under 3 *sous* per person per day.[111] Hospital daily allowances are lower, but as noted, it is hard to know what they covered, nor do we know what degree of self-provisioning existed. Patients were presumably confined to bed, so would have had lower energy requirements than if working. Quantities of food per head are unknown, and thus it is impossible to estimate calories, nor can we know how many families might realistically have attained a respectability basket at home.

The diet seems to have been varied, judging by foodstuffs purchased. As expected, the main components of the diet were bread, wine, meat and olive oil. Other foods were rice, pasta, sugar, spices, eggs, apples, almonds and raisins. Only Vila-seca and Puigcerdà out of the sample of accounts studied recorded payments for fish. Interestingly, Banyoles, Puigcerdà and Vila-seca also purchased chocolate, as noted for Olot above. Although becoming more common during the eighteenth century, chocolate remained something of a luxury for the poorer sorts.[112] Hospitals probably purchased it for medicinal reasons, as was made clear at Puigcerdà, where chocolate was purchased in 1757 year 'by order of the doctor'.[113] Vegetables and fruit feature less frequently in accounts than other foodstuffs, but hospitals with gardens were likely growing their own. Banyoles had a garden larger than the hospital building, according to a surviving plan.[114] Brandy and sweet wine (*malvasia*), and milk also appear in accounts, but may have been medicinal rather than part of the regular diet.[115]

Reform and Renewal

Although the traditional care that continued to be the focus of provision at most hospitals had much to offer to both transient and local poor, hospitals were not isolated from developments in medical practice. Here Hickey's emphasis on reform and renewal in French hospitals can be applied equally well to the Catalan case. Local doctors frequently instituted reforms and took part in a diffusion of medical knowledge. The practice of *conducta* described above aided such diffusion, by ensuring the recruitment of university-trained practitioners across the Catalan countryside.[116] Smallpox vaccination in Catalonia was pioneered in 1800 by Francesc Piguillem, doctor at Puigcerdà, using serum obtained from Paris.[117] He had previously been the first to recognise that neonatal tetanus was caused by incorrect cutting of the umbilical cord. Antoni Millet, doctor at

[110]Céline Mutos Xicola, *Dans l'ombre du démarrage industriel: les manufactures des maisons de charité. L'Hospice de Gérone et la bonneterie de coton en Catalogne (1750–1830)* (PhD, University of Girona, 2022), 386–92. This would have purchased 2,067 calories per person. The basket assumes a family of four. Girona prices may have been higher than those in the locations discussed here, but probably not by much.

[111]I could also have deducted clothing and shoes, which would reduce the sum further, but conversely, the respectability basket does not include medicines.

[112]On the significance of chocolate as a new commodity in the eighteenth century, see Marfany, *Land*, 155–7.

[113]ACCE, Hospital de Puigcerdà, Comptes 1756–7.

[114]ACPE 362, Planol del hospital (loose leaf, undated, but probably early nineteenth century).

[115]Berga recorded these as extras.

[116]Zarzoso, *La pràcitica mèdica*, 259–323.

[117]Jordi Nadal, *La población española (siglos XVI a XX)* (4th ed., Barcelona: Ariel, 1991), 104–13.

the hospital in Vic between 1770 and 1793 instituted separate wards for smallpox and consumptive patients, prescribed the use of spa treatments, was interested in vaccination and wrote a medical treatise based on his work at the hospital, shortly after being appointed physician at the royal court in Madrid in 1797.[118] Vic also built a separate hospital for 40 convalescent patients at the end of the eighteenth century. As noted above, the Manresa hospital had a separate fever ward, while Solsona had individual cubicles for patients. Numerous other doctors attached to smaller towns and rural hospitals wrote medical treatises, often as part of admission to the Royal Academy of Medicine.[119]

A further development was the introduction of nursing orders, notably the Daughters of Charity. Their arrival in Catalonia was late, given the long existence of the order in France. They were first installed in Barcelona in 1790, alongside the existing nursing order, the Darderes, but their time there was short-lived. By contrast, they were installed in Lleida in 1792 and Reus and Girona in 1793, and remained there for longer, followed by Cervera (1805), while Mataró, Arbúcies, Olot and Tàrrega had their own nursing orders, modelled on that of Barcelona.[120] The administrators of Figueres and Valls engaged in a lengthy correspondence with those of Reus and Lleida soliciting their views on the Daughters of Charity. A letter from Reus preserved in the Figueres archive enthused over the level of care, describing the sisters as 'models of virtue, mirrors of the greatest cleanliness and aid to the sick and possessed of such great charity that these [the sick] are looked after continuously day and night'.[121] Some historians have viewed the introduction of religious orders as the 'professionalisation' of nursing with the implication that nursing prior to the arrival of the orders was of poorer quality.[122] The new statutes drawn up for the hospital at Lleida in 1797, claimed that care for the poor was better since the arrival of the Daughters of Charity five years previously.[123] The sisters do appear to have had a certain degree of training in basic surgery and apothecary skills, though the latter may not have distinguished them from other women.[124] However, despite the enthusiasm of contemporaries, it is unclear that the order offered anything by way of care (washing, serving food, sitting up with patients at night) that had not previously been provided. Dinet-Lecomte's spirited defence of the care offered by nursing orders could arguably be extended to all nursing in the early modern period.[125] It may be that their religious vocation and training did translate into greater devotion to their patients, but there is no way to tell, and no way to compare care before and after their

[118]Pladevall Font et al., *Hospital de la Santa Creu de Vic*, 60–4; José Manuel López Gómez, *La topografía médica de Vic de Antonio Millet (1798)* (Barcelona: PPU, 1992).

[119]For biographical accounts and details of works, see the website of the Col.legi de Metges, Barcelona at https://www.galeriametges.cat/galeria.php

[120]Reventós, *Història* vol. I 95–7, 120–3; Anguera, *Hospital*, 27–31.

[121]ACAE, Hospital de Figueres, capsa 356, 'Relación de las señoras que serveixen de Infermeras al Hospital de la Vila de Reus', undated and unsigned.

[122]See especially Jones, *Charitable imperative*, 89–205; Hickey, *Local hospitals*, 169–74; Comelles *et al.*, *L'hospital de Valls*, 164–89; Tejero Vidal, *Las Hijas*, 223–31.

[123]Institut d'Estudis Ilerdencs, Fons Antic Hospital de Santa Maria, *Constituciones para el gobierno del Santo Hospital General de la ciudad de Lérida, hechas de órden del Supremo Consejo de Castilla…* (Madrid: Blas Román, 1797), 5–7 (available at https://mdc.csuc.cat/digital/collection/hospstmaria/id/77/rec/75). See also Tejero Vidal, *Las Hijas*, 298–9.

[124]Jones, *Charitable imperative*, 192–7.

[125]Marie-Claude Dinet-Lecomte, 'Les religieuses hospitalières dans la France modern: une même vocation dans une multitude d'instituts', *Revue d'histoire de l'Église de France*, vol. 80, num. 205 (1994), 195–216; idem, 'Les soeurs hospitalières au service des pauvres maladies aux XVIIe et XVIIIe siècles', *Annales de démographie historique* (1994), 277–92.

arrival. As likely an explanation for the enthusiasm of hospitals in trying to recruit them was cost-saving, particularly given increased financial pressure. While nursing orders did require financial support from communities, there are indications that this worked out cheaper in Catalonia.[126] This was certainly the hope expressed by the administrators of Figueres in a letter to those at Lleida.[127] The 1797 statutes noted above cite better 'economic management' as one benefit of the order. In 1792, when the first four sisters arrived in Lleida, the hospital was paying 18 *lliures* a month to Sebastià and Mariangela Planer to look after the sick.[128] Whether they also received bed and board on top is unclear, but if they did, the nuns did represent a saving, since they were to be given bed and board, and 35 *lliures* each a year for clothes. From paying 216 *lliures* a year, the hospital was paying 140, though with increased costs of bed and board. The bishop of Lleida some years later cited the need to continue the work of the Daughters of Charity because they provided a degree of cleanliness and care that 'could not be hoped for from mercenary servants'.[129] The elevation of nursing to a vocation, rather than paid work, says as much about male perceptions of value as about the care provided. Moreover, what the order also offered was education for girls, thus killing two birds with one stone. The letter from Reus cited above waxed as lyrical about the educational role of the order as the nursing role. Indeed, a similar letter to Josep Cesat, the parish priest of Valls, describing the typical daily activities of the sisters, focused almost entirely on the teaching day, mentioning the sick only in relation to the midday meal.[130] Class may also have played a role: one source alleged that the Daughters of Charity were to be preferred over the Darderes, because the latter were usually former domestic servants, and thus lacked 'the social graces' of the former.[131]

Nevertheless, recruitment of nursing orders shows a continued commitment by local communities and authorities to their hospitals. Further proof of this commitment is shown by the number of new foundations and renewed or rebuilt hospitals. In some cases, this rebuilding was forced upon institutions by war or other calamities. The hospital in Girona was destroyed during war with the French in 1654 and gradually rebuilt between 1666 and 1677 (patients were housed in a nearby convent in the meantime).[132] Ripoll was also destroyed by the French in 1654, and rebuilt in 1662. The hospital at Camprodon also fell victim to the French in 1689.[133] Other rebuilding work or new foundations corresponded to the growing needs of local populations and to the desires of some inhabitants to leave a legacy. Founding or refounding a hospital was still considered a worthy legacy. It is hard to know from the sources how many hospitals were new,

[126]The French evidence is mixed: Hickey argues that nursing orders were usually more expensive (*Local Hospitals*, 167–9) but Jones (*Charitable Imperative*, 139) finds that at Montpellier at least, the Daughters of Charity were paid 'considerably less' than their predecessors.

[127]ACAE, Hospital de Figueres, capsa 162, letter dated 17 December 1798. Further correspondence from 1801 to 1802 suggests Figueres may have given up on the idea. See ACAE, Hospital de Figueres, capsa 163.

[128]Tejero Vidal, *Las Hijas*, 320.

[129]Cited in Tejero Vidal, 235.

[130]Cited in Comelles *et al*., *L'hospital de Valls*, 172–3. Cesat was unable to recruit the Daughters of Charity, possibly because of concerns among the civic authorities overseeing the hospital that the Daughters would be answerable to the Order rather than to them. However, he hospital created its own nursing and teaching order in 1805.

[131]Cited in ibid, 170.

[132]Narcís Castells, Narcís Puigdevall and Francesc Reixach, *L'hospital de Santa Caterina* (Girona: Diputació de Girona, 1989), 36–59.

[133]Borrell, 32.

as opposed to replacing earlier medieval foundations that might have fallen into disuse, but either way, they testify to the significance communities still placed on these institutions. The hospital at Sant Feliu de Codines, according to Zamora, was built by the joint efforts of the parish priest and residents, to the extent of carrying stone in on foot as well as by cart since the terrain was so steep.[134] The new hospital at Tossa de Mar, replacing an older and very poor establishment, was founded in 1764 by a local merchant, Tomàs Vidal, who had made a fortune in the Americas.[135] Begur was founded by a legacy from a local doctor, Francesc Comas, though a dispute over the bequest delayed the opening until 1771.[136] That at Palamós, on the north-east coast, was a new building, founded in 1768 to replace an earlier medieval one, although a dispute over the founder's bequest had delayed construction. Arbúcies was even newer, with a foundation date of 1786, and funded by charitable donations, as was that of Santa Coloma de Farners, under construction when Zamora visited.[137] Palafrugell and La Bisbal were also being rebuilt.[138] Arenys de Mar was described as new.[139] Whether building from scratch or replacing an older building, those in charge of such projects aimed to make them as suitable as possible, emphasising light and air, often around interior courtyards or gardens.[140] The founder's bequest for the hospital at Tossa stipulated there should be a herb garden.[141] Such efforts at renewal, in a period traditionally perceived as one in which charity was 'in crisis', testify to the significance to communities of local care.

Conclusion

Local hospitals have been surprisingly neglected by historians, overshadowed by the larger institutions of the cities. Such neglect stems in part from the lingering perception that they were marginal to the lives of their communities, restricted in the scope of what they could provide. For Catalonia, even quantifying how many hospitals there were is challenging. Combining available sources, however, suggests that there were around 200 such institutions across the region in the seventeenth and eighteenth centuries, ranging in size, but by no means obsolete. It is true that their finances were often limited. A detailed examination of a sample of accounts has shown that income fluctuated, and by the end of the eighteenth century, war and soaring prices had hit most institutions hard. Over the longer term, the ability to weather storms depended on the sources of income: those with land were less vulnerable to price rises than those dependent on *censals* and other rents. Charitable income dropped in some places but held up better in others.

Financial resources obviously dictated the level of care that could be provided. Nevertheless, where resources existed, care could be substantial. Medium-sized hospitals offered medical care that was arguably as advanced as could be expected outside of large cities. Smaller places could not have dedicated wards or herb gardens, but

[134]Zamora, *Diario*, 277.
[135]Ibid, 381. See also Esther Loaisa Dalmau, Joan Molla Callís and David Moré Aguirre, 'Dos cents cinquanta anys d'*ets* i *uts* de l'Hospital de Pobres de la Vila de Tossa: un vincle entre Tossa i Calonge', *Quaderns de la Selva*, 21 (2009), 241–82.
[136]Vaquer Catà, *El Sant Hospital*, 44–5.
[137]Zamora, *Diario*, 295, 302.
[138]Ibid, 371, 374.
[139]Ibid, 391.
[140]See Reventós, *Història dels hospitals*, vol. 1, 86–9. Examples, all of which still survive, include the hospitals of Girona, Vic, Cervera and Torroella de Montgrí.
[141]Loaisa Dalmau et al., 'Dos cents cinquanta anys', 246.

that does not mean no medical care was offered. Any medical care at all was likely to be welcome for the poor. Moreover, the function of hospitals takes on a much greater significance once the caring work traditionally performed by women is given its proper recognition and value. Shelter, food, washing, clean linen, sitting up with the sick and dying, laying out of the dead were not and are not, marginal activities. The shelter offered to the transient poor, including a network of support for foundlings, was important, but care extended beyond such temporary hospitality to the local community. The example of Berga points to lengthy and frequent care for some inhabitants. In turn, local people invested in their hospitals: making charitable donations, leaving bequests in wills (even if the straitened circumstances of the later eighteenth century made charity more difficult) and rebuilding and renewing hospitals when finances allowed. Not all hospitals were models of care, but the picture that emerges from the sources is overwhelmingly one of institutions doing the best they could with what they had.

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