Competition and collaboration between public and private sectors: the historical construction of the Spanish hospital system (1942-1986)

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Acknowledgements:

Both authors gratefully acknowledge financial support from Spain's Ministry of Economy and Competitiveness for the project entitled Management and Construction of the Spanish hospital system from the perspective of economic history: between public and private sectors Ref. HAR2015-66063-R.

Abstract

In general, healthcare, along with diet, has historically been an essential component of life and a country's welfare. In particular, a country's hospital system is a key indicator for analysing the level of welfare achieved in health coverage. Its study from an economic history perspective is relevant since it stems from public and private investment and produces positive externalities by creating employment and stimulating other economic sectors such as construction and health. Spain provides a significant case study for determining the factors of backwardness in a country of the European periphery which, in the late twentieth century, attained a degree of quality confirmed by the current international hospital rankings and even by the phenomenon of health tourism. The study analyses the creation of the Spanish hospital system during the Franco dictatorship and the transition to democracy. It reveals how the maintenance of a regressive tax system, the use of health policy as political propaganda and disputes within the political elite of the dictatorship led to an inadequate and fragmented public hospital system, which needed to collaborate with the private hospital system and which was full of financial holes and tainted by corruption, while remaining at the service of privileged groups.

The hospital system has been a key factor in the development of the welfare state and public healthcare. Moreover, its study from an economic history perspective is essential, as it is one of the more expensive social programmes, and its development entails demanding infrastructure, technology and professional requirements. Despite its importance, and although there are many works available of in-depth studies on specific cases of long-established hospitals, there are very few studies that analyse the historical construction of hospital systems in major countries, their characteristics and their role in the development of different healthcare systems. Without a doubt, the greatest number of interesting works studying the development of the hospital system can be found in Europe. The British and French cases[1] are especially noteworthy here, and outside Europe there are classic studies from the United States[2] and more recent contributions on the hospital systems in Japan and China.[3]

Spain provides an excellent case study in this field for three reasons. First, because it passed compulsory sickness insurance legislation and modernized its hospital system relatively late compared to other western European countries and under an autarkic dictatorship. Second, because it is an interesting example of the collaboration or competition, depending on the stage, between the public and private sectors in the

[1]For the British case, see Cherry, 'Before the National Health Service'; Doyle, *The politics*; Gorsky, Mohan and Powell, 'The Financial Health'; Gorsky, Mohan and Willis, *Mutualism contributory schemes*. For their integration into the National Health Service (NHS), see Berridge, *Health and Society*; and some of the works included in Sturdy, *Medicine, Health*. For the French hospital system, see Domin, *Une histoire économique*; Chevandier, *L'hôpital dans la France* and Smith, 'The Social transformation'. For a comparison of the British and French cases, see Doyle, 'Healthcare before Welfare States'.

[2]Rosenberg, *The care of strangers*; Stevens, *In Sickness and in Wealth.*

[3]Outside Europe, see the case of Japan in Donzé, 'Hospital construction'; and the hospital model adopted by China in Xi, 'Conceptualizing balance'.

creation of a hospital model. Third, because after starting from considerable relative backwardness in this area,Spain achieved a highly-regarded level of hospital coverage that led to the country occupying a prominent position in the international healthcare rankings from the end of twentieth century.[4]

Nowadays, there is still no consensus in the literature on the impact of the type of political regime on the development of social policy.[5] Even among authors who consider democracy to be a positive factor, some see it as a necessary but insufficient condition. In this respect, there is also no consensus on the role of democracy itself. Dictatorships, meanwhile, can also have incentives to make social concessions, win over the masses and legitimize their power.[6] Even in this case, however, redistribution in a dictatorship would be less than in a democracy, as the elite close to power is usually a minoritarian and relatively wealthy group opposed to redistribution. Rather than examining whether the Spanish dictatorship's social spending was greater or less than that of European democracies,[7] our main focus is to analyse the different goal of social policy under the Franco dictatorship and the different form of financing this expenditure. The creation of the hospital system offers an excellent area of analysis,

[4]See the Healthcare Access and Quality Index (HAQ), published in the UK journal The Lancet in 2017, where Spain scored 90 points out of a maximum 100, placing it eighth in the world rankings, above the healthcare systems of Italy (89), France (88), Greece (87), Germany (86), the UK (85) and Portugal (85). See http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)30818-8.pdf

[5]The main authors who have participated in these debates include Lindert, *Growing Public*; Haggard and Kaufma, *Development*; Mulligan, Gil and Sala-i-Martin, 'Social Security', Cutler and Johnson, 'The birth' and Congleton and Bose, 'The rise'; and an excellent synthesis of this theoretical debate in Espuelas, 'Political Regime'.

[6]Cutler and Johnson, 'The birth'; Acemoglu and Robinson, *Economic origins*.

[7]This aspect has already been studied by Espuelas, 'La evolución del gasto' and Espuelas, 'Are dictatorships'.

because it is one of the most expensive insurances, as well as one of the most desired, and thus entails a greater need for resources and is a key element in gaining social and political legitimation.

Overall, the Spanish case may contribute to evidence that western Europe followed heterogeneous paths in the construction of welfare systems and in the development of state systems of healthcare provision after the Second World War. Focusing on this aspect, the literature usually establishes the model of financing as a basic criterion for classifying countries at this time. On this basis, G. Carrin and C. James highlight two basic models.[8] On the one hand, a health financing system under which general tax revenue is the main source of funding health services. These health services are usually provided by a network of public and contracted private providers, often referred to as a national health service. This would be the British case, for example. On the other hand, a health model financed by workers' and employers' contributions based on wages, where the government may provide contributions for those segments of the population that have no contributory capacity, such as the unemployed or low-income workers. This group would include Germany, Austria and Belgium, for example.

These authors suggest that the key to the success of these historical processes, in terms of quality of healthcare and hospital provisions and coverage capacity, did not lie with the chosen financing model, that is, through taxation or contributions. In fact, the more developed western European countries achieved compulsory membership and universality in the 1950s and 1960s by both paths. Moreover, particularly in the case of countries with contributory models (such as Spain in the period under study), they point out that their final success lay more with the five factors that historically conditioned

[8]Carrin and James, *Reaching universal.*

and determined their quality and universal health and hospital coverage. These are the functioning of the labour market (sufficient wages and sustainable payroll contributions); competent and efficient bodies to manage the system; a legal framework with clear rights and duties of insured members; availability of an adequate infrastructure to provide quality health services; and the existence of a broad consensus among society's stakeholders (especially insured members and patients, healthcare providers and employers, and Parliament and Government) in order to guarantee the viability and smooth working of the system.

Having indicated that Spain is interesting as a case study and having outlined the theoretical framework, this study focuses on three basic objectives. First, to demonstrate that compulsory sickness insurance, and within it, the hospital system, was used by the dictatorship as a key propaganda tool to legitimize its power and to try to gain popular acceptance. In relation to this, it is important to explain how the burden of financing fell mainly on the workers through employees' contributions in a context of political and union repression, low wages and a nineteenth-century tax system, which led to serious obstacles that delayed universal health (and hospital) coverage. The differences between dictatorships and democracies are therefore analysed not only in terms of the level of social expenditure, but also with regard to the management and funding mechanisms of the system. Second, the Franco dictatorship further fragmented the inherited hospital system due to the internal struggles of the different political 'families' that comprised the upper echelons of the regime. This resulted in a waste of resources, opaque administrative and financial management and the creation of a parallel hospital infrastructure. An attempt to reorganize the system in 1963 was not successful because by then the division was deeply entrenched in a complex bureaucratic structure. Finally, the role played by the private healthcare system and its hospitals in this process is

analysed; on occasions as collaborators of the public system and at other times as competitors.

In order to address these objectives it is first necessary to define the concept of hospital that will provide the basis for this paper and explain (and justify) the hospital classification criterion used. During the period under study, Spain had already gone beyond the old nineteenth-century concept of hospital, whose prime objective consisted in providing shelter for the terminally ill, sustenance for the destitute and spiritual aid. The modern hospital was conceived as a therapeutic establishment, where each patient had an individualized space, modifiable according to the evolution of the illness, and where hospital organization was concentrated in the hands of doctors and their auxiliaries, replacing religious personnel. Moreover, these centres incorporated permanent files where the evolution of the patient was noted in a documentary record, an indispensable step for the advance of clinical science.[9]

With respect to the hospital classification criterion, due to historical tradition and (not very abundant) available sources, the Spanish historiography has been based on the property ownership of public or private hospitals in order to analyse the long-term development of the hospital system. This method will be used in this paper: the basic division between hospitals of public or private ownership. In this case, hospitals built and financed by public institutions will be included in the public sector. The public sector will encompass hospitals linked to the state, provincial and municipal authorities, the National Welfare Institute (*Instituto Nacional de Previsión*; hereinafter INP)[10], the

[9]For the evolution of the concept of hospital, see Henderson, Horden and Pastore 'Introduction'; Risse, *Mending bodies;* Rosenberg, *The care of strangers.*

[10]The INP, founded in 1908, was responsible for the legislative development and implementation of the first social insurances in Spain. See Gaceta de Madrid, 26/12/1908, no. 361.

General Secretariat of the Movement (*Secretaría General del Movimiento*; SGM)[11], the Directorate General for Health (*Dirección General de Sanidad*; here in after DGS),[12] the Ministry of Defence and the National Anti-Tuberculosis Trust (*Patronato Nacional Antituberculoso*; PNAT).[13] On the other hand, privately-owned hospitals included 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 the type of public or private 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 is much more confusing. 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-oriented hospitals which were based on business and market criteria and treated paying patients. This difficulty lies 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.

[11]The '*Movimiento*' was equivalent to the *Falange*, the single party of the dictatorship (*Falange Española Tradicionalista y de las Juntas de Ofensiva Nacional Sindicalista* FET y JONS), see Lanero, '¿La salud es lo que importa?'.

[12]Created by the royal decree of 10 March 1847, see Marset, Sáez and Martínez, 'La Salud Pública'.

[13]This was an organization to combat tuberculosis, created by the insurgent camp in 1936 during the Spanish Civil War, see Molero, 'Enfermedad'.

I

The Franco dictatorship - established after a failed coup d'état in July 1936 and victory in a civil war (1936-39) - inherited a nineteenth-century public hospital system managed through a heterogeneous set of institutions of internment that combined the healthcare function with the offer of shelter or refuge, food and social assistance (small hospitals, asylums, maternity homes, homes for the poor, hospices[14], etc.) and belonged to provincial and municipal charity, inherited from the disentailment of Catholic Church land in the nineteenth century.[15] The income of provincial and municipal hospitals came from their own sources; bequests, alms, and donations from individuals and aid from the state and local authorities and, finally, as the nineteenth century progressed, some of those who were taken in by these institutions were charged for their stay, either in money or in kind.[16]

Against this backdrop, sickness insurance was the only social risk that had not been legislated for before the Spanish Civil War (1936-39).[17] Apathy and a lack of state resources due to an obsolete tax system, and the opposition of the medical profession and private insurance companies,[18] delayed the introduction of an insurance that

[14]The term 'hospice' here should be understood as a charitable establishment which took in and educated poor orphans.

[15]See the General Charity Law published in 1849 in López, 'El buen samaritano'.

[16]Marín, *Apuntes para el estudio*, p. LXV and Esteban de Vega, 'La asistencia liberal', p. 123.

[17]Vilar and Pons, 'The Introduction'; Pons and Vilar, *El seguro de salud.*

[18]This situation also occurred in other countries. Some doctors and some Catholics in France opposed the law of 1928 extending the insurance and causing the disappearance of the 'maison des pauvres', as this attacked their independence and the idea of private charity and the Church's social role. Smith, 'The Social Transformation', p. 1081.

required infrastructures and a substantial budget.[19] As a result, health and hospital coverage in Spain was provided under a system of mixed economy of welfare: the state, which restricted its role to the realm of charity; the market, where the insurance companies' premiums were prohibitive for the majority of workers; the traditional family network, less robust in urban areas; and solidarity among workers, especially through friendly societies.[20]

Immediately after the Civil War, many of the working classes did not qualify for the healthcare aid provided by charity, envisaged for the extreme poor, but they could not afford to pay for private assistance.[21] Within this context, the Franco dictatorship passed a law on compulsory sickness insurance (*Seguro Obligatorio de Enfermedad*, herein after SOE) in 1942, which was an essential part of its system of propaganda. The INP was designated as the sole administrator of the insurance, although in practice it played a role of mere controller of an insurance financed by workers' and, officially although not always in practice, employers' contributions throughout the dictatorship.

During this period, there was a struggle between the different political factions of the Franco dictatorship for the control of health policy. On the one hand, the Falangists sought to unify all aspects related to healthcare and welfare provision (including the INP) under the Ministry of Labour (*Ministerio de Trabajo*) which

[19]Tax revenue as a percentage of GDP in Spain was far lower than that of other European countries: Spain (1930: 9.8 and 1950: 7.8); France (1930: 20.0 and 1950: 26.7); United Kingdom (1930: 21.8 and 1950: 20.9). In addition, there was a tremendous amount of fraud and concealment, see Comín, *Historia de la Hacienda.*

[20]Vilar and Pons, 'Economic Growth'; and for the historical importance of the mixed economy of welfare in Europe, see Harris, *The Origins*; Grell, Cunningham and Jütte, *Health Care.*

[21]Pieltain, *Los hospitales de Franco.* This sector of the population only had access to primary healthcare coverage through friendly societies, see Pons and Vilar, 'Friendly Societies'.

remained under their control. However, this objective could not be fully achieved, as the dictatorship assigned control of the Ministry of the Interior (*Ministerio de Gobernación*) - on which the DGS and the PNAT were dependent - to military and Catholic circles favourable to the monarchy, another of the dictatorship's political families.[22] This division of healthcare between ministries and political families of the dictatorship led to constant confrontation which was evident, for example, in the case of tuberculosis.

Why was the Falange determined to control healthcare provision? This fascist party provided the ideological backbone of the dictatorship. Its leaders concentrated on gaining control of two strategic spheres of power after victory in the Civil War: social insurances and propaganda.[23] It must be taken into account that Franco's social policy adopted a dual strategy. On the one hand, the violence and repression typical of a military dictatorship was applied. Behind the structural violence of the Franco regime against workers (purges, mass detentions and disciplinary dismissals) lay the fear of a reorganization of the working-class movement, capable of jeopardising the continuity of the dictatorship.[24]

On the other hand, the dictatorship made some friendly political gestures and created a massive propaganda machine to win over as many people as possible, control the population and achieve greater social cohesion after a divisive civil war. Social welfare became one of the flagships of this second strategy. Somehow, the dictatorship intended to gain legitimacy by implementing social insurances in a situation where citizens lacked basic human and social rights. From this perspective, social insurance schemes in dictatorial Spain acquired a somewhat different significance compared with

[22]Álvarez Rosete, '¡Bienvenido, Mister Beveridge!'; Álvarez Rosete, 'Elaborados con calma'; Majuelo, 'Falangistas y católicos-sociales'; Molero, 'Enfermedad'; Menéndez-Navarro, 'The politics of silicosis'.

[23]Ministerio de Trabajo, *Alocución del Sr. Ministro*.

[24]For more details, see Vilar, *Los salarios*, p. 59.

other European countries. In fact, social insurances in the first decades of the dictatorship were considered to be charitable benefits restricted to the lower echelons of the workforce.[25]

As part of this situation, the power struggle between the INP and the DGS was prolonged for decades. The DGS repeatedly requested the creation of a Ministry of Health to coordinate all public healthcare centres, while constantly criticising the SOE project. Meanwhile, the INP forged ahead with its project and duplicated functions that were already performed by the DGS. Within this context, the INP promoted its own hospital network and did everything it could to minimize the ability of the DGS to influence the healthcare sector.

Hence, the INP only used the hospitals under its control to implement the compulsory insurance. This entailed just a small number of its own hospitals and those that belonged to the single Falangist party. After the Civil War, the Falange had accumulated considerable property through plunder, largely expropriated from the disbanded workers' and Republican organizations, but also from private owners. Consequently, in 1949, the insurance only had at its disposal 36 hospitals belonging to the INP (providing a total of 1,356 beds) and 41 pertaining to the SGM (with 2,321 beds) (Table 1). This latter figure remained almost unchanged until 1963 when it had 45 hospitals providing 2,230 beds.

All other public hospitals were excluded from the SOE. This publicly-owned hospital system was disorganized and had heterogeneous proprietorship, which made good coordination and management of its scarce resources very difficult. At the

[25]The SOE initially only covered primary healthcare for employees (and their families) who were working mainly in industry (agricultural workers were excluded) and who did not earn in excess of a maximum annual income, see Pons and Vilar, *El seguro de salud*, p.113.

beginning of the 1940s, there were hospitals attached to the Ministry of the Interior (DGS, General State Charity, anti-tuberculosis sanatoriums); hospitals attached to the Ministry of Education, which were, essentially, the clinical hospitals of the faculties of medicine; and also the facilities belonging to the Ministry of Justice, basically prison healthcare institutions. Meanwhile, the Ministry of Defence maintained its own network of independent hospitals.[26] In 1963, there were 48 military hospitals functioning in Spain, almost one per province. Finally, the municipal and provincial hospitals dependent on the provincial council (*diputación*), predominant before the Civil War and also inherited by the dictatorship, went into a marked decline between 1949 and 1981. This decrease was due to new interests created by the Ministry of Labour and the implementation of the National Healthcare Facilities Plan (*Plan Nacional de Instalaciones Sanitarias*; hereinafter PNIS), an essential element of the SOE, which is dealt with below. In particular, the hospitals of the provincial councils fell from 140 in 1949 to 120 in 1963 and 108 in 1981. In the case of the municipal hospitals, their number plummeted from 325 in 1949 to 156 in 1963 and finally 58 in 1981 (Table 1). Under these circumstances, there were insufficient hospitals, beds and medical staff to implement the SOE. This deficiency became a serious obstacle when in 1947-48 public healthcare coverage was extended from primary care to include specialities and hospital attention, although still with many limitations.[27]

How was this problem addressed? The INP and those responsible for the SOE adopted a dual strategy: a) using temporary measures and signing collaboration

[26]Massons, *Historia de la sanidad* and Puell, *Historia de la protección*.

[27]The second stage of the insurance was initiated in 1947, intending to extend provisions to general surgery, surgical hospitalization and medical specialities. The service of medical hospitalization was conditional on the construction of a plan of national facilities for the insurance; see Pons and Vilar, *El seguro de salud*, p. 118.

agreements with the private sector; which also provided this lobby with business and silenced voices that were critical of the competition from the public system; b) initiating a plan for building large public hospitals. Therefore, unlike other European countries, the INP, responsible for managing the SOE, did not modernize existing hospitals but rather planned and built its own healthcare centres in the medium term.[28] Meanwhile, the charitable hospitals continued to attend only to the poor. Within this context, those affiliated to the SOE were excluded from the charity hospital system (as they received a regular wage and paid workers' contributions) and hospital coverage under the SOE remained limited.[29] It must not be overlooked that in 1960 the SOE only provided healthcare coverage to 50 per cent of workers and their families. In the early 1960s, beneficiaries of the SOE could still only be hospitalized in exceptional cases in order to treat psychiatric illnesses or contagious diseases, or to undergo surgery, and with a maximum number of weeks in hospital.

The limited hospital capacity sped up the establishment of measures for signing agreements with the private sector; a temporary but necessary solution to provide sufficient hospital coverage. A decree of 2 March 1944 allowed the INP to reach

[28]Conde, 'Los últimos 20 años', p. 250. In France, the law of 1941 introduced plans to centralize all hospital resources and establish regional hospitals. The law of 17 May 1943 further medicalized the hospitals and increased doctors' managerial roles within them, see Smith, 'The Social transformation' p. 1086. In the British case, according to Berridge, *Health and Society*, p. 17, the structure established for the NHS, inaugurated in 1948, perpetuated the previous system. The regional hospital structure was effectively handed over to voluntary hospital interests.

[29]Unlike other more developed countries in western Europe that were moving towards universal coverage in the 1950s and 1960s, see Carrin and James, *Reaching universal*.

agreements with collaborating bodies. The agreements were signed for 10 years.[30] Simultaneously, the promoters of the SOE initiated studies and projects to equip the insurance with its own hospitals.[31] In 1944, the provision of 34,000 beds was initially envisaged. This figure came from an initial estimate made by the technical specialists of the INP, as part of 'an ideal Plan'[32], assuming that the insurance would cover 60 per cent of the Spanish population (it was expected that 12 per cent of the population would remain as beneficiaries of charitable services and 28 per cent would be under private health insurance) and setting a ratio of 5.5 beds per 1,000 inhabitants as the objective. Consequently, with a population of 26 million, according to the census of 1940, around 40,000 hospital beds were considered necessary. The INP technicians estimated that the SOE could use around 13,200 hospital beds belonging to different entities through collaboration agreements. Nevertheless, after all these opaque calculations, it was finally concluded that the aforementioned figure of 34,000 beds would be needed to implement the insurance.

This figure had to be immediately reduced in view of the government's real financial and economic situation in a period of autarky, hunger and a lack of resources. Thus, a ministerial order of 19 January 1945 finally approved the PNIS with a more modest objective of 16,000 beds; although building work on the hospitals did not start

[30]BOE (Official State Gazette) 19/3/1944, no. 79, pp. 2291-3; BOE 9/7/1944, no. 191, pp. 5309-10. Private providers were also initially established for health and hospital coverage in Germany. Compulsory insurance was channelled through friendly societies, other mutual funds and insurance companies that covered the hospital costs of the insured, see Hüntelmann, 'The Birth of the Patient' and Dross, *Health Care Provision*, p. 90.

[31]Vilar and Pons, *La construcción.*

[32]INP, *Seguro de Enfermedad*. This report does not provide details of the calculations made to obtain the final figures.

until 1948. The plan allowed five years for its implementation and envisaged the construction of 86 large hospitals with between 100 and 500 beds, 149 large outpatient clinics, 110 smaller ones and 73 maternity institutions. The project would require 1,000 million pesetas. The chosen model was based on US hospitals.[33] The choice of the United States was justified on three grounds: the awful hospital situation in the major European countries after the Second World War, the excellent hospital organization in the United States, and the availability of a substantial number of recently-constructed hospitals. Following this US model, it was decided to build monoblock hospitals, unlike the majority of European hospitals that had been built horizontally or as pavilions, such as the *Beaujon Hospital* in Paris or the *Hospital Mayor* in Milan.[34]

How did the INP manage to finance the PNIS without reforming the obsolete tax system inherited from the nineteenth century and without receiving direct state funding? This is difficult to trace because only those items that were charged to the account of the PNIS amortization fund appear in the INP's technical balance; other entries only appear in the INP's internal accounts. In fact, special resources from three main sources were used to fund the plan. First, advance payments granted by the other social insurances made from the reserve funds. The transfer of funds between the different social insurance items with independent accounts was common practice during the Franco dictatorship. This mechanism led to opaque accounts within the INP (Table 2).[35]

Second, the financial insufficiency of the above method eventually made it necessary for the INP to issue bonds in order to fund the PNIS (Table 3). The first loan

[33]INP bosses were sent to the United States in 1945 to study their characteristics, see Garay, *Los hospitales* and Cámara, *Fisonomía y vida*.

[34]INP, *Seguro de Enfermedad*.

[35]Archivo INGESA, Estudio Estadístico del Seguro de Enfermedad de los años 1954, 1955, 1956 y 1957, Alberto Rull Sabaté, 1959, p. 60.

to the plan was authorized by a decree of 11 January 1952, which established the issue of bonds to the value of 965 million pesetas.[36] The main subscribers of these bonds were savings banks and *mutualidades laborales*.[37] In this respect, from 1947, the *obra social* (social action programme) of the savings banks had been 'kidnapped' by the Ministry of Labour, the authority they were dependent on, and above all by the financial requirements of its social policy within a framework of scant tax resources and a high budget deficit.[38] Finally, to complete the response to the high financial demands of the PNIS, the government also authorized the INP to open a credit account with the Bank of Spain.

In a nutshell, the Franco dictatorship intended to construct its own hospital system, comprising large public hospitals known as *residencias sanitarias*. This term was intended to differentiate the new facilities from older hospitals, as the term 'hospital' had become tarnished by the old network of public charitable institutions. However, the public-owned hospital system lacked an organized and integrated network and had serious shortcomings in terms of the number of hospitals, technological advances and the professionalization of medical attention.

Construction was on the basis of the award-winning models from the competition held in 1946. Almost all initial proposals were awarded in an opaque manner to four companies managed by businessmen who had good contacts in the upper echelons of the regime: *Eguinoa Hermanos*; *Empresa Ramón Beamonte; Empresa Huarte y Cía S.L.* and *Empresa Agroman S.A.* (Table 4). This process fits in with the standard practice of commissioning large building projects and the way of doing

[36] BOE 16/2/1952, no. 47, p. 719.

[37]For a definition of *mutualidades laborales* and their limited role in healthcare and hospital funding and coverage, see Pons and Vilar, *El Seguro de Salud*, p. 166.

[38]Comín, *Historia de la cooperación*, p. 227.

business under the Franco dictatorship. In fact, the Spanish historiography has described Francoism as a network of common interests between Francoist politicians and entrepreneurs.[39] It seems obvious that the PNIS was not set up to give profits to a handful of entrepreneurs; but once it was decided to build facilities the *modus operandi* was basically as described above. However, limited funding prevented the proposed objectives from being achieved. As from 1958, triennial plans for healthcare facilities were approved, which effectively replaced the unfinished original PNIS.

II

Privately-owned hospitals also have a long history in Spain, linked, to a large extent, to individual benefactors and the Church. As well as this historical inheritance related to private charity, in the late nineteenth and early twentieth centuries new hospitals emerged in response to the demand created by new social regulations on work and the workplace. Labour legislation, first on industrial accidents and later on sickness insurance, directly or indirectly obliged companies and employers to build clinics and hospitals to attend to their employees.[40] This was the start of company hospitals and clinics and employers' industrial accident mutuals. In these cases, they specialized in orthopaedics and occupational illnesses such as hernias, a common disorder in mining. The availability of this infrastructure eventually led to these hospitals accepting other groups of clients and extending their medical care to all types of illnesses. Furthermore, in the first quarter of the twentieth century, a significant number of private healthcare centres were founded thanks to the initiatives of professional doctors. During the 1920s,

[39]'Interests' understood here as advantages that are not always legitimate obtained in exchange for other favours, Sánchez, 'El franquismo' and Sánchez and Tascón, *Los empresarios de Franco*.

[40]Pons, 'La gestión patronal'; Menéndez-Navarro**,** 'Hospitales de empresa'; Menéndez-Navarro and Rodríguez Ocaña, 'Aproximación al estudio'**;** Cohen and Fleta, 'El 'desgaste' en el trabajo'**;** Pérez Castroviejo, 'Salud laboral'**;** Martínez Soto, Pérez de Perceval and Sánchez Picón**,** 'Entre miseria y dolor'.

in the larger provincial capitals, specialist doctors founded small clinics equipped with new diagnostic and surgical technology to attend to the better off.

In 1944, privately-owned hospitals were very interested in the possibility of collaborating with the state when compulsory sickness insurance was approved and there was a lack of appropriate hospital infrastructure. All firms, insurance companies, mutual societies, *montepíos* (similar to friendly societies), and *igualatorios* (doctors' associations) that signed agreements with the INP to manage the SOE were considered to be collaborating bodies. The decree of 2 March 1944 established the implementing provisions of these agreements. The first agreements were for 10 years. In most cases there was total managerial control: the collaborating body took charge of collecting premiums and also took responsibility for providing economic benefits and healthcare (including hospital treatment). From 1945 to 1957, these entities accounted for more than 70 per cent of premiums of the SOE. The INP required collaborating bodies to pay a deposit and in return for their management they received a percentage of the premiums to cover administration costs. These entities were excluded from the management of the SOE after the Basic Law of Social Security was passed in 1963.[41]

This collaboration was profitable both economically and politically, and led to an increase in the number of private hospitals and clinics, supported by public demand. Simultaneously, it prompted improvements in terms of management, costs and the coverage provided by these infrastructures, while the collaborators also benefited by assuming control of the management of the premiums collected. In 1945, the collaborating bodies covered 55 per cent of the companies affiliated to the SOE, 77 per cent of the insured and 74 per cent of the beneficiaries of the insurance. In 1955, this coverage was still 40, 64 and 61 per cent respectively. These private entities attended to

[41]Pons, 'El seguro obligatorio' and Pons and Vilar, *El seguro de salud*, p. 118.

those covered by the insurance with their own hospital network. These collaborating bodies retained a percentage of the premiums paid by workers and employers, which was set at 20 per cent in 1947 for companies operating on a national scale. However, this percentage was gradually reduced, reaching 11 per cent by 1958. With these percentages, collaborating bodies were able to build new hospital infrastructures.[42] Most of these collaborators had already covered industrial accident insurance since 1900; in other words, they were large companies, employers' mutuals and private insurance companies.

Thanks to this collaboration, the number of privately-owned hospitals increased significantly from 885 to 1,037 between 1949 and 1963, and the availability of beds rose from 38,264 to 52,036 (Table 1). This growth was largely due to the converging interests of the government and the private sector. In 1963, the group of private hospitals accounted for almost 66 per cent of the major health centres in Spain. The total of 1,037 centres included in privately-owned categories for this year included clinics and hospitals belonging to the Church (93), the Red Cross (38), private benefactors (105) and two more that are difficult to categorize. Private hospitals and clinics were registered with the branch of healthcare during the period under study.[43]

The Church, through its own funding or by means of private charity institutionalized in foundations, maintained an important number of rural and urban hospitals run and staffed by religious communities, especially the order of *San Juan de Dios*, or by lay personnel. This network linked to the *ancien régime* survived despite the sale of Church lands and prolonged its activity, at times in precarious conditions, until the twentieth century. In 1949, there were still 113 hospitals that were the property of

[42]Pons and Vilar, *El seguro de salud*, pp. 121-4.

[43]For more details, see Pons and Vilar, *El seguro de salud*, pp. 269-70.

the Catholic Church and which offered 13,030 beds.[44] By 1963, the number of hospitals had fallen to 93, although the number of beds provided had actually increased to 16,978 (Table 1). Following tradition, many of the Church's centres maintained an important function as asylums and psychiatric hospitals. Specifically, of the 93 Church-owned centres, 13 were asylums and 15 psychiatric hospitals. Most of them, however, maintained the category of general or surgical hospital.

As regards the Red Cross, its healthcare work in Spain was initiated in 1870, although the number of hospitals increased from 1918 as a result of war in Morocco, and especially during the Spanish Civil War from 1936 to 1939.[45] The number of Red Cross hospitals remained more or less constant from 1949 to 1963. Its network of medical attention was made up of 32 centres with 1,466 beds in 1949, numbers that had risen to 38 with 1,988 beds by 1963. It must be borne in mind that the hospitals of both the Church and the Spanish Red Cross had virtually no connection with the collaboration agreements of the SOE, and this put a brake on expansion during this period.

The hospitals that were classified as voluntary hospitals (dependent on private charity) are more difficult to detect. In the 1963 catalogue, 105 hospitals were included in this category. Most of them had historically enjoyed the patronage of industrialists and merchants, including individuals who had returned from the American continent with fortunes and contributed substantial sums to fund their construction and maintenance. In some cases, these new private foundations allowed modernization, in

[44]The Church maintained significant weight in the hospital system in Catholic countries. See the case of Ireland in Lucey, *The End of the Irish*, p. 3.

[45]http://www.cruzroja.es/principal/web/cruz-roja/inicio (accessed on 26 April 2017).

contrast to the obsolete hospital model that was maintained in the case of public charity.[46]

However, the most heterogeneous group of privately-owned hospitals in Spain in 1963 comprised those classified as profit-making hospitals, and which amounted to a total of 541 centres. The most outstanding case was the province of Barcelona with 97 private clinics and hospitals, followed by Madrid with 58, A Coruña with 44 and Biscay with 42. Most of them were private clinics, promoted by doctors and especially specialists who, especially from the 1920s onwards, had created diagnostic centres or centres for recently-developed medical specialties, and which were favoured by a growing demand in the larger cities. However, another two types of private centres can be distinguished within this group with different origins: hospitals and clinics created by industrial companies, especially mining companies, and those founded by mutual societies and insurance companies.[47]

The Dato Law of 1900 obliged employers to provide medical attention and to compensate injured workers in the industrial sector, but it also allowed them to take out insurance. This insurance was made compulsory for the first time in 1932-33.[48] Large companies, especially mining companies, built hospitals to treatsick or injured workers. However, most employers resorted to insurance companies or they joined employers'

[46]Barceló and Comelles, 'La economía política'.

[47]To compare the role of friendly societies, insurance mutuals and insurance companies in the private provision of health insurance in Spain and France, see Faure, 'Health Care Provision', p. 318.

[48]Pons, 'La gestión patronal', p. 115. As coverage of the risk of industrial accidents was considered from the outset to be the responsibility of the employer. Workers' societies were only created in order to address one of its consequences: disability. From 1915 to 1925, 12% of the friendly societies accounted for in Spain were specifically concerned with worker disability, Vilar and Pons, 'The Introduction' p. 76 and Menéndez-Navarro, 'Hospitales de empresa', p**.** 331.

industrial accident mutuals. Mining company hospitals were especially important in the area of Huelva, and in the provinces of Murcia, Córdoba, León and Biscay.[49] By 1963, many of the mining hospitals had already closed, as mining activity in the area came to an end. However, there were also mining hospitals that remained active.[50] As a result of this process, the group of private hospitals catalogued in 1963 included 25 hospitals and clinics throughout Spain identified as being the property of an insurance company or mutual.[51]

On the other hand, there were very few cases of friendly societies with their own hospitals, or at least that were still maintained in 1963. Most friendly societies, after a period of success and growth from 1880 to 1940, had gone into decline in the face of competition from the SOE and difficulties in integrating into the public system.[52] One exception was *La Quinta de Salut L'Aliança* which, unlike other friendly societies whose members had to undergo operations in associated centres, had its own clinics (1963: 8) (Table 5). The exceptional nature of the hospital network created by *La Quinta de Salut* friendly society was probably due to two main factors. First, it attracted a growing number of members in provincial capitals in Catalonia through the creation

[49]See Cohen, 'Los registros hospitalarios'; Fleta, 'Los riesgos del trabajo'. The creation of hospitals in other European mining regions is recorded in the works compiled by Rainhorn, *Santé et travail*, in different countries including Belgium, Germany, France and Spain.

[50]Martínez Soto and Pérez de Perceval, 'Asistencia sanitaria'.

[51]Most of these hospitals were surgical and treated the insured of the insurance companies and mutuals that owned them. What provisions were available depended on the clauses included in the policy. Apart from these patients, the management boards of these hospitals could enter into contracts with other companies or provide care for private patients in order to maximize hospital bed occupancy, see Pons and Vilar, 'The genesis'.

[52]One exception worthy of note is the case of the *Federación de Mutualidades de Cataluña* which included *La Quinta de Salut L'Aliança*, Pons and Vilar, 'Friendly Societies'.

of clinics. This strategy differentiated this society from other local mutuals, whose members had to go to Barcelona when surgery was required. Second, from very early on it offered free childbirth care whereas other friendly societies only covered hospitalization in cases of difficult births. These features, and others, led to an increase in the number of members, and the scale of its operations enabled this hospital network to be maintained.[53]

The other private hospitals belonged to companies created by specialists and surgeons. These were concentrated in the larger provincial capitals. One of the more paradigmatic cases is that of Barcelona. Many medical specialists, some linked to university teaching and with experience at international level, opened private clinics in this city in the 1920s, taking advantage of the demand from the social classes with greater purchasing power and the incapacity of the public sector to provide adequate surgery, new treatments and diagnostic tests. Examples include *Clínica Corachán*, founded in 1921, and *Clínica Platón*, *Clínica San Jorge* and *Clínica Bretón*, opened in 1925, all three being linked to important medical figures of the time.[54] From 1942 to 1963, these clinics grew not only due to the demand of the better off in urban areas, but also thanks to collaboration with the public sickness insurance, through agreements with insurance companies and mutuals that did not have their own clinics and facilities. Thus they did not just rely on cash payments but could tap into state and mutual insurance.

As a result of these different factors, and converging interests with the public health system, private hospitals increased between 1949 and 1963. The 740 hospitals with 23,768 beds in 1949 rose to 906 with 33,070 beds during this period. However, as

[53] www.diaridegirona.cat/opinio/2012/03/18/historia-clinica-lalianca/552732.html (accessed on 10 Oct. 2016).

[54] Casares and De Fuentes, *Història de la Clínica Platón*, p. 41.

from the late 1960s, as the hospital services and coverage under the compulsory insurance improved (thanks to progress in the construction work under the PNIS), privately-owned hospitals were obliged to find new ways of competing, since some of their former patients were now being treated in the *residencias sanitarias* of the SOE. This situation initiated a new period of redefining and reorganising the privately-owned hospital system in order to survive and adapt to the new times.

It must be taken into account that many of the hospitals built for the PNIS remained underused after their construction had been completed; some of them did not even have permanent staff or an organized provision of integrated services and specialities. Bureaucratic management, scarce resources and precarious services converted many of these *residencias sanitarias* into a kind of large, underused polyclinic that performed its function inadequately. Basically, in the early 1960s, those affiliated to the SOE attended these hospitals for surgery, but for little else. There are many examples of this: the *Residencia Sanitaria Enrique Sotomayor*, which was built in Baracaldo and opened its doors in July 1955, had been financed with an economic plan of 12 million pesetas. It then remained underused for over a decade, since only 350 of the 650 beds initially envisaged were kept in use.[55]

III

By the beginning of the 1960s, the weight of the respective political factions within the dictatorship had changed, and so had the proposed economic policy with the arrival in power of the so-called technocrats. The Spanish economy took on a new direction after the Stabilization Plan was implemented in 1959; a plan that had basically been drawn up and funded by the IMF. This change entailed leaving behind the autarkic phase of the post-Civil War period and initiating a rapid process of economic growth.

[55]*Memoria Anual del Hospital de Cruces*, 2011.

With regard to the healthcare and hospital sector, two important legislative changes were introduced: the Basic Law of Social Security (1963), promoted by the Ministry of Labour; and the law on hospitals (1962) championed by the Ministry of the Interior.[56] The new legislative framework consolidated the institutional dualism and rivalry that had existed between these two ministries since the end of the Civil War, but also produced some notable innovations.

First, the basic law of 1963 intended to make the transition from a set of social insurances to a unitary system of social security. However, once again the goals established were too ambitious for a system that lacked sufficient state funding and where there were multiple class or sectoral interests that led to the continuance of numerous special schemes for agriculture, civil servants and other public employees, the military, etc.[57] Nevertheless, the 1963 law did make a radical change by suppressing any possible profit-making intention from the management bodies of the social insurances. This led to very strict criteria and a progressive end to the profit-seeking collaborating entities that had come to cover three-quarters of healthcare provision in circumstances where the public healthcare facilities had gradually improved in the shade of the PNIS.[58] Most of the collaborating bodies were liquidated and their staff pensioned off (employees over 60 years of age) or taken on by institutions pertaining to the INP (employees between 35 and 60). Although the 1963 law established state control over the management of the SOE through the INP, the shortage of beds in public hospitals made it necessary to sign agreements with private hospitals in order to refer or transfer patients.

[56]Law 37/1962 of 21 July, on hospitals. BOE 23/7/1962, no. 175, pp. 10269-71.

[57]Pons and Vilar, *El seguro de salud*, p. 223.

[58]Pons, 'El seguro obligatorio', p. 244.

Second, the new 1962 law on hospitals attempted to promote a national hospital network comprising all hospitals belonging to the state[59] and its autonomous agencies, the Social Security, the *Organización Sindical*, local authorities, and all others that were ultimately under the auspices of the state (with the exception of military hospitals which were excluded from this law). However, expectations for effective coordination were not met, basically due to the constant failure to comply and the impediments raised by the most powerful entity within the hospital network, the INP. It seems that this institute was never capable of understanding the changes or accepting the guidance of the DGS.[60] The legislation was also intended to modernize the internal management of hospitals by appointing a doctor as director, chosen from those on the staff, and/or a trained manager. As regards the training and preparation of managerial and administrative personnel, the first training course for hospital managers was organized in 1967.

How did these legislative changes affect the hospital map? As can be seen in Table 1, the number of private hospitals fell between 1963 and 1981. This was due to three basic reasons: they abandoned their activity after the termination of the agreement with the state, they integrated into the SOE or they engaged in mergers to become more efficient and to improve their services. Meanwhile, the number of public hospitals also fell, although it was above all the smaller and obsolete ones that disappeared as the construction of larger hospitals related to the PNIS progressed and the demand for new hospital services increased. It must be borne in mind that the function of publicly-owned hospitals in Spain was changing. Until then, the hospitals of the PNIS had only

[59]Private hospitals were now subject to the law in terms of maintaining minimum standards for inspection services and the healthcare system.

[60]Pieltain, *Los hospitales de Franco*, p. 264.

been planned for the admission of patients who were going to undergo surgical treatment, as the SOE established, but now the right to hospitalization, although still seriously limited in terms of time and services, would be gradually extended to include paediatric, obstetric and medical cases. During this stage, the increase in the number of beneficiaries of the SOE and the extension of hospital provisions meant that it was necessary to change the strategy of hospital construction. Not only were more hospitals needed, but larger ones providing a greater variety of services.[61]

In short, at the beginning of the 1970s, the network of healthcare institutions could be broken down as follows: 14 *ciudades sanitarias* (large healthcare complexes) comprising a total of 49 centres, which included paediatric hospitals, rehabilitation and orthopaedic centres and maternity centres, among others; 88 large hospitals distributed throughout the other provinces, all of the above providing a total of 41,582 beds. This supply of hospital services was completed with other charitable hospitals of a municipal and provincial nature, those specialized in chronic or contagious diseases and those inherited from other institutions of the Franco regime. Finally, the hospitals managed by the Church lost ground and specialized more and more in the care of children, the elderly, the helpless and the chronically ill.

This entire process gave rise to an increase in the number of beds between 1963 and 1981 (fewer hospitals, but with greater capacity). But what happened with regard to the distribution of beds between publicly and privately-owned hospitals in this period? (Table 6). While the agreements between the INP and private collaborating bodies to manage the SOE were in force, from 1949 to 1963, the number of beds in private hospitals grew more than in public hospitals. However, once the basic law was passed in 1963, which put an end to the possibility of this private management, and more

[61]It is interesting to compare the Spanish case with the British NHS; see Berridge, *Health and Society*.

publicly-owned hospitals were built under the PNIS, the number of beds in public hospitals grew more than in private hospitals. Nevertheless, private hospitals maintained their market share because the demand of those with private insurance increased in circumstances where the population's income was on the rise, and agreements with private hospitals continued due to a shortage of beds within the public system.

All in all, by the mid-1970s there were now a total of ten million contributors and more than twelve million beneficiaries (excluding those directly insured) of the general system of healthcare provision, which effectively meant a level of coverage of almost 84 per cent of the population (1976 figure). There was still some way to go to achieve the universality of the system.[62] However, the Spanish hospital system at this time continued to suffer from two basic problems that persisted.

First, the dictatorship's social welfare system was launched with serious financial shortcomings, as it was based on workers' and employers' contributions in a context of low wages and virtually no input from the state. In fact, the state's financial contribution to the social security system remained very low throughout the entire dictatorship, around 10 per cent, which was funded with fixed subsidies and resources derived from property (sale and rental of real estate). The rest of the financing came from the contributions paid by workers and employers (which accounted for around 20 per cent of total labour costs) but, actually, the real financial burden was far greater for the workers who were enduring a loss in purchasing power.[63]

The problem did not stem from the choice of a contributory model to cover sickness insurance, since other countries (Germany, Austria) had success with such a

[62]Pons and Vilar, *El seguro de salud*, p. 244 and p. 316.

[63]During the dictatorship, real wages in industry fell more than 50% compared with the pre-war period, see Vilar, *Los salarios* and Vilar 'La ruptura'.

model.[64] The key, and differentiating, element of the Spanish case was the excessive cost of the social contributions that fell on the workers in a context of political and union repression and tough working and pay conditions. These factors were in stark contrast with the advances in social and labour rights of European workers in capitalism's golden age. Indeed, in the 1950s, Spanish employers argued that it was better to abolish the welfare system and put the percentage of wages absorbed by employees' contributions directly into workers' pockets in order to reactivate the consumption of goods and services. Wages in Spain remained very low throughout the dictatorship; in 1966 the wage of a skilled milling machinist was 91.08 pesetas in Switzerland, 70.29 pesetas in Belgium, 66.22 pesetas in France, 65.91 pesetas in Germany and only 35.10 pesetas in Spain.[65] Within this framework, the capacity of payroll contributions to finance the system was extremely limited.

Second, the meagre state contribution may have been due to two fundamental reasons: a lack of political will, which would reinforce the idea that the social welfare system was essentially a central theme of the dictatorship's propaganda; and a lack of financial capacity. The two reasons are not mutually exclusive and probably the actual result was a product of both. It should be taken into consideration that the Franco dictatorship regressed in terms of tax policy, with regard to both revenue and expenditure.[66] In this respect, it differed from the European democracies of the time as, instead of advancing along the path of social and political rights, it regressed towards nineteenth-century state models with a lower tax burden based on taxes on products, the consumption of specific goods and priority spending on defence. Consequently, the

[64]As shown by Carrin and James, *Reaching universal*.

[65]Vilar, 'El mercado de trabajo'.

[66]Comín and Martorell, *La Hacienda Pública*.

state's weak financial commitment hindered the progress of the healthcare system in general and the hospital system in particular.

The structure of the hospital system continued to be very fragmented. Many hospitals remained underused after they had been built due to a lack of resources, there by failing to live up to the population's expectations. In an attempt to overcome the lack of a coordinated hospital network, the decree-law of December 1972 was passed. Its only effect was the reorganization of hospitals under the control of the DGS through a new body called *Administración Institucional de la Sanidad Nacional* (AISNA).[67] The hospitals related to the PNIS were excluded from this process. The inertia resulting from the dualism of the institutions controlled by different families of the regime, and the bureaucratization that was rife in the INP and the DGS, along with management issues and problems of corruption, thwarted the objective of fully coordinating the public hospital network in the hands of the central government.

IV

Therefore, as indicated in the initial thesis, the factors established by G. Carrin and C. James, crucial to explaining the success of the countries that financed their health and hospital models through workers' and employers' contributions, were not satisfied in Spain.[68] This country introduced its state health coverage relatively late and without any historical precedent, except the limited maternity insurance passed in 1929. The state's lack of legislative and financial commitment in this area led to an obsolete public hospital structure based on charity. Through its ideological wing, the Falange, the dictatorship used social policy to legitimize its power, increase its acceptance by the masses and improve social cohesion after the Civil War. Paradoxically, the burden of

[67]Decree-law 13/1972, of 29 December, BOE 10/1/1973, no. 9, pp. 488-90.

[68]Carrin and James, *Reaching universal*.

financing this system fell on the workers who were considered the losers of the Civil War and subject to harsh social and labour repression.[69] In this respect, the paper demonstrates the importance of analysing which segment of the population financed the social system, as this is a key element in differentiating the dictatorship's *modus operandi* from that of democracies of this period, from a redistributive point of view. Moreover, payroll contributions based on very low wages were not sufficient to fund an expensive insurance, with considerable infrastructure requirements. The cost of infrastructures mushroomed due to the overambitious hospital-building projects of the Falange (through the INP) and unnecessary duplication, resulting from a lack of coordination between (recently-constructed or already existing) facilities and institutions and the exclusion from the system of the hospitals under the DGS, the Falangists' rival political faction in the inner circles of the regime. The INP, the leading manager of the system, was not a good administrator and remained under the shadow of corruption, opaque accounting and political interests throughout the dictatorship, which did not contribute to the smooth functioning of the system.[70] Finally, G. Carrin and C. James highlighted the need for social and political consensus between stakeholders. This did not exist in Spain, as workers did not have any bargaining or decision-making capacity and the dictatorship continuously catered to the interests of economically powerful groups (including those linked to the private hospital system), which guaranteed the continuance of the regime until the end.

As a result, the hospital model that accompanied the development of health coverage was built slowly, following political criteria and serving propaganda purposes rather than concentrating on harnessing and coordinating new and existing resources. When construction of the so-called *residencias sanitarias* was completed, they

[69]Pons and Vilar, 'Labour repression'.

[70]Vilar and Pons, 'El debate en torno al seguro de salud'.

remained underused (with floors closed and limited provision of services) and poorly managed (with directors handpicked by the political powers and disregarding medical professionals). In sum, to what extent did the social provisions of the Spanish dictatorship offer protection compared with western European democracies? In 1970, social provisions (economic and in kind) as a percentage of national income accounted for 19.4 in Belgium; 18.3 in Germany; 18.8 in France; 17.3 in Italy; 18.9 in the Netherlands and only 8.2 in Spain.[71]

During the transition to democracy, in 1977, Fernández Ordoñez's eagerly-awaited tax reform was approved, which modernized the Spanish fiscal system. In the same year, it was agreed that the state contribution to financing the Social Security would be increased to 20 per cent of its budget. 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 healthcare services, the INSALUD (*Instituto Nacional de Salud*; National Health Institute). 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 laid, but Spain still lacked a general health law establishing a healthcare 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 healthcare sector, which during the years of the transition to democracy was awaiting necessary reforms to modernize both its regulatory framework and its business structure.

[71]Data obtained from Pons and Vilar, *El Seguro de Salud*, Table 3.8.

Thus, by the beginning of the 1980s, the following were still pending in Spain: a general health law (finally passed in 1986); public funding of the healthcare system through taxation (historically hampered by the failure to implement fiscal reform), universal coverage (limited by the lack of sufficient resources)[72] and the integration of the hospital system (a victim of the historical political bipolarity that existed under the dictatorship between the INP and the DGS with respect to healthcare). The solution to these shortcomings did not arrive until the consolidation of democracy and the inception of a real welfare state project, the approval of a new tax system in 1977 that enabled this process to be financed, and the general health law of 1986 which finally defined the country's healthcare and hospital model. From this point on, Spain began a rapid process of modernization of its healthcare and hospital system which enabled the country to reach the leading positions of the international healthcare rankings.

[72]By the end of the dictatorship, self-employed workers, those employed in domestic service, artists and other collectives were still not eligible for public healthcare, Pons and Vilar, *El Seguro de Salud*, p. 316.

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Table 1. Evolution of publicly-owned and privately-owned hospitals in Spain 1949-81.

	1949		1963		1981	
	1	2	1	2	1	2
PUBLICLY-OWNED						
Military	67	18,245	48	14,367	37	10,299
State (P.N.A. y E.T., DGS, others)	128	18,196	164	26,368	206	74,601
INP	36	1,356	56	11,985		
SGM	41	2,321	45	2,230		
Provincial Council	140	37,021	120	40,256	108	40,896
Municipal Council	325	11,940	156	7,044	58	4,502
Total public	737	89,079	589	102,250	409	130,298
PRIVATELY-OWNED						
Church	113	13,030	93	16,978	65	13,820
Spanish Red Cross	32	1,466	38	1,988	33	3,482
Private (profit-making and charitable)	740	23,768	906	33,070	547	46,296
Total private	885	38,264	1,037	52,036	645	63,598
TOTAL	1622	127,343	1,626	154,268	1,054	193,896

1: Number of establishments. 2: Number of beds.
Source 1949: *Anuario Estadístico de España*, 1951, p. 684; Source 1963: *Boletín Oficial del Estado* (Official State Gazette) 13/6/1966, no. 140, pp. 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: *Anuario Estadístico de España*, 1985, p. 709.

Table 2. PNIS. Received through advances, loans and credit account

Revenue	1954	1955	1956	1957
1. Advance payments from other social insurances to the PNIS				
a) Voluntary insurance schemes	9,824,402	6,308,217	3,966,134	26,679,496
b) Industrial accident insurance	291,247,142	158,443,879	385,020,746	553,784,382
c) Family allowances	221,594,122	296,801,920	72,564,721	340,274,183
d) Old-age and disability insurance	20,138,159	160,285,685	-	-
MINUS: Refunds to old-age and disability insurance			-307,098,223	-615,409,104
Total 1	542,803,825	621,839,701	154,453,378	305,328,957
2. Placement of the sickness insurance loan				
a) National Industrial Accident Insurance Fund	-	-	3,500,000	
b) *Mutualidades Laborales*	80,300,000	17,500,000	-	3,800,000
c) Savings Banks	42,411,000	-	-	-
Total 2	122,711,000	17,500,000	3,500,000	3,800,000
3. Arranged through Bank of Spain credit account	6,537,431	-	-	-
TOTAL (1+2+3)	672,052,256	639,339,701	157,953,378	309,128,957

Note: The minus sign that appears in the figures for old-age and disability insurance for the years 1956 and 1957 indicates a refund of advance payments which in fact were covered with greater contributions from the other insurances. This was due to the serious financial difficulties of this insurance.
Note: the figures for loan bonds placed were determined by obtaining the difference between the balance-sheet accounts of said loan corresponding to two successive financial years. The figure for those that were placed in *mutualidades laborales*, savings banks and the CNSAT (*caja nacional de seguros de accidentes de trabajo*; national industrial accident insurance fund) were obtained by examining the bond register.
Note: The amount arranged through the credit account was determined by obtaining the difference between the balances of this account.
Source: *Archivo INGESA, Estudio Estadístico del Seguro de Enfermedad de los años 1954, 1955, 1956 y 1957, Alberto Rull Sabaté, 1959, p. 60.*

Table 3. Settled by amortisation of the sickness insurance loan and cancellation of the Bank of Spain credit account

Outgoing payments	1955	1956	1957
1. Amortisation of bonds of the sickness insurance loan:			
a) Corresponding to bonds held by the *mutualidades laborales*	-	5,317,000	5,648,000
b) Corresponding to bonds held by the savings banks	-	803,000	926,000
	-	6,120,000	6,574,000
2. Cancellation of the Bank of Spain credit account	232,043,424	-	-
Total	232,043,424	6,120,000	6,574,000

Source: *Archivo INGESA, Estudio Estadístico del Seguro de Enfermedad de los años 1954, 1955, 1956 y 1957, Alberto Rull Sabaté, 1959, p. 60.*

Table 4. Basic figures for the implementation of the Health Care Facilities Plan. Large hospitals built to complete the first phase of the PNIS, December 1953[a]

Company	Year work was initiated	Location	Region	Project	Beds
Eguinoa Hermanos	1948	Almería	Andalusia	Martín José Marcide	348
	1949	Bilbao	Basque Country	Martín José Marcide	702
	1950	Málaga	Andalusia	Germán Álvarez de Sotomayor	360
	1951	Albacete	Castile La Mancha	Eduardo Garay	175
	1951	Alicante	Valencia	Aurelio Botella	345
Empresa Agroman S.A.	1948	Cádiz	Andalusia	Juan de Zavala	187
	1948	Huelva	Andalusia	Empresa Agromán S.L.	304
	1948	Valladolid	Castile León	Martín José Marcide	372
	1950	Jaén	Andalusia	Germán Álvarez de Sotomayor	150
	1950	Palencia	Castile León	Eduardo Garay	125
	1950	Seville	Andalusia	Juan de Zavala	600
Empresa Eguinoa Hermanos	1948	Guadalajara	Castile La Mancha	Fernando García Mercadal	130
	1948	Valencia	Valencia	Juan de Zavala	214
	1950	Granada	Andalusia	Aurelio Botella	446
	1951	Cáceres	Extremadura	Aurelio Botella	239
Empresa Huarte SL/Agroman	1949	Badajoz	Extremadura	Aurelio Botella	448
Empresa Huarte y cía.	1948	Barcelona	Catalonia	Aurelio Botella	812
	1948	Zaragoza	Aragón	Fernando García Mercadal	540
	1950	Gerona	Catalonia	Aurelio Botella	305
	1950	P. de Mallorca	Balearic Islands	Marcide	379
	1948	Teruel	Aragón	Fernando García Mercadal	180
	1948	Calatayud	Aragón	Fernando García Mercadal	60
	1950	Lérida	Catalonia	Fernando García Mercadal	320
Empresa Jose M. Puldain la Bayen	1947	Puertollano	Castile La Mancha	Germán Álvarez de Sotomayor	35
Empresa Ramón Beamonte	1948	Coruña, A	Galicia	Martín José Marcide	291

	1948	Logroño	La Rioja	Fernando García Mercadal	294
	1948	Oviedo (Mieres)	Asturias	Fernando García Mercadal	10
	1948	Vigo	Galicia	Marcide	381
	1949	Mahón	Balearic Islands	Martín José Marcide	122
	1949	Santiago de Compostela	Galicia	Martín José Marcide	197
	1949	Vitoria	Basque Country	Fernando García Mercadal	190
	1950	Córdoba	Andalusia	Juan de Zavala	439
	1950	Lugo	Galicia	Germán Álvarez de Sotomayor	145
	1951	Zamora	Castile León	Martín José Marcide	175
Servicio Militar construcciones	1948	Burgos	Castile León	Martín José Marcide	346

Source: INP, *Ministerio de Trabajo. Instalaciones Sanitarias del Seguro de Enfermedad,* 1952, *Biblioteca INGESA, XXXVI; Notas de INP, Ministerio de Trabajo, Dirección de la Asistencia Sanitaria de Instalaciones del Seguro de Enfermedad, Plan de Instalaciones, Obras concluidas, 1953, XXXIV.*

[a]As part of the regime's propaganda, many of these infrastructures were considered to be built by December 1953, although photographs shown in some publications reveal that many of these buildings were still in construction.

Table 5. Clinics created in Catalonia and Huesca by the *La Quinta de Salud La Alianza* friendly society (1963).

Province	Name	Municipality	Beds
Barcelona	Clínica Comarcal de Quinta de salud "La Alianza" de Barcelona	Sabadell	20
Barcelona	Clínica Comarcal de Quinta de salud "La Alianza" de Barcelona	S. Sadurni de Noya	32
Barcelona	Clínica Comarcal de Quinta de salud "La Alianza" de Barcelona	Vich	104
Gerona	Quinta de Salud "La Alianza"	Gerona	66
Gerona	Quinta de Salud "La Alianza"	La Bisbal	10
Huesca	Sanatorio Antituberculoso de Quinta de Salud "La Alianza" de Barcelona	Boltaña	65
Lérida	Clínica Comarcal de Quinta de salud "La Alianza" de Barcelona	Seo de Urgel	32
Lérida	Clínica Comarcal de Quinta de salud "La Alianza" de Barcelona	Tremp	24
Tarragona	Quinta de Salud "La Alianza"	Tortosa	70

Source: Official State Gazette (BOE), 13/6/1966, no. 140, pp. 7389-427.

Table 6. Health care establishments in the public and private sectors 1949-1981

	1949		1963		1981	
	No. beds	Beds per 1000 inhabs.	No. beds	Beds per 1000 inhabs.	No. beds	Beds per 1000 inhabs.
Total public	89,079	3.18	102,250	3.31	130,298	3.45
Total private	38,264	1.37	52,036	1.68	63,598	1.68
Total	127,343	4.55	154,268	4.99	193,896	5.14

Source: see Table 1.