Chapter 1

The Historical Creation of the Hospital System in Spain: Private Hospital Sector Strategies in Relation to the Development of the Public System.[1]

Margarita Vilar-Rodríguez*
(University of A Coruña)

Jerònia Pons-Pons
(University of Seville)

Introduction

The available historiography has shown how the so-called mixed economy of welfare (co-existence of forms of solidarity, state action and private companies) was a preliminary step towards the creation of two basic models of health insurance in the mid-twentieth century: state insurance schemes prevailed in Western Europe, while private insurance companies predominated in the United States.[2] Thus, from a historical point of view, public health care systems that progressed towards universal coverage were prevalent in Western Europe, which prompted the construction of a solid network of publicly owned hospital infrastructure.

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In particular, some studies have analysed the historical creation of public hospital systems in certain countries in Western Europe, driven by the passage of compulsory social insurance legislation and increasing state participation, and coinciding with a parallel decline in philanthropy and charity in the Western world.[3] Significant differences between countries are to be found within this general model, both in ways of funding and managing the system and in the historical configuration of the hospital map, depending on whether or not hospitals of different origin and specialisations were incorporated into the public network. On the other hand, there is the US model, where health and hospital care have historically been covered by private insurance companies. This has been explained in terms of a complex set of factors, especially the lobbying power of the private interest groups involved in this process in combination with other political interests and the preferences of professional doctors. Other factors include the increase in family income, the development of medical technology and government policies that consolidated private sector predominance through measures such as tax incentives.[4] In this respect, R. Stevens concludes that as a result of this historical evolution, the US hospital system has become unique: a combination of public and private institutions that are at once charities and businesses, social welfare institutions and icons of the country's science, wealth, and technical achievements.[5] Despite the cuts in public health systems in recent years, it seems to be beyond all doubt that the US model is a more expensive system in the long run, and less successful in meeting the needs of the chronically ill and the socially disadvantaged.[6]

Overall, the available literature on the creation of hospital systems in an international context provides us with three key lessons.[7] First, the danger of over-simplifying when classifying countries into the two large typical models related to Western Europe and the United States. It seems clear that the global scene is in fact much more

complex, and even within Western Europe each country must essentially be considered as a unique case. Second, the importance of the public and private approach to analysing the historical development of hospital systems and the important implications in terms of efficiency, coverage and equity. Third, the relevance of the historical perspective, as different forms of hospital coverage had priority in each country according to the period and the adopted model. Here, factors such as expeditiousness in implementing state insurance schemes, social spending performance and the more recent initiation of privatisation processes within public health systems in some countries have led to changes to the original models and have produced a different historical fit, or correlation, between public and private hospital coverage, depending on the period analysed.

The case of Spain provides an excellent example for substantiating these three points. This country was one of the last in Western Europe to pass its first state sickness insurance (1942); it belatedly consolidated a universal public health system with the law of 1986; and it is an interesting case study of how a private hospital sector was capable of developing strategies in each historical stage to maintain (and expand) its market niche during the development of the public system. From the last third of the nineteenth century and throughout the twentieth century, the modern Spanish hospital system was fashioned over the course of different historical stages that may be examined by focusing on the interaction (whether collaborative or competitive) between public and private sectors. In this respect, the private hospital sector increased the private provision of hospital beds as a reaction to different factors. One was the emerging demand of the middle and working classes who were not covered by the country's public health institutions (including those run by municipal councils and provincial authorities known as *diputaciones*).[8] Others were the obligations imposed on employers due to the approval of regulations or social insurance

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schemes, and increasing medicalisation together with new medical or pharmacological techniques that were not provided by the public health system. Consequently, and for other reasons that are analysed in this chapter, during some periods the private hospital sector substituted for the public sector, in others complemented it, and at times both sectors were in competition with one another. As a result, a complex relationship between both sectors evolved that vacillated between necessary cooperation and logical competition.

With respect to the hospital classification criterion, due to historical tradition and the (not very abundant) sources available, the Spanish historiography has been based on whether hospitals were publicly or privately owned in order to analyse the long-term development of the hospital system.[9] This article follows this tradition, categorising hospitals as being under public or private ownership. In this case, hospitals built and financed by public institutions are included in the public sector. On the other hand, privately owned hospitals include those of the Church, the Spanish Red Cross (*Cruz Roja*), private charitable institutions—similar to the British voluntary hospitals—and private profit-seeking hospitals. This classification according to type of ownership remained essentially unchanged until 1986. Although property ownership is quite clear, the type of funding and the groups of patients admitted by each type of hospital are much less obvious. In particular, it is difficult to distinguish between the charitable foundations of privately-owned hospitals, which in theory covered poor patients, and the private profit-orientated hospitals which were based on business and market criteria and treated paying patients. This difficulty is rooted in the fact that, over time, the private charity hospitals increased the number of beds dedicated to paying patients, while a similar process also occurred with the hospitals belonging to the Church and the Red Cross. Meanwhile, some private profit-seeking hospitals dedicated a few working hours a week to treating poor

patients, on the grounds of Christian charity. Owing to these blurred distinctions, we feel that property ownership is a much clearer guideline for the Spanish case.

The creation of the hospital system before the passage of state insurance (1880-1936)

Between 1880 and 1936, the public/charitable hospital network in Spain remained antiquated and tied to the limited state, provincial, and municipal budgets and only treated the population classified as poor. These institutions had limited therapeutic efficacy and their main aim was to provide shelter for the sick poor, most of them chronically or terminally ill, who did not have the support of a family care network.[10] It must be borne in mind that the welfare system of the *Ancien Régime* in Spain, based on religious charity, was transformed in the nineteenth century by means of the disentailment laws, which liquidated a large part of Church property and transferred the management of many of its hospital establishments to state, provincial and municipal authorities (General Charity Law of 20 June 1849).[11] However, provincial and local charity had sparse resources during this period. Thus, their main efforts were concentrated on providing food, clothing and hospital attention for the poorest families, and on the confinement of the old, vagrants and foundlings in hospices and children's homes.[12] On the other hand, general charity establishments under state management were few in number, funded by small items in the general state budget, alms and royal subsidies, and most of them were located in the capital, Madrid.

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Table 1.1: General charity hospitals existing on 30 March 1886

Name	City	Purpose of the institution	No. of beds
Hospital de la Princesa	Madrid	For the sick of both sexes with acute non-infectious disorders*	200
Hospital de Jesús Nazareno	Madrid	To house disabled and incurable women	250
Hospital de Nuestra Señora del Carmen	Madrid	To house disabled and incurable men	250
Hospital del Rey	Toledo	To house the decrepit and blind of both sexes	120

Source: Statistical Yearbook of Spain (*Anuario Estadístico de España*), Reseña geográfica y estadística de España, 1888, 1030-1.
* Note: On one hand, an acute patient would be a patient at risk of death, who needed urgent treatment and, in some cases, an urgent surgical operation. On the other hand, a chronic patient would be a patient who needed lifelong treatment, in some cases with hospital admission.

Provincial authorities, however, were obliged by the Charity Law of 1822/36 (the first law regulating this area in Spain) to establish four charitable establishments in each province: a *Casa de Maternidad y Expósitos* (maternity and foundling home), a *Casa de Socorro* (emergency medical and surgical treatment), a *Casa de Misericordia* (home for children and the elderly) and a public hospital (in most cases treating infectious patients).[13] In fact, hospitals exercised a crucial police function for the maintenance of public order; that is to say, to remove children, vagrants and old people from the streets by means of confinement in hospices, asylums and refuges. Moreover, as noted above, provincial councils inherited some of the disentailed hospitals. In 1909, official figures registered 183 provincial charitable establishments operating throughout the country.[14] As for town and city councils, they managed

an old network, part of it of medieval origin and the rest inherited from the disentailment of ecclesiastical property, comprising modest establishments of charitable aid.[15] Many of these establishments disappeared in the second half of the nineteenth century due to a lack of resources. Sources accounted for 363 charitable institutions run by municipal authorities to treat the sick in 1909.[16]

Altogether, the charitable establishments of the provincial and municipal councils provided a total of 66,014 beds in Spain in 1909, which was equivalent to a ratio of 3.3 beds per thousand inhabitants.[17] Most of these beds were used for asylum purposes and not for surgical treatment or medical care; in fact, a significant part of the funds of these institutions was used for providing food for the sick rather than for curing them. The population with an official certificate of poverty (which identified a person without minimal resources or the capacity to obtain them) had priority to be treated in these institutions free of charge.[18] In 1909, the census of poor families in Spain showed the figure of 813,815 (around 3.25 million inhabitants if we take into account an average of approximately four members per family). Meanwhile, there was a total of 7,769 doctors in charitable establishments in 1909, which was equivalent to a ratio of 418 poor people per practitioner.[19] However, they were unequally distributed geographically and thus, in rural areas and in the smaller municipalities, infectious or more seriously ill patients were sent to hospital in the provincial capital. The cost of a poor sick person's stay was covered by the municipality where he or she was registered, which at times led to non-payment or disputes between the provincial commission and municipal councils.[20]

There were also hospitals classified as private charity (which belonged to the Church because they had not been disentailed or were privately owned) existing alongside this precarious network of public charity. These hospitals received private funds from their founders (income, public debt, urban and rural real estate), and they were managed

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by their patrons as foundations (voluntary hospitals). Private charity had its own legislative framework.[21] According to official statistics, there were 337 private charitable hospitals in Spain in 1886, concentrated above all in three provinces: Barcelona (41), Navarre (36) and Cordoba (33).

Table 1.2: Charitable Establishments financed with private funds from their respective founders in 1886

Province	Hospital	Population*	Province	Hospital	Population*
Álava	-	102,494	León	4	354,737
Albacete	1	221,444	Lérida	-	330,677
Alicante	5	426,636	Logroño	19	184,073
Almería	-	352,946	Lugo	10	464,358
Ávila	8	176,769	Madrid	10	491,984
Badajoz	6	430,049	Málaga	4	490,826
Baleares	-	284,398	Murcia	13	427,208
Barcelona	41	749,443	Navarre	36	316,340
Burgos	21	387,856	Orense	-	394,638
Cáceres	3	303,700	Oviedo	-	588,031
Cádiz	3	417,346	Palencia	2	194,527
Canarias	-	267,036	Pontevedra	2	469,439
Castellón	5	288,921	Salamanca	6	281,511
Ciudad-Real	-	264,908	Santander	7	236,105
Córdoba	33	379,464	Segovia	16	134,262
Coruña	1	609,337	Seville	4	500,567
Cuenca	-	242,231	Soria	-	157,173
Gerona	-	322,631	Tarragona	-	341,601
Granada	2	478,347	Teruel	1	250,604
Guadalajara	9	211,249	Toledo	14	343,951

Province	Hospital	Population*	Province	Hospital	Population*
Guipúzcoa	11	176,297	Valencia	3	648,159
Huelva	-	191,303	Valladolid	15	255,438
Huesca	-	272,157	Vizcaya	-	183,098
Jaén	-	390,115	Zamora	21	262,524
			Zaragoza	1	403,362
Spain, Total	337	16,642,273			

Source: For hospitals see *Reseña geográfica y estadística de España*, 1888, 52, 1030-31. For population see Statistical Yearbook of Spain (*Anuario Estadístico de España),* 1866-1867, 53. *Inhabitants in December 1867.

The territorial distribution of these hospitals did not correspond to demographic criteria; the most populated provinces of the country did not have more establishments. Consequently, there were considerable territorial inequalities. We do not have data available on what kind of sick people were admitted, how many combined charitable care with paying patients, or how many focused exclusively on providing refuge for children, the elderly and the chronically and incurably sick. However, most of them were run by trusts comprised of members of the medical class and the urban patriciate.

The patrons defended the classification of their hospitals as private charity, and themselves as benefactors, in order to obtain more freedom in their management, but also to take advantage of tax exemptions and other benefits. One of the most paradigmatic cases is that of Hospital de Santa Creu in Barcelona, which was the city's only hospital for more than five hundred years and a benchmark scientific institution in the country. An order of 15 September 1853 declared it a public and provincial establishment. Nevertheless, in the following decades the managers who ran the hospital fought to convert it into a private charity hospital and thereby prevent Barcelona's financial authorities from carrying out an operation to confiscate its property and assets. On 18 June 1874,

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the Directorate General for Charity, Health and Penitentiary Establishments (*Dirección General de Beneficencia, Sanidad y Establecimientos Penitenciarios*) revoked the public classification and declared Hospital de Santa Creu a private charity establishment.[22] This reclassification enabled the hospital's patrons to regularly apply for exemption from paying the taxes levied on the assets of legal persons, which contributed to the preservation of its considerable assets, beyond the control of the public authorities.[23] These assets were further increased by means of bequests and raffles.[24] Over time, these institutions, without losing the charitable category that benefited them fiscally, increased their supply of pay beds and, in future stages, especially from 1942, participated in economic agreements with public institutions to cover the demand for beds in the public hospital system.

This public and private hospital network proved to be increasingly insufficient in the light of Spain's economic, urban and industrial development from the late nineteenth century, within a framework of growing social demands, notable among which were calls for the extension and improvement of health coverage for the population as a whole.[25] This process was accompanied by advances in bacteriological research, especially from the 1870s onwards, which opened the way to significant progress in the care and treatment of transmissible diseases (tuberculosis, cholera, diphtheria and malaria). This in turn led to the need to create new facilities such as laboratories and diagnostic devices. Within this context, the function of hospitals changed, and Spain was no exception. Some of the old hospitals, now obsolete, were demolished (*Hospital de San Juan de Dios* in 1897), others were renovated (*Hospital Provincial de Madrid*) and, in some cases, transferred to new locations (*Hospital del Buen Suceso* was founded in 1583 and transferred to a new site in 1885, and Hospital de los Franceses was created in 1615 and relocated in 1881). This process of change also included the creation of clinical hospitals with a heavy focus on teaching and research linked

to universities and training. Thus, *Hospital Clínico de Madrid* (founded by the central state) became a university hospital in the first decades of the twentieth century and the clinical hospital in Barcelona, work on which had commenced in 1881, was opened in 1906. Meanwhile, as regards public hospitals, despite limited resources and within a system that was archaic in terms of both management and materials, a number of important research and teaching initiatives led by prominent specialists emerged in diverse surgical specialities. This was the case, for example, of the *Instituto de Terapéutica Operatoria*, founded in 1880 by the surgeon Federico Rubio y Galí as a department—with two wards of twenty beds for men and women—within the obsolete *Hospital de la Princesa* in Madrid.[26] This institute played a key role in the training of doctors and nurses during the 1880s in a context of high mortality, especially infant mortality, in Spain as a whole, but also in Madrid.[27]

However, in the first three decades of the twentieth century, the main problem relating to hospital coverage in Spain lay in the high percentage of the population that was not officially registered poor (*pobre de solemnidad*) but also could not afford to pay for health care services. This was the case of two large segments of the population: the growing mass of urban labourers along with the urban middle class, and the vast population engaged in agriculture (around half of the active population). The latter group had to make do with the archaic system of coverage provided by rural municipal hospitals or provincial hospitals. Consequently, workers who were not treated by these hospitals turned to friendly societies to seek medical attention, even though this usually entailed no more than primary medical care due to the limited resources of most of these institutions. There were exceptions, however, such as the dense network of Catalan friendly societies that was able to create a small hospital network. In 1939, the Federación de Mutualidades de Cataluña (Federation of

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Mutual Benefit Societies in Catalonia) encompassed 1,023 affiliated mutual societies with a total of 334,881 members.[28] Some of these (*La Quinta de Salud La Alianza, Mutual Salus, Clínic Rabasa* and *Alianza Mataronense*, among others) provided clinic and hospital services without a time limit for patients' stays.[29]

Industrial employers, for their part, obliged by law to treat employees injured in accidents as from 1900, promoted small clinics providing trauma surgery and associated specialties by means of mutualism or insurance contracts. Large companies in sectors with significant accident rates—mining and the railways—acted more directly by establishing and financing their own hospital systems through foundations or local institutions. This was the case of the hospital in Riotinto, Huelva, and the Triano mining hospitals (Gallarta, Matamoros and El Cerco) in Biscay province.[30] Finally, doctors who worked in public or private charitable hospitals frequently funded small, specialised clinics to meet a growing demand for new varieties of surgical coverage from the middle classes and insurance companies and mutuals. The increase in small clinics was especially significant in Catalonia and the Basque Country—the most industrialised regions and with a greater percentage of urban population—founded by urologists, gynaecologists and other specialists. These clinics incorporated diagnostic advances such as laboratories and X-rays and further improvements including electric lighting in operating theatres, ventilation and aseptic wards. Clinics and polyclinics offered modernisation in comparison with the outdated public hospitals and attracted the middle and upper classes. Examples of this process include *Clínica San Ignacio* in Guipúzcoa (1906), and *Clínica Corachán* (1921), *Clínica Platón, Clínica San Jorge* and *Clínica Bretón* (1925) in Barcelona. In this way, private professional initiatives increased the supply of private beds as opposed to the public sector apathy during the period of Primo de Rivera´s Dictatorship (1923/30) rooted in charity and incapable of establishing a public health system

similar to other Western European countries.[31] Political apathy, a lack of state resources due to an obsolete tax system, and opposition from the medical profession and private insurance companies delayed the introduction of a sickness insurance system that required new infrastructure and a substantial budget.[32] This led to better hospital coverage and more beds available in industrial regions, which in the long term created territorial inequalities in health care coverage.

The hospital system in Spain after the passage of compulsory public sickness insurance (1936/63)

The trend described above for the creation of the hospital map in Spain during the first decades of the twentieth century was interrupted by the Spanish Civil War (1936/9), which affected the medical class profoundly. An important element had to go into exile, thereby interrupting some clinical projects; others saw how their hospitals were destroyed or seriously damaged during the conflict that led to the establishment of the Franco Dictatorship (1939/75).[33] Under these circumstances, new political and propaganda propositions linked to National Catholicism (an ideology represented by the Falange, the single party of the fascist dictatorship) had a significant impact on the gestation process of the hospital system in Spain.[34] The Falangists maintained control of the Ministry of Labour (*Ministerio de Trabajo*), also responsible for social and family policies, and which entailed control of the National Welfare Institute (*Instituto Nacional de Previsión*; hereinafter INP), the managing body of the social insurance schemes. Using paternalistic language and intense propaganda, the Falange sought to win over the masses to its cause, proposing measures to protect the traditional Catholic family, through subsidies, birth rate and marriage prizes, and large-scale

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social projects, championed by the introduction of compulsory sickness insurance (*Seguro Obligatorio de Enfermedad*, hereinafter SOE). This form of insurance was one of the most desired by the population in the long, tough post-war period in Spain and it was the only social insurance that had not been legislated for before the Spanish Civil War, which added further value to the Falange's social project.

Figure 1.1: Interior view of one of the many buildings that were adapted as "blood hospitals" during the Spanish Civil War.

Source: Biblioteca Nacional de España, ref. GC-CAJA/114/14

The urgency of implementing this insurance scheme led to it being passed quickly in 1942. However, this was without an accompanying financial plan or sufficient infrastructure for its application.[35] Spain's

precarious economic situation, characterised by autarky and the post-war economic crisis, obliged two important decisions to be taken. First, from the outset the insurance scheme was severely limited in terms of coverage of the population (it was initially only for the lowest-paid industrial workers in a country with a predominance of agricultural labourers)[36] and provisions (initially only general practitioners, with no specialities or hospital services apart from emergency surgery). In any case, insurance opened the door to a new form of health coverage for part of the population, unconnected with traditional charity (for the poor) and private health care (for those who could afford to pay for it). Second, in view of the lack of resources, senior figures at the Ministry of Labour decided to hand over management of the new health insurance to the private sector (including both private for-profit and non-profit mutuals) for over a decade. In return, the private sector provided the administration, medical staff and infrastructure (clinics and hospitals) required to cater for insured workers. In 1945, the collaborating bodies covered 55% of the companies affiliated to the SOE, comprising 77% of the insured. In 1955, coverage was still 40% and 64% respectively.[37] These management agreements were by no means free of tension between the private sector and Falange leaders who, from 1963, with an incipient but insufficient public hospital network, recovered public management of compulsory sickness insurance through the Basic Law of Social Security.

In order to achieve this control and consolidate its social project, in the 1950s the INP tried to implement its own National Healthcare Facilities Plan (*Plan Nacional de Instalaciones Sanitarias*). This plan envisaged the construction of a network of primary health care centres (outpatient clinics) and above all large hospitals (known as *'residencias sanitarias'*) throughout the country. Public hospitals surviving in the post-war period (state, provincial and municipal) were not used for the SOE or the Facilities Plan. This was a consequence of the power

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struggle between the INP—under the control of the Ministry of Labour, which was in the hands of Falange—and the Directorate General for Health (*Dirección General de Sanidad*, hereinafter DGS)—under the control of the Ministry of the Interior (*Ministerio de Gobernación*)—which was in the hands of the Catholic branch of the dictatorship's power groups. Many of these old hospitals continued, although with obsolete infrastructure, to provide charitable functions as refuges, under the control of the DGS, which was basically responsible for public hygiene and control of epidemics. This body was also charged with meeting the basic health care needs of rural Spain, beyond the scope of the INP's ambitious projects. In this way, the rural population was doubly marginalised by the dictatorship in terms of health care, as it was left on the side-lines with regard to both the coverage of the SOE and the construction of basic care facilities. This was especially significant if we bear in mind that Spain was predominantly an agrarian society in its production structure and distribution of employment until the 1960s.

The objectives of the Facilities Plan had to be reduced on several occasions due to the lack of material and financial resources in a country still hit by shortages and harsh living conditions. The large and spacious INP hospitals were built slowly, and many remained underused once the work was finished, due to a lack of human and material resources. Official sources show sixty-three *residencias sanitarias* built throughout Spanish territory with a capacity of almost 12,000 beds in a country with a population of 30.6 million; although probably in many cases the building work had still not been completed and others that were finished had not started functioning. Some reports from this time reveal that most of the hospitals built remained underused; some did not even have permanent staff or the organised provision of integrated services and specialities.[38] Furthermore, the administrative and executive management of health care facilities, including hospitals, under the umbrella of the INP was concentrated

in a single body dependent on the Institute's provincial authority (*delegado provincial*). This arrangement gave preference to the political control of functions and relegated good resource management and the quality of services to second place. Moreover, the vast majority of directors or managers responsible for public health centres were 'health inspectors politically connected to the governing regime, or persons linked to the regime who always had the approval of the civil governor who was, at the same time, the Provincial Head of the Movement'.[39]

Table 1.3: 'Residencias Sanitarias' of the National Welfare Institute (INP) in 1963

Province	No.	Beds	Population	Beds per 1,000 inhab	Province	No.	Beds	Population	Beds per 1,000 inhab
Álava	1	144	138,934	1.04	Logroño	1	240	229,852	1.04
Albacete	1	190	370,976	0.51	Lugo	1	115	479,530	0.24
Alicante	1	363	711,942	0.51	Madrid	9	857	2,606,254	0.33
Almería	1	329	360,777	0.91	Málaga	1	307	775,167	0.40
Ávila	1	67	238,372	0.28	Murcia	0	0	800,463	0.00
Badajoz	1	424	834,370	0.51	Navarre	0	0	402,042	0.00
Baleares	2	398	443,327	0.90	Orense	1	23	451,474	0.05
Barcelona	2	773	2,877,966	0.27	Oviedo	3	688	989,344	0.70
Burgos	1	309	380,791	0.81	Palencia	1	100	231,977	0.43
Cáceres	1	217	544,407	0.40	Las Palmas	1	268	453,793	0.59
Cádiz	2	242	818,847	0.30	Pontevedra	1	250	680,229	0.37
Castellón	0	0	339,229	0.00	Salamanca	0	0	405,729	0.00
Ciudad-Real	2	46	583,948	0.08	Castellón	5	35	490,655	0.07
Córdoba	1	364	798,737	0.46	Santander	1	156	432,132	0.36
La Coruña	1	258	991,729	0.26	Segovia	0	0	195,602	0.00
Cuenca	0	0	315,433	0.00	Seville	1	593	1,234,435	0.48

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Province	No.	Beds	Population	Beds per 1,000 inhab	Province	No.	Beds	Population	Beds per 1,000 inhab
Gerona	1	291	351,369	0.83	Soria	0	0	147,052	0.00
Granada	1	428	769,408	0.56	Tarragona	0	0	362,679	0.00
Guadalajara	1	148	183,545	0.81	Teruel	1	160	215,183	0.74
Guipúzcoa	1	330	478,337	0.69	Toledo	0	0	521,637	0.00
Huelva	1	304	399,934	0.76	Valencia	1	411	1,429,708	0.29
Huesca	0	0	233,543	0.00	Valladolid	1	310	363,106	0.85
Jaén	1	176	736,391	0.24	Vizcaya	1	600	754,383	0.80
León	2	53	584,594	0.09	Zamora	1	99	301,129	0.33
Lérida	1	254	333,765	0.76	Zaragoza	2	648	656,772	0.99
Spain Total	56	11.968	30,430,998	0.39					

Source: BOE, no. 140, 13 June 1966, 7389-427; Population from Statistical Yearbook of Spain (*Anuario Estadístico de España)*, 1963, 455.

In general terms, the place and the programme to build each *Residencia Sanitaria* were decided according to political criteria based on the power and contacts of each provincial governor. These criteria resulted in territorial inequalities between population and beds (Table 1.3). All in all, bureaucratic management, scarce resources and precarious care provision converted each of these '*residencias sanitarias*' into a kind of large, underused polyclinic that performed its function inadequately. Basically, at the start of the 1960s, those affiliated to the SOE attended these hospitals for surgery, but for little else.[40] Consequently, the agreements with the private sector continued in force.

In any case, and in spite of the slow progress, the INP's '*residencias sanitarias*' gradually gained weight in Spain's hospital system and were treating a growing number of people, as the percentage of the population covered and the provisions offered by the SOE increased (Table 1.4). The number of public hospitals diminished compared with 1949 (1949: 737 and 1963: 589), but the number of beds increased (1949: 89,079 and

1963: 100,782). The drop in the number of hospitals was due, above all, to the closure of old hospitals of municipal and provincial charity. The increased number of beds was mainly due to the construction of large '*residencias sanitarias'* located in provincial capitals and other cities of high demographic concentration. Meanwhile, the state had also increased the number of hospitals for treating tuberculosis and other infectious diseases and mental hospitals under the direction of the DGS. The 'state' group also included hospitals attached to the Ministry of Education, which were, essentially, the clinical hospitals of the Faculties of Medicine, and prison health care institutions attached to the Ministry of Justice.[41] On top of these must be added the 48 military hospitals operating in Spain in 1963, created to treat troops and officers during times of peace and in wartime.[42] Finally, the number of hospitals under the control of the *Secretaría General del Movimiento* (SGM) of the Falange, which basically treated party members in the absence of other infrastructure, remained almost unchanged between 1943 (41) and 1963 (43).

With regard to the private hospital system from 1949 to 1963, the number of establishments increased between 1949 (885) and 1963 (1,037) along with the number of available beds, 38,264 and 52,109 respectively (Table 4). Altogether, the group of private hospitals accounted for almost sixty-six per cent of the total number existing in Spain in 1963. This group had a very diverse composition, and included clinics and hospitals founded by the Church (93), the Spanish Red Cross (*Cruz Roja*) (38), private benefactors (105), and two more that are difficult to categorise.[43] However, the most heterogeneous group of private hospitals in 1963 comprised those classified as 'privately owned' and which amounted to a total of 799 centres in this year. This increase was largely due to the converging interests of the government and the private sector. The development of maternity clinics was especially noteworthy within this group at a time when Spain initiated a historic 'baby boom' and the SOE did not have sufficient facilities to provide this service. Only one maternity

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hospital of the SOE appeared in the 1963 catalogue, managed by the INP and located in Madrid. Meanwhile, there were around thirty maternity centres under the control of municipal and provincial authorities (some of them successors to the old charitable maternity homes founded in the nineteenth century) and 107 private clinics specialised in maternity care. Meanwhile, the DGS, outside the Falange's control, catered to the needs of the rural population through the so-called *Centros Maternales de Urgencia* (emergency maternity centres), located in small municipalities or district centres. For any other type of medical care, the rural population had to travel to the nearest charitable provincial and/or municipal hospitals or otherwise pay for the services of a private clinic.

Table 1.4: Transformations of the public and private hospital map in Spain (in percentage)

	1949		1963		1981	
	1	2	1	2	1	2
Publicly Owned						
Military	9.09	20.48	8.15	14.05	9.05	7.90
State (P.N.A. y E.T., DGS, others)	17.37	20.43	27.84	25.79	1	2
INP	4.88	1.52	9.51	11.72	1	2
SGM	5.56	2.61	7.64	2.18	50.37	57.25
Provincial Council	19.00	41.56	20.37	39.37	26.41	31.39
Municipal Council	44.10	13.40	26.49	6.89	14.18	3.46
Total public (A). Number	737	89,079	589	102,250	409	130,298
Privately Owned						
Church	12.77	34.05	8.97	32.63	10.08	21.73
Spanish Red Cross	3.62	3.83	3.66	3.82	5.12	5.48
Private (profit-making and charitable)	83.62	62.12	87.37	63.55	84.81	72.79
Total private (B). Number	885	38,264	87.37	52,036	645	63,598

A in total (%)	45.44	69.95	36.22	66.28	38.80	67.20
B in total (%)	54.56	30.05	63.78	33.73	61.20	32.80
Total A+B. Number	1,622	127,343	1,626	154,268	1,054	193,896

Notes: 1. Number of establishments; 2. Number of beds. *It refers to inpatient units. Source 1949: Statistical Yearbook of Spain (*Anuario Estadístico de España)*, 1951, 684; Source 1963: *Boletín Oficial del Estado* (Official State Gazette) 13 June 1966, no. 140, 7389-427. In the 1963 catalogue hospital infrastructure in the colonies is also recorded: (Fernando Po (4), Río Muni (11) and Spanish Sahara (5); all under the presidency of the Government). This source also includes the hospitals of the *Secretaría General del Movimiento* (S.G.M.) and the *Patronato Nacional Antituberculoso y de las Enfermedades del Tórax* (P.N.A. y E.T.); Source 1981: Statistical Yearbook of Spain (*Anuario Estadístico de España)*, 1985, 709.

Overall, the hospital map in Spain from 1949 to 1963 shows three relevant trends. First, as regards publicly owned hospitals, there was a very significant fall in the number of old charitable hospitals managed by municipal and provincial institutions, an increase in the number of large hospitals and bed capacity of the INP (under the Facilities Plan) and a more modest growth in the number of hospitals under the DGS, specialising above all in treating infectious diseases such as tuberculosis, which had a great impact on Spain in the post-Civil War period. Finally, the number of military hospitals and the number of beds they provided fell around 30 per cent between 1949 and 1963. Second, with regard to privately owned hospitals, the Church reduced the number of hospitals it had operating (most dedicated to charitable functions and serving as refuges), while the number of private hospitals increased, driven by market opportunities and agreements signed with the SOE. Generally speaking, the hospitals providing shelter and charity lost weight in circumstances where some of their users were able to receive care or treatment under the SOE. Third, and paradoxically, the implementation of the sickness insurance scheme led to a fall in the number of public hospitals compared with private

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Figure 1.2: Illustrated scale model of the Residencia Francisco Franco (Barcelona), the first "Residencia Sanitaria" (large hospital) inaugurated by the Franco dictatorship in 1955.

Source: Catálogo Plan de Instalaciones del Seguro Obligatorio de Enfermedad. Huarte y Cía, S.L. constructor.

hospitals, although there was a more comparable trend for both types in terms of the number of beds, due to the large capacity of the new hospitals built by the INP.

The 1960s saw some significant changes in the dictatorship's policies. The Falangists lost political power at the highest levels, and their capacity to mobilise the masses was diminished. The so-called technocrats took over most of the ministerial posts and the regime initiated the path laid down by the Stabilisation Plan of 1959, a plan

dictated and financed to a large extent by the International Monetary Fund. In any event, health coverage was a goal to be achieved. Two decades after its introduction, there were now five million insured under the SOE, and around 7.5 million beneficiaries between direct insurance and the collaborating entities, which altogether accounted for thirty-nine per cent of the total population. During this initial period the limited public hospital network provided the private sector with a market niche, either by covering the population without any right to coverage, or through the signing of agreements by means of which the SOE was applied.

In summary, the system of social insurance introduced by the Franco dictatorship was an indispensable instrument within the overall strategy of propaganda and subjugation of the workers.[44] In particular, sickness insurance played a key role in the dictatorship for two fundamental reasons. First of all, before the Civil War, the state did not legislate, regulate or fund the area of health care provision, which remained in the hands of mutual societies and private companies. This resulted in substantial deficiencies in the coverage of the population. The dictatorship took advantage of the weakness of these institutions, and of the gap in state regulation of the risk of sickness, to convert this insurance into a key element of its political propaganda. Once the subordination of the workers had been achieved through the repressive measures that were imposed by means of strict labour regulation, it was necessary to ensure a certain degree of social stability. In order to achieve this aim, the regime needed to show a 'friendlier' face to workers. Social insurance and family policies, which included goals typical of fascist regimes such as encouraging a higher birth rate or defending maternity and the traditional family, fulfilled this role to perfection. The construction of hospitals fitted well into this framework.

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Limited transformations of a hospital model in permanent imbalance in the last years of the dictatorship: 1963/75

The Spanish economy experienced strong growth in the 1960s, which was accompanied by a baby boom and a massive rural exodus. Population growth, urbanisation and improved living conditions brought new consumption habits and greater demand for health care, which highlighted the fragile public health and hospital system developed in previous decades. In particular, three major shortcomings came to light: a) health care philosophy was based on limited care in terms of coverage and provision, a model far removed from the universal health care existing in other European countries; b) funding, in view of the scarcity of public resources, encumbered by an archaic tax system inherited from the nineteenth century, and the prevalence of propaganda purposes in a dictatorship with insufficient political will to promote a modern hospital system; c) management, with underutilisation, lack of coordination and poor administration of available hospital establishments and services. In this regard, it is important to bear in mind the diversity of owners and management bodies of the public hospitals shared between the Ministry of Labour (to which the INP, managing body of the SOE, belonged), the Ministry of the Interior (to which the DGS belonged), the Ministry of Education (responsible for the clinical hospitals) and the Ministry of Justice and the Army (military hospitals). This complex map was completed by the provincial and municipal institutions that continued to manage most of the country's public charitable hospitals.

Within this context, two key laws for health coverage were passed: the law of 1962 regulating hospitals and the Basic Law of Social Security of 1963 (implemented in 1967). The former was intended to improve coordination between the various administrations and hospital networks existing at that time. However, a substantial part of this legislation was

not implemented due to the lack of public health resources. Nevertheless, this paralysis did not block the process of building large public hospitals or a modest improvement in hospital care, above all in large cities. The law of 1963 was theoretically intended to pave the way towards universal health coverage, increase the state's financial contribution, and improve provision. In practice it consolidated a shared system, sustained by the social contributions of employers and workers (particularly onerous for the latter in a context of low wages), while at the same time it demonstrated that universalisation was not economically possible, for the time being.[45] Perhaps the main novelty of this legislation was the suppression of any possible profit-making intention of the managers of the social insurance schemes, which entailed the elimination of the agreements for the private management of the SOE. Consequently, health coverage progressed very slowly from 41.8% of the population in 1965 to 54.28% in 1970 and 61.74% in 1975, the last year of the dictatorship. This general system of coverage coexisted with other special regimes that provided health coverage to groups of workers excluded from the SOE (agriculture, marine workers, coal industry, services, self-employed etc.), either due to the resistance of employers, or the economic limitations of the insurance, or because they preferred to remain under a system that offered better coverage and provisions than the general regime (especially in the case of white-collar workers). On the other hand, 75.2% of public health expenditure was still funded through social contributions in 1980; financing through taxes only started to become predominant from 1989.[46] The problems of funding the public health system in general, and the hospital system in particular, made this insurance scheme one of the main destabilising elements of the Social Security accounts in Spain at this time.[47]

Despite all these difficulties, there were some significant developments in the hospital sector during this period. First, the INP tried to respond to the growing demand for coverage with the construction

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of *ciudades sanitarias* (large complexes comprising a group of adjacent independent buildings specialising in maternity, trauma and orthopaedics, children etc. that shared services such as laboratories, laundry or cafeteria).[48] Work on building *ciudades sanitarias* commenced in 1964 in the large provincial capitals: Madrid, Barcelona, Valencia, Seville, Zaragoza, Oviedo and Bilbao. In most cases (except Madrid and Valencia) these *ciudades sanitarias* were built around the large hospitals created under the Facilities Plan. This process reinforced the hospital-based health care model that was being established in Spain.[49]

Second, planning of hospitals in the new *ciudades sanitarias* was designed within a new organisational framework and with a renewed philosophy of health care as a public service, that is, as a right rather than as a work of charity. This was achieved thanks to the implementation of the Basic Law of Social Security of 1963.[50] In this situation, a paradigm shift occurred in the training of medical specialists. In the first decades of the twentieth century, most doctors trained as assistants of a skilled practitioner in the doctor's surgery or hospital.[51] In the 1950s, a new generation of doctors understood that in order to specialise with any degree of assurance it was necessary to go abroad, as they were not guaranteed adequate training in Spain. These doctors who travelled to the United States or countries in Western Europe became a key element in the modernisation of medicine in Spanish hospitals, both public and private, and in the introduction of new medical and surgical specialities. In particular, the training of doctors as specialists under the MIR medical internship system, based on 'learning by working', had originated at Johns Hopkins Hospital (Baltimore, USA) in the late nineteenth century and was incorporated into the Spanish hospital system in the 1960s by a group of doctors who had undertaken their specialist training in the United States.[52] Within this process, the percentage of doctors who worked in hospitals in Spain grew (1949: 32.8%, 1963: 39.7% and 1973: 68.4%).[53] The instigation of training programmes for medical specialists, the pro-

fessionalisation of the body of nurses and assistant nurses as opposed to the voluntary and religious personnel present in a large number of hospitals, and the creation of a board of directors with a hospital manager of a more technical and professional nature, enabled the old *residencias sanitarias* to be transformed into more modern hospitals. Meanwhile, in order to train the management and administrative staff, the first training course for hospital managers was organised in 1967.[54] Third, and as part of this new strategy, the dictatorship promoted the inauguration of new university clinical hospitals geared towards teaching and training. Their objective was the renewal of education in the medical faculties and subsequent coordination with the Social Security.

The desire to modernise was present in all of these initiatives. However, progress was slow. In fact, what is seen is a Spanish hospital structure where two contradictory systems were forced to coexist.[55] First, there were still a considerable number of hospitals (above all of a charitable nature) operating under the old model from the previous stage, which were coexisting with new thriving (private and public) hospitals, with a heavy focus on teaching and research and a more professional management. That is to say, there was a problem of lack of integration, coordination, planning and the rational use of resources because there was no state institution that properly coordinated this complex hospital structure. Second, the new hospitals needed to expand their outpatient facilities while the old outpatient clinics needed hospitals. Third, there was an increase in the number of doctors trained through modern teaching programmes that did not find employment in the 'old' hospitals.[56] This enforced coexistence led to serious defects and aggravated the organisational crisis inherited from previous decades.

All in all, in the final years of the Franco dictatorship (1939-75), the Spanish hospital system was near to collapse, with three basic problems: insufficient coverage, provision and infrastructure;

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heterogeneous strategic approaches and management; and funding problems.[57] These were three problems inherited from previous stages that were exacerbated in a situation where the hospital function had finally started to be modernised in Spain. The hospital map available for 1981 reveals the perpetuation of a model consisting of a constellation of numerous hospitals of different proprietorship and different stages of development. Nevertheless, the extension of coverage both in terms of provision and the number of insured, along with the increasing number of beds available in the *residencias sanitarias* of the SOE, weakened the role of the provincial, and especially the municipal, public charitable hospitals, which in 1981 showed a decline in number and in beds compared with the preceding period (Table 4). Nevertheless, the construction of large centres such as the *residencias sanitarias* and the *ciudades sanitarias* as a result of public insurance increased the weighting of hospital beds available in the public sector compared with the private sector (Table 1.5). However, it is necessary to be aware of the limitations of these figures. In this regard, an article published in the *El País* newspaper in 1977 pointed out that 'the national statistics in the Catalogue of Hospitals would lead to false conclusions. There are many centres with an extremely low occupation rate and others that should be closed. We have found numerous examples that do not meet minimum standards either technically or in terms of comfort'.[58] There was still a long way to go within an exceptionally turbulent political context (lack of leadership at the national level) and social conflict (strikes and protests) and in the middle of the country's transition to democracy after almost forty years of dictatorship.[59] The 1970 Foessa Report revealed that Spain had one of the most deficient hospital situations in Europe.

Table 1.5: Hospitals and beds in Spain according to property ownership

Year	Public		Private		Total	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
1949	737	89,079	885	38,264	1622	127,343
1963	589	102,250	1037	52,036	1226	154,286
1973	488	125,254	797	55,293	1285	180,547
1977	476	132,907	753	61,190	1229	194,097
1981	409	130,298	645	63,598	1054	193,896
1986	380	116,938	509	54,922	889	171,860

Source: See Table 4 and for 1973, 1977 and 1986, see *Estadística de Establecimientos Sanitarios con Régimen de Internado*, web INE (1978), AEE (1980), 349 and (1990), 118. Source 1981: Statistical Yearbook of Spain (*Anuario Estadístico de España)*, 1985, 709.

The exclusion of insurance companies and mutuals from the private management of the SOE after the implementation of the Basic Law of Social Security of 1963 did not result in the decline of private hospitals. They actually flourished on the basis of agreements to provide beds for surgery patients who were insured under the SOE, along with the demand for private hospitals to cover certain specialities, especially gynaecological, and for the provision of medical attention to an emerging middle class and public servants with privileged mutual coverage. Although there are no public data on the number of agreements between private sector hospitals and the Social Security (former INP and SGM hospitals, see Table 1.4), the *Anuario Financiero y de Sociedades Anónimas* yearbook for 1980, with data from 1964 to 1980, includes the creation of joint-stock companies in the hospital sector, especially in Madrid (15) and to a lesser extent in Barcelona (5) and Biscay (4). This coincides with the demand for hospital care linked to urban growth, increased incomes and a shortage of beds. As a result of these factors, the number of private beds grew continuously from 52,036

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in 1963 to 63,598 in 1981. However, the number of hospitals belonging to the entire private sector was actually declining, falling from 1,037 to 645 in the same period (Table 1.5). The rise in the number of beds was due to the increase in the size of hospitals, a similar trend to the evolution of public hospitals. This process was linked to the closure and removal from the catalogue of establishments serving as refuges for the elderly, the closure of private establishments where there was little activity and also the grouping and re-categorisation of hospitals and medical centres that were previously accounted for independently. Within this group of private hospitals, comprising companies operating for profit but also the Church, the Spanish Red Cross and private charitable or voluntary hospitals, the latter continued to benefit from favourable tax treatment and were exempt from paying taxes imposed on the assets of legal persons. This was despite the fact that the number of pay beds was progressively increasing, which demonstrated that they were also engaged in profit-making activities.[60]

By the end of the dictatorship, the problems of the health system in general and the hospital system in particular continued to be very similar to those observed in the previous section. It is nevertheless true that the percentage of the population covered had increased, provision had been extended and there were more *residencias sanitarias*. Moreover, these public hospitals had improved with respect to private hospitals in terms of facilities and resources and had introduced new training methods for specialised medical staff. However, health care continued in the hands of the INP, an institute that managed the Social Security accounts in an opaque fashion and which had a long history of corruption, and the hospital system remained fragmented, without coordination, and with serious deficiencies in its internal functioning. The poor territorial distribution of hospitals had led to an unequal allocation of material and human resources (Table 1.6).[61] In general, the country lacked a health strategy in a framework where there was neither a Ministry of Health nor a general health law to define the model to follow. *Residencias Sanitarias*

and *Ciudades Sanitarias* continued to specialise in acute medicine and surgical operations, within a structure where public and private hospitals coexisted and collaborated in a number of ways.

When Franco died in November 1975, Spain had not recognised health care as a basic right, the SOE was far from achieving universal coverage (1975: 61.74%),[62] its provisions remained limited, its accounts had serious financial imbalances. There was no health law that defined the country's health care model and no Ministry of Health to manage the country's health policy in a coordinated and structured manner. Almost forty years of dictatorship had left too many tasks pending in the health sphere. Nonetheless, in 1981, on the verge of passing legislation to tackle these shortcomings, the public hospital system in Spain was actually evolving better than the private hospital sector, although it still required the collaboration of private hospitals (Table 1.4).

Table 1.6: Public and private hospital facilities in 1977 (Number)

Facilities	Social Security hospitals*	Private hospitals
Operating theatre	100	93
X-rays	96	80
Pharmacy	87	28
Emergency service	85	52
Laboratory	78	28
Radiotherapy	72	27
Blood bank	72	18
Intensive care unit	61	14
Artificial kidney machine	39	4
Cobalt bomb	24	2

Source: INP (Instituto Nacional de Previsión), *Investigación sobre la asistencia farmacéutica en España: Estudio socioeconómico sobre el conjunto de la asistencia sanitaria española* (Madrid: Ministerio de Trabajo, 1977), 285-306. *This basically refers to INP (*Residencias Sanitarias*, *Ciudades Sanitarias*), and SGM hospitals, see Table 4.

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On reflection: democracy, universal coverage and decentralisation of health care in Spain

The establishment of democracy in Spain enabled some key foundations to be laid for the development of the country's health care model. In 1977, Fernández Ordoñez's eagerly-awaited tax reform, which modernised the Spanish fiscal system, was approved. In the same year, it was agreed that the state contribution to financing Social Security would be progressively increased to 20 per cent of its budget. In 1981, this contribution was set at just 10.39% of the total revenue of the system, and the contribution of employers and employees was 73.85% and 13.14% of the revenue budget, respectively. Meanwhile, also in 1977, the INP (plagued by corruption and blighted by the opacity of its accounts) disappeared and a new institution was created for the administration and management of health care services, the INSALUD (*Instituto Nacional de Salud*; National Health Institute).[63] In parallel, during the first legislature of the democracy, the Ministry of Health was created (1977), which integrated all competencies in health matters, managed up to this point by the Ministry of the Interior, and the competencies of the Under-Secretariat for Social Security. The foundations for change had been set in place, but Spain still lacked a general law establishing a health and hospital system. The first governments of the democracy, from 1977 to 1985, were incapable of successfully implementing the project due to the lack of political consensus. Something similar occurred with the private health care sector, which during the years of the transition to democracy was awaiting necessary reforms to modernise both its regulatory framework and its business structure.

After years of debate on the health model since the beginning of the transition to democracy and no consensual solution, PSOE's victory with an absolute majority in the elections of 1982 opened the way to the success of the health bill in Congress. In presenting the bill to Parliament

in 1985, the Health Minister Ernest Lluch indicated that his project proposed the universalisation of provision (to meet social demand) and the creation of more employment in the health sector, free exercise of the medical profession (doctors who worked in public hospitals could also open private clinics) and an improvement in working conditions (a demand of unions and professional groups). Finally, in his speech the Minister pointed out that, in fact, 'it was not possible to establish a National Health Service' in Spain, as there existed a system allowing for 'political autonomy of services', although the state must provide minimum guarantees for all Spaniards (a demand of the autonomous communities—*comunidades autónomas*—that is, regional governments). Furthermore, the project proposed the 'maintenance of a mixed funding mechanism where social contributions continue to be considered as a source of funding', although with the intention to progressively increase the state's contribution. The passage of the bill encountered the opposition of conservative party (AP/PP)[64] and communist party (PCE), although from very different perspectives and strategies. The only consensus of all the groups seemed to be on the need for a health care reform and on the serious (financial, managerial and health care provision) problems of the Spanish health system.

After a stormy process of more than three years, with complicated negotiations among diverse political sectors, social forces and professional groups, the General Health Law was passed in 1986. It addressed the difficult task of laying the foundations for two complex processes:[65] the modernisation of Spanish health care and the decentralisation of its management. However, the text failed to satisfy almost anyone. The political right labelled the law as '*dirigista*' (dirigiste) and basically accused it of not establishing the free choice of doctor and health system.[66] Progressive sectors criticised the law for not setting up a national health service, along the lines of the British model, and for not guaranteeing that health care be provided totally free of charge

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(limited care benefits in some medical specialties) and, consequently, its universality. After numerous debates, adjustments, and a lack of consensus, the law, *Ley General de Sanidad (LGS) 14/1986, of 25 April*, was finally passed with the votes in favour of left-wing parties (PSOE and PCE) and Basque and Catalan nationalist parties (PNV and CIU),[67] which entailed the state legislative implementation of the right to health protection established in the Spanish Constitution. However, the text of this law contained more a set of principles and far-reaching goals than a plan for the immediate implementation of health reform.[68]

Meanwhile, the processes for the transfer of health care management to the autonomous communities had already begun, which by 1986 had now been assigned fifty-four hospitals with 14,604 inpatient units. The transfer of functions and services to the autonomous communities was initiated in 1981 with Catalonia and was concluded in 2001. The profound changes that Spanish health care underwent during this period with the passage of a health law, the process of transferring health care to the autonomous communities, the transformation of the hospital map and the modernisation of health and hospital services did not break the link between the public and private hospital sectors. Ernest Lluch stated during the debate on the health law in Congress that his project aspired to 'maintain a stable relationship between public and private health care' within the public sector's guidelines (demand of the private sector).[69] Moreover, he added that 'most of the private hospital sector in this country operates in relation to the public sector. In other words, it could not survive without having interaction with the public sector'. According to his calculations, only seventeen per cent of private health services were not part of agreements with the public sector. These services were used by high income groups. These words proved to be true, and during this period public and private hospital sectors continued to be closely linked.

Furthermore, the oil crises of the 1970s, the increase of the bed capacity of the public system and the consequent reduction in agreements signed with the private sector, along with the obsolete facilities of some small hospitals, triggered a crisis in the private hospital system. This was the case in Bilbao where, in 1984, the INSALUD rescinded the agreements of eleven small and medium-sized clinics.[70] This phenomenon was instrumental in the fact that the number of private hospitals fell again from 645 in 1981 to 509 in 1986 and the number of beds went from 63,598 to 54,092 (Table 1.5).

The private sector implemented numerous strategies to resist this downturn. Three of them are worth highlighting: the creation of associations of private hospitals and lobbies,[71] the need to modernise in order to meet the demand of civil servants' mutuals,[72] and the regional decentralisation of health care were the mechanisms that made it possible to overcome the crisis and reinforce the private system in the following decades.[73] With the devolution of health care competencies to the autonomous communities and the adoption of models closer to the interests of the private sector in some regions, the private hospital sector started to grow again. This growth was once again sustained by agreements with public health services, and some regional governments even handed over the management of public hospitals to private companies.

In conclusion, the originality of the Spanish public health model was determined by the long Franco dictatorship that made the adoption of a welfare state impossible, without a structural and financing model defined at the beginning, although some Bismarckian elements were incorporated to support the compulsory health insurance programme within a social contribution system. The long transition to democracy generated an in-depth debate over the health system model. Finally, a model financed in large part by the state (following the British model) was presented but opposing positions among political parties only

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allowed the passage of a Health Law. This law, although it progressively increased the financing of the state funding through taxes, did not manage to introduce universal coverage and benefits. In addition, its approval in 1986 went against the current of neoliberal policy processes that were underway in many European countries, imposing cuts in social spending, especially in public health systems. On the other hand, for pragmatic, financial and ideological reasons, the first state interventions under the Franco dictatorship when health insurance was created in 1942 had the opened way to the active collaboration of insurance companies and private hospitals insurance benefits.

The transfer of health care competencies to autonomous communities from the 1980s consolidated the public health model in many territories, especially those governed by left-wing parties, which put an end to signing of agreements with the private sector for the provision of health services. In other regions, especially those governed by conservative parties, health care management was encouraged in collaboration with private insurance and hospital companies. The key historical factors that determined the evolution of public and private health care derived from the state health model were both basically political (dictatorship and democracy) and financial (a regressive tax system until 1977). The dictatorship, for reasons of propaganda and ideology, delayed the adoption of health insurance that could be considered as part of a welfare state model. The lack of consensus in the first ten years of the transition to democracy prolonged this situation. Despite this, the Spanish health system managed to reach the top positions in the international health rankings by the end of the twentieth century. Public investment during democracy and the training of excellent professionals in the field of health care played a key role in this success. It may well be the case that this could have been achieved much earlier if the country had enjoyed democratic institutions similar to those of other Western European countries after the Second World War.

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* Corresponding Author. Email: mvilar@udc.es. Postal address: Margarita Vilar-Rodríguez; Facultad de Economía y Empresa, Universidad de A Coruña, Campus de Elviña, s/n, 15071 A Coruña (Spain).

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7. See, for example, Gerard A. Ritter, El Estado Social, su origen y desarrollo en una comparación internacional (Madrid: Ministerio de Trabajo, 1991); Thomas Janoski and Alexander M. Hicks (eds), The Comparative Political Economy of the Welfare State (Cambridge: Cambridge University Press, 1994), 254-77; Isabela Mares, The Politics of Social Risk. Business and Welfare State Development (Cambridge: Cambridge University Press, 2003); David M. Cutler and Richard Johnson, 'The Birth and Growth of the Social Insurance State: Explaining Old Age and Medical Insurance across countries', Public Choice, 120 (2004), 87-121.

8. Diputaciones were provincial government institutions created from 1812 onward, see Ana M. Rodríguez Martín, 'La participación femenina en la Beneficencia española. La Junta de damas de la casa de maternidad expósitos de Barcelona, 1853-1903', Cuestiones de Igualdad y la diferencia, 9 (2013), 134-57.

9. This criteria is the same as that used for Margarita Vilar-Rodríguez and Jeròmia Pons-Pons, 'Competition and collaboration between public and private sectors: the historical construction of the Spanish hospital system, 1942–86', The Economic History Review, 72 (2019), 1384-1408.

10. Pedro Carasa Soto, El sistema hospitalario español en el siglo XIX. De la asistencia benéfica al modelo sanitario actual (Valladolid: Universidad de Valladolid, 1985), 30-4. Josep M Comelles; Elisa Alegre-Agís and Josep Barceló-Prats, 'Del hospital de pobres a la cultura hospitalo-céntrica. Economía política y cambio cultural en el sistema hospitalario catalán', Kamchatka. Revista de Análisis Cultural, 10 (2017), 57-85; Margarita Vilar-Rodríguez and Jeròmia Pons Pons, 'The long shadow of charity in the Spanish hospital system, c. 1870-1942', Social History, 44, 3 (2019), 317-42.

11. This process obliged the sale of property belonging to religious corporations and the closure of many monasteries, convents, colleges and religious communities, which put an end to their tithes and other incomes. The disentailment laws cut off the sources of financing of religious charitable establishments. Consequently, some religious hospitals were destined for public use and came under the control of civil authorities, above all municipal or provincial councils. See Josep Fontana, Crisis del Antiguo Régimen 1808-1833 (Barcelona: Critica, 1979).

12. Mariano Esteban de Vega, 'La asistencia liberal española, beneficencia pública y previsión particular', Historia Social, XIII (1992), 123-8.

13. For the Basque case, see Pedro M. Pérez Castroviejo, 'La formación del sistema hospitalario vasco administración y gestión económica, 1800-1936', TST: Transportes, Servicios y telecomunicaciones, 3-4 (2002), 73-97. For Málaga, see the documentation deposited in the Diputación (Provincial Council) Archive, link: www.malaga.es/base/descargas/.../breve-historia-fondo-documental-hospital-civil (accessed 26 November 2018).

14. Ministerio de Gobernación, Apuntes para el estudio y la organización en España de las instituciones de beneficencia y previsión. Memoria de la Dirección General de Administración (Madrid: Establecimientos Tip. Sucesores de Rivadeneyra, impresores de la Casa Real, 1909), CI-CII and LXIV); Elena Maza, 'El mutualismo en España, 1900-1941. Ajustes e interferencias', in Santiago Castillo and Rafael Ruzafa (eds), La previsión social en la historia (Madrid: Siglo XXI, 2009), 333-68.

15. Statistical Yearbook of Spain (Anuario Estadístico de España) (1859-1860), 151, 160.

16. Ministerio de Gobernación, op. cit. (note 14), CI-CII and LXIV; and Maza, op. cit. (note 14), 336.

17. Using the population data of the National Statistics Institute (Instituto Nacional de Estadística, INE) for Spain in 1910, of 19,990,000 inhabitants (link: www.ine.es).

18. This certificate was required, for example, in the Hospital Hidrológico de Carlos III in Trillo in order to receive medicinal baths. Moreover, the document was supposed to indicate whether the poor sick person was in receipt of aid from any charitable association or corporation and, if so, how much. Gazeta de Madrid, no. 182, 1 July 1883, 2.

19. Ministerio de Gobernación, op. cit. (note 14), CI-CII and LXIV; and Maza, op. cit. (note 14), 336.

20. Gazeta de Madrid, no. 45, 12 February 1879.

21. Notably, among others, the decree of 27 April 1875 and another specific law of 14 March 1899.

22. Gazeta de Madrid no. 51, 20 February 1876, 429.

23. See for example the exemptions granted in the Gazeta de Madrid no. 106, 16 April 1913, 147; and Gazeta de Madrid no. 234, 21 August 1920.

24. One example would be the authorisation of the Directorate General for Taxation (Dirección General de Tributos) for a charity raffle between 28 April and 29 May 1963 for a total of 400,000 tickets costing 2.5 pesetas each, Boletín Oficial del Estado, BOE (Official State Gazette) no. 96, 22 April 1963, 6718.

25. Vicente Pérez Moreda, David-Sven Reher and Alberto Sanz Gimeno, La conquista de la salud: mortalidad y modernización en la España contemporánea (Madrid: Marcial Pons Historia, 2015).

26. Biblioteca Nacional de España (Spanish National Library), Fondos históricos digitalizados, Reseña del primer ejercicio del Instituto de Terapéutica Operatoria del Hospital de la Princesa (Madrid, 1881).

27. Pérez Moreda, Reher and Sanz, op. cit. (note 25). Madrid is described as the 'city of death' for this reason in Isabel Porras, 'Un acercamiento a la situación higiénico—sanitaria de los distritos de Madrid en el tránsito del siglo XIX al XX', Asclepio, Revista de historia de la medicina y de la ciencia, 54, 1 (2002), 219-51.

28. Marcel.lí Moreta i Amat, Cataluña en el movimiento mutualista de previsión

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social en España (Barcelona: unpublished manuscript, 1991), 69; Jerònia Pons Pons and Margarita Vilar-Rodríguez, 'Friendly Societies, Commercial Insurance, and the State in Sickness Risk Coverage, The Case of Spain (1880-1944)', International Review of Social History, 56 (2011), 71-101.

29. Jerònia Pons-Pons and Margarita Vilar-Rodríguez, El seguro de salud privado y público en España. Su análisis en perspectiva histórica (Zaragoza: Prensas de la Universidad de Zaragoza, 2014), 153.

30. Angel P. Martínez Soto and Miguel A. Pérez de Perceval, 'Asistencia sanitaria en la minería de la Sierra de Cartagena/La Unión (1850/1914)', Revista de la Historia de la Economía y de la Empresa, IV (2010), 93-124.

31. The causes of this backwardness can be found in the political apathy during the Primo de Rivera dictatorship and in the financial difficulties for implementation, see Francisco Comín, Historia de la Hacienda Pública II. España (1808-1995) (Barcelona: Crítica, 1996) vol II, 272. In addition, insurance companies and doctors opposed the implantation method, see Josefina Cuesta, Los seguros sociales en la España del siglo XX. Las crisis de la Restauración (Madrid: Ministerio de Trabajo y Seguridad Social, 1988), 415.

32. Vilar-Rodríguez and Pons-Pons, op. cit. (note 9).

33. For more on the hospital coverage of the two armies in conflict, see Jose M. Gómez Teruel, La hospitalización en Sevilla a través de los tiempos (Sevilla: Fundación Real Colegio de Médicos de Sevilla, 2006).

34. National Catholicism was the state consent that the Franco regime gave to the Catholic Church, as an institution legitimising the dictatorship, so that it could exercise control of decisive social and political spaces. Public morals, social behaviour, education and charity were subject to the authority and ecclesiastical norms of the Catholic hierarchy, see Carme Molinero, La captación de las masas política social y propaganda en el régimen franquista (Madrid: Cátedra, 2005).

35. The state did not contribute any money to the implementation of the SOE. 50 million pesetas of this period, coming from the funds of other social insurance schemes and family allowances, were used. Henceforth, the sickness insurance was sustained with the social contributions of workers (above all) and employers, in a context of precarious working and wage conditions, and recourse to the issue of public debt and credit from the Bank of Spain. Boletín de Información del Instituto Nacional de Previsión, 1944, no. 6, 853. This financing plan was foreshadowed in the Law of 1942, BOE 27 December 1942, 10592-97, art. 38.

36. For more on the health coverage of the agricultural population in Spain, see Margarita Vilar-Rodríguez and Jerònia Pons-Pons, 'La cobertura social de los trabajadores en el campo español durante la dictadura franquista', Historia Agraria, 66 (2015), 177-210.

37. Boletín de Información del Instituto Nacional de Previsión, 1944-1945; Revista Española de Seguridad Social, 1947-1951; Anuario Estadístico de España, 1950, 1955, 1960 and 1963.

38. See Margarita Vilar-Rodríguez and Jerònia Pons-Pons (eds.), Un Siglo de Hospitales entre lo público y lo privado (1886-1986) (Madrid: Marcial Pons, 2018), 226.

39. Carme Pérez, 'El misterio acceso a la gestión sanitaria', El Español newspaper, 3 February 2014, link: https://cronicaglobal.elespanol.com/pensamiento/el-misterioso-acceso-a-la-gestion-sanitaria_4526_102.html

40. The Residences or Sanitary Cities were built by the National Institute of Housing (Instituto Nacional de la Vivienda). See, for example, that of Valencia built in 1967. Decreto 2299/1967, 19 August, BOE, n. 224, 19 September 1967, 12967-8.

41. For more on these hospitals, see Jacint Corbella, 'Cent anys de medicina. La nova facultat i l´Hospital Clínic de Barcelona 1906-2006', Catálogo de la Exposición Cent anys de Medicina. La nova Facultat i l´Hospital Clínic de Barcelona 1906-2006 (Barcelona: Digitised, online, 2006), link: http://diposit.ub.edu/dspace/handle/2445/33946.

42. For more on the military hospitals, see Pablo Gutiérrez, 'Los hospitales militares y la sanidad militar. La transición de un modelo segregado a la creación del ISFAS (1940-1986)' in Vilar-Rodríguez and Pons-Pons, op. cit. (note 38), 367-400.

43. The particular features of the Church's centres can be found in Pilar León, 'Hospitales de la Iglesia Católica en España', in Vilar-Rodríguez and Pons-Pons, op. cit. (note 38), 325-66. In countries such as Ireland, see Donnacha Lucey, The End of the Irish Poor Law? Welfare and healthcare reform in Revolutionary and Independent Ireland (Manchester: Manchester University Press, 2015), and in France the Church was influential in the creation of the hospital system, see Timothy B. Smith, 'The Social transformation of Hospitals and the Rise of Medical Insurance France, 1914-1943', The Historical Journal, XLI, 4 (1998), 1055-87.

44. Jerònia Pons-Pons and Margarita Vilar-Rodríguez, 'Labour repression and social justice in Franco's Spain: the political objectives of compulsory sickness insurance (1942-1957)', Labor History, 53, 2 (2012), 245-67.

45. Pons-Pons and Vilar-Rodríguez, op. cit. (note 29), 219.

46. Rafael Aracil, Sistema Gráfico de información sanitaria en España (Madrid, MSD-Artusa, 1996).

47. Not even the law on funding entitled Ley de Financiación y Perfeccionamiento de la Acción Protectora del Régimen General de la Seguridad Social, passed in 1972, achieved its main objective of correcting the imbalances in the system's accounts. BOE, 22 June 1972, no. 149, 11174.

48. The idea for these came from the monoblock hospital in USA, Beaujon Hospital in Paris, France, and Mayor Hospital in Milan, Italy. For more information, see Alberto Pieltain, 'Los hospitales de Franco. La versión autóctona de una arquitectura moderna', (Unpub. Ph.D. Dissertation at Universidad Politécnica of Madrid, 2004), 257.

49. Josep Barceló and Josep M. Comelles, 'Las bases ideológicas del dispositivo hos-

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pitalario en España: cambios y resistencias', in Vilar-Rodríguez and Pons-Pons, op. cit., (note 38), 83-138.

50. For more information, see Pons and Vilar, op. cit., (note 29), 239.

51. For further details, see the excellent work by Juli Nadal, La construcción de un éxito. Así se hizo nuestra sanidad pública (Barcelona: Ediciones La Lluvia, 2016), 60.

52. For further details, see Juan D. Tutosaus, Jesús Morán-Barriosa, and Fernando Pérez Iglesias, 'Historia de la formación sanitaria especializada en España y sus claves docentes', Educación Médica (2017), link: http://dx.doi.org/10.1016/j.edumed.2017.03.023.

53. Obtained from Jesús De Miguel Rodríguez, La reforma sanitaria en España. El capital humano en el sector sanitario (Madrid: Cambio 16, 1976), 198.

54. Order of 5 December 1967, BOE, no. 300, 16 December 1967, no. 300, 17456.

55. An observation already made by Luis Albertí López, 'La asistencia sanitaria en el conjunto de la previsión social española', in Varios autores (eds), 4 siglos de Acción Social, de la beneficencia al bienestar social, Seminario de historia de la acción social (Madrid: Siglo XXI, 1988), 297-338.

56. During the years 1972, 1973 and 1974, around 12,000 posts for doctors in the hospital system were filled by open competition on the basis of merit, most of them by doctors coming from the training programme for medical specialists (MIR), see Varios autores (eds), op. cit. (note 55), 333.

57. Pons-Pons and Vilar-Rodríguez, op. cit. (note 29), 137.

58. 'Reportaje: Los hospitales en España y la Seguridad Social/y 2', El País newspaper, link: https://elpais.com/diario/1977/08/17/sociedad/240616801_850215.html

59. Fernando J. Gallego, El mito de la transición. La crisis del franquismo y los orígenes de la democracia (1973-1977) (Barcelona: Crítica, 2008).

60. For example, in the case of Hospital de la Santísima Trinidad in Salamanca there were 121 charitable beds and 74 pay beds. The patrons of the hospital argued in favour of maintaining the proprietary category of private charitable hospital because the income from the pay beds was used to cover the costs of the charitable beds. BOE, no. 28, 2 February 1966, 1252-3.

61. Instituto Nacional de Previsión, INP, Investigación sobre la asistencia farmacéutica en España: Estudio socioeconómico sobre el conjunto de la asistencia sanitaria española (Madrid: Ministerio de Trabajo, 1977), 765.

62. Memoria Estadística de la Seguridad Social, 1976; and population data from Roser Nicolau, 'Población, salud y actividad', in Albert Carreras and Xavier Tafunell (coord), Estadísticas históricas de España, siglos XIX y XX (Bilbao: Fundación BBVA, 2005), vol. 1, 79-154.

63. In Vilar-Rodríguez and Pons-Pons, op. cit. (note 38), 406. There is an in-depth anal-

ysis of the debate surrounding public and private health insurance in Spain from the political transition to the General Health Law (Ley General de Sanidad). It includes aspects such as the corruption and opacity that accompanied the history of the INP; the lack of agreement on the country's health care model and the problems to draw up a general health law that achieved the necessary consensus in the Spanish Parliament.

64. AP/PP: Alianza Popular/Partido Popular; PCE: Partido Comunista Español.

65. Juan Ventura Victoria, 'Organización y gestion de la atención sanitaria', in Informe Anual del Sistema Nacional de Salud 2003 (Madrid, Ministerio de Sanidad y Consumo-Observatorio SNS, 2003), 307-62, see, http://www.msps.es/organizacion/sns/planCalidadSNS/pdf/equidad/Informe_Anual_nexo_V.pdf.

66. 'Change under democracy has barely touched the structure of health care', El País newspaper, 10 June 1986.

67. PSOE: Partido Socialista Obrero Español; PCE: Partido Comunista Español; PNV: Partido Nacionalista Vasco; CIU: Convergencia i Unió.

68. Pons-Pons and Vilar-Rodríguez, op. cit. (note 29), 363.

69. Diario de Sesiones del Congreso de los Diputados, II Legislatura, 1985, no. 215, sesión plenaria no. 215, 9852-55.

70. La Vanguardia newspaper, 9 April 1984, 14. The representatives of these clinics criticised these agreements because INSALUD assigned them 3,795 pesetas per day to care for each patient who required surgery. The clinics claimed that the real cost was actually 5,813 pesetas per patient per day, which was needed to maintain the agreement, with an average stay of 8 days per patient. Moreover, they reproached INSALUD with charging 19,000 pesetas per bed per day in its centres.

71. With respect to associationism, there were at least two associations in the private sector at this time: Unió Catalana d'Hospitals with headquarters in Barcelona, created in 1975, and the Federación Nacional de Clínicas Privadas, of national scope and located in Madrid.

72. In the mid-1970s there were four important mutuals that covered public servants: MUFACE for civil servants, MUGEJU for the judicial administration, MUNPAL for civil servants in the Local Administration and ISFAS for coverage of the armed forces. The government allowed the public servants who were members of these mutuals to have private health coverage via agreements with insurance companies. In 1984, 90.4 per cent of the members of MUFACE (1.1 million) were covered by private health insurance companies, see Jerònia Pons-Pons and Margarita Vilar-Rodríguez, 'The genesis, growth and organisational changes of private health insurance companies in Spain (1915-2015)', Business History 61, 3 (2019), 558-79, link: http://dx.doi.org/10.1080/00076791.2017.1374371.

73. The first of the Autonomous Communities to obtain the transfer of competencies in the area of health care was Catalonia, through Royal Decree 1517/1981, of 8 July.

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