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The historical roots of the creation of the Catalan private-public hospital model: c. 1870-1935

Abstract

This paper analyses the roots of the creation of the Catalan hospital model, based on a preponderance of privately owned hospitals and beds over those of public provision. In particular, on the basis of new statistical and documentary sources and a review of the existing historiography, this study reinterprets the keys that shaped this historical model during what is considered to be a strategic period of the process, 1870-1935. In the late nineteenth century, hospitals dependent on provincial authorities became private charity institutions in the provincial capitals, under the control of the medical and economic elites (a decisive process in the case of the city of Barcelona). Later, during the dictatorship of Primo de Rivera and the Second Republic, institutional impetus helped foster a system of district hospitals intended to meet the public demand for a network of public utility hospitals. This network was made up the few publicly owned hospitals and numerous privately owned ones. The philosophy of this model was taken up again during the transition to democracy after responsibility for healthcare was devolved to the Government of Catalonia 1981.

Keywords: hospital; healthcare; Catalonia; 19th-20th centuries

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Introduction

This paper analyses the factors that have contributed to the historical creation of the hospital system in Catalonia, on the basis of new statistical and documentary sources and the reinterpretation of some already known.[1] This process has been characterised by the numerical preponderance of privately owned hospitals and beds over those of public provision, in contrast to other Spanish regions (Comelles 2006; Comelles, Alegre-Agís and Barceló 2017; Vilar and Pons 2018, Pons and Vilar 2019a, and Vilar and Pons 2019; Barceló and Comelles 2020). A detailed analysis of the first hospital catalogue drawn up with a criterion of proprietorship, for 1963, makes it possible to establish different territorial models and determine the historical weight of different public and private institutions. Privately owned hospitals and beds only predominated in four regions: the Basque Country, Galicia, Cantabria and Catalonia.[2] The catalogue allows us to verify the greater weight of private hospitals in Catalonia compared with Spain as a whole, both in terms of the number of hospitals and the availability of beds. While in Catalonia four out of every five hospitals were privately owned (80%), in Spain this percentage was only three out of five (60%). This imbalance was even greater with regard to

[1] The backwardness of the Spanish hospital system, which the Catalan model was part of, during the period analysed in this paper, is evident if compared to the British or French systems. The most studied case is that of the United Kingdom, where most works have analysed the *voluntary hospitals*, hence Cherry (1997); Gorsky, Mohan and Powell (2002), and Gorsky, Mohan and Willis (2006). A look at the hospital system from a regional perspective can be found in Doyle (2014) and for an analysis of the integration of regional hospital services, see Gorsky (2004). With regard to the incorporation of voluntary hospitals into the National Health Service (NHS) the works of Berridge (1999) and Sturdy (2002) are very interesting. Among the most outstanding contributions on the development of French hospitals, we can cite the works of Domin (2008) and Chevandier (2009). For the development of America's hospital system, the work of Rosenberg (1987) is a classic. For Asia, see the studies on the creation of the Japanese and Chinese hospital systems by Donzé (2016) and Xi (2016), respectively. There is an interesting compilation of articles on the history of hospitals in the Mediterranean region, Northern Europe and America over many centuries (300-2000) in Henderson, Horden and Pastore (2007).

[2] These regions also show a greater weight of beds in private hospitals, but with different characteristics to the situation in Catalonia. Thus, for example, the state of affairs in the Basque Country was studied by Pérez Castroviejo (2002); in the case of Cantabria, the data are conditioned by the large size of Hospital de Valdecillas, studied by Salmón, García Ballester and Arrizabalaga (1990); or the circumstances in Galicia, where the data are also conditioned, this time by the great capacity of private hospitals devoted to caring for the mentally ill, such as Conxo, in Santiago de Compostela.

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the number of beds, with the provision of public hospitals being preponderant in Spain, whereas private provision was more prevalent in Catalonia. From this initial overview, it seems clear that the Catalan hospital model displayed a clearly different format to the country as a whole in 1963. Two types of institution set the pattern in the creation of the Catalan hospital system: the considerable weight of municipal hospitals in the public sphere and the predominance of private hospitals; private charity hospitals, meanwhile, were far less common in the private sector. This model was developed in the long term on a diverse substratum of charitable institutions, both public and private, inherited from the Old Regime and from liberal beneficence, on top of which would be added a large number of private clinics and sanatoriums from different sources: friendly societies, industrial accident insurance companies and mutuals, and specialist doctors.[3] The interaction between hospital institutions of different origin varied over time depending on different periods of political and/or economic history. Overall, however, this heterogeneous base enabled Catalonia to benefit from a bed capacity and availability of private hospitals well in excess of the average figures for other Spanish regions. The thesis put forward by this paper, using official administrative sources and information from the media during this period, is that the basis of this hospital map was already laid out before the Civil War. The social and economic forces that promoted this model of private predominance sought and found, in key and critical periods, strategies to continue with their prevalence.

In particular, this paper argues that there were two critical moments that made it possible to lay the foundations of this model before the passage of compulsory sickness insurance in 1942. The

[3] For further details on the friendly societies, see Castillo and Ruzafa (2009); Vilar-Rodríguez and Pons-Pons (2012); or the approach from social capital by Largo and Pujol (2016). For private health companies in Spain from a historical perspective, see Ponsand Vilar-Rodríguez (2019b). For a broader analysis from a regional perspective, see Vilar and Pons (2018, 250).

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first turning point was in the 1870s, as a result of the laws on disentailment and charity passed by the state. The former forcibly expropriated large properties of both lay and ecclesiastical origin, including hospitals, hospices and religious charitable institutions known as *obras pías*, and put them up for public auction (Vilar and Pons 2019). Via the latter, the state transferred responsibility for the management of, and the costs of funding, public charity to municipal and provincial authorities. In the case of Catalonia, the managing elite created hospital trusts to drive processes that led hospitals to be classified as private charity, in order to maintain ownership of hospital property under their control, and thereby evade the process of liquidation of property in exchange for public debt that other hospital institutions underwent in other parts of the country. Within this context, and after a long lawsuit, the trust administrators of Hospital de la Santa Creu, one of the main and most prestigious hospitals in Catalonia, managed to revoke its classification as a "public and provincial" hospital, established in 1853, and convert it into a private charity hospital. Hence, on 18 June 1874, the *Dirección General de Beneficencia, Sanidad y Establecimientos Penitenciarios* (Directorate General for Charity, Health and Penitentiary Establishments) revoked the public classification and declared Hospital de la Santa Creu a private charity establishment.[4] The claim was based on the grounds for exception included in the Royal Decree of 1853: a) ongoing compliance with the purpose of its foundation; b) to be paid for with its own donated or bequeathed funds; c) management and administration entrusted to patrons designated by its founder (Barceló and Comelles 2020, 38-

[4] *Gazeta de Madrid*, 51, February 20, 1876, 429. Its private charity statute continued until 1978, when it started to serve as a service provider for the Catalan Health Institute within the framework of the *Xarxa Hospitalària d'Utilització Pública de Catalunya* network. See Josep M. Comelles' works on Hospital Santa Creu, particularly Comelles (2006) where he provides a complete analysis demonstrating exactly this for Hospital Santa Creu i Sant Pau. Moreover, there is a new book by Barceló and Comelles (2020) that provides a precise summary of previous works of these authors on the evolution of the private-public hospital system in Catalonia and advances new findings. These works are based on archival sources from Hospital Santa Creu i Sant Pau, which makes it possible to supplement, compare and contrast his theses with those established in this paper on the basis of official statistical sources.

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42). These were grounds that could be identified with a large number of hospitals throughout Spain but, however, very few used them. This reclassification enabled the hospital's patrons to regularly apply for exemption from paying the taxes levied on the assets of legal entities, which contributed to the preservation of their considerable property, beyond the control of the public authorities.[5] These assets were further increased by means of bequests and raffles. This strategy of the leading hospital in Barcelona at this time paved the way for other Catalan hospitals. This was the case of the hospitals of Tarragona[6], Lleida and Vic, which also followed the path towards pseudo-privatisation.[7] In exchange, these provinces and cities ceased to have provincial hospitals under public control, since these hospitals, although they received subsidies from the municipal and/or provincial authorities, were privately managed. Thus, they were not directly accountable to these public authorities, and these institutions also had little influence over their investments, recruitments or administrative and healthcare practices, which in practice effectively meant privatisation of their management.[8] This process has been identified by Barceló and Comelles (2020, 43), who affirm that "these privatisation strategies differentiated the Catalan case during the period under analysis". The aforementioned authors interpret this decision not only as response arising from fear of losing control of the governing bodies of local hospitals but also as a strategy in view of the risk of losing proximity care services, and they lean more towards this second factor. They also affirm that Catalonia was an exception to the process of centralising care resources in the capitals or large cities of a province (Barceló and

[5] See for example the exemptions granted in the *Gaceta de Madrid*, 106, April 16, 1913, 147 and in the *Gaceta de Madrid*, 234, August 21, 1920.
[6] For the history of the hospital of Tarragona, see Barceló (2017) and Barceló and Comelles (2020).
[7] For further details, see Barceló and Comelles (2018, 115) and Barceló and Comelles (2020).
[8] For the evolution of hospital management, see Fernández and Sabaté (2019) and Fernández (2018) and the articles of the special issue of the journal *Business History* 61(3) published in 2019 and entitled "Health Industries in the 20th century".

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Comelles 2020, 38). Our thesis is more inclined towards an explanation that focuses on the interest of the elites and the professionals concerned in controlling the management and maintaining ownership of the entity and evading public scrutiny and auditing. The fact that during a large part of the twentieth century Hospital Santa Creu i Sant Pau effectively functioned as a provincial hospital, concentrating a large proportion of patients from the entire province and even from the rest of Catalonia, does not support the decentralisation thesis. It was therefore managed as a private hospital with a 'centralising' function that received subsidies from public institutions, but without direct supervision by these institutions (Fernández i Pellicer 1932, 392). It is certainly true that many hospitals of a local scope survived, but these were mainly privately owned, and consequently they were not a viable option for the poorer sectors of the population with few resources.[9]

The second turning point started with the creation of the *Mancomunitat* (1914-1925), a federation of the four Catalan provincial councils, which was accompanied by the start of a debate on the design of the Catalan hospital model, its proprietorship and its territorial organisation. The new institution tried to move towards the regionalisation of healthcare services in this territory. The Primo de Rivera dictatorship, however, aborted the project. As Barceló and Grau (2014) point out, the idea was to integrate all surviving charitable and hospital institutions in a single healthcare network. These institutions were in a very precarious economic situation due to the chronic lack of state investment in the health sector. It was an attempt to establish a mixed-ownership model of healthcare institutions, consisting in a mutual relinquishment of power between the old administrators and the new representatives of the

[9] See the statistical annex in Pons-Pons and Vilar-Rodríguez (2019a, 27-29). There were 143 private hospitals and only 24 public ones in the province of Barcelona in 1963.

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Mancomunitat (Fernández i Pellicer, 1932). The Republican *Generalitat* or Government of Catalonia (1931-1939) replaced the mixed-ownership model with another that concentrated the healthcare institution's decision-making power in the hands of political representatives and attempted to promote an investment plan to modernise hospitals, but without altering the prevailing model of the private hospital system. However, the outbreak of the Civil War made it necessary to shelve the plan and attend to more urgent needs (Sabaté, 1993; Pons and Vilar, 2019a). As a result, Catalonia missed the opportunity, at this time, to create an efficient and sustainable hospital network on the basis of the structure of existing local institutions.

1. Barcelona and the shortfalls of public charity: the role of private provision (c. 1870-1935)

In the early twentieth century Barcelona was one of the principal urban and industrial centres in Spain with a population of over one million inhabitants by 1930, which accounted for more than half of the total population of Catalonia.[10] Industrial growth and migratory flows evidenced the lack of healthcare infrastructures.[11] Furthermore, the concentration of business and population required greater efforts in terms of individual and collective hygiene as a necessary means of guaranteeing a healthy workforce and maintaining social order. Despite this, the main demographic indicators showed a changing trend, with a rapid fall in mortality rates first and then in the birth rate, an increased life expectancy and progress in the urbanisation process.[12] Moreover, an improvement in eating habits and personal and public hygiene also reduced the

[10] The figure for Catalonia comes from *Idescat* (Statistical Institute of Catalonia). *Estimaciones de población*, https://www.idescat.cat/pub/?id=aec&n=245&lang=es. For the city of Barcelona: *Anuario Estadístico de la Ciudad de Barcelona* (Statistical Yearbook of the City of Barcelona), https://www.bcn.cat/estadistica/castella/dades/anuari/cap02/C020101.htm.
[11] As recorded in the *Anuario Estadístico de Barcelona for 1902* (Ayuntamiento de Barcelona 1903, 335).
[12] Urban areas became crucial in the fight to reduce the mortality rate in the early 20th century, see Pérez Moreda, Reher and Sanz (2015).

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propensity to catch infectious diseases. Nevertheless, the process was slow and the accumulated backwardness considerable. Although it is true that the public authorities launched informative and educational health campaigns and promoted the vaccination of the population, the public provision of healthcare at the beginning of the twentieth century continued to be dispersed in multiple entities, most of them of a charitable nature, local in scope and poorly financed. The influenza pandemic of 1918-1920 (also known as the Spanish flu), which occurred in several outbreaks, aggravated the country's health situation and led to a temporary increase in the mortality rate.[13] The influenza and its indirect effects in the form of infectious and parasitic diseases, such as diarrhoea, gastritis and enteritis, increased mortality to levels similar to those at the beginning of the twentieth century. Meanwhile, periodic outbreaks of typhus, tuberculosis or smallpox highlighted the need to introduce urgent improvements in the country's healthcare policy.

Under these circumstances, public health and medical care were synonymous with charity. In this field, provincial and municipal councils carried out an essential task in two ways:[14] the provincial authorities mainly took responsibility for the hospitalisation of the sick and accommodating orphans and the destitute in hospices, while the local authorities concentrated their efforts on charitable work and helping the needy and providing medical assistance to poor families. According to the few sources available, Barcelona had twelve[15] hospitals in 1898, although only two of them were publicly owned, and neither of these was municipal or

[13] For more information on this phenomenon see, for example, Echeverri (1993), Huertas (1993, 94) and Nicolau (2005).
[14] For more on the regulations that governed Public Charity, see *Anuario Estadístico de la Ciudad de Barcelona. 1913* (Ayuntamiento de Barcelona 1915, 308-309). In the *Anuario Estadístico de la Ciudad de Barcelona* for 1914 (Ayuntamiento de Barcelona, 1915, 380) it is acknowledged that the healthcare and charity services in the city are intertwined and become indistinguishable "as the former are basically charitable and free".
[15] See Vilar and Pons (2020, in press), Table 1.

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provincial: Hospital Clínico, linked to the Faculty of Medicine – in the process of being built and whose inauguration would take place in 1906 – (Ayuntamiento de Barcelona. 1923, 448), and the military hospital, which enjoyed a special status.[16] The rest were all privately owned: three belonging to the Church, one to the *Cruz Roja* (Spanish Red Cross) and six were classified as private charity hospitals, although they were managed by foundations which in some cases had the participation of municipal institutions.[17]

Hospital de la Santa Creu i Sant Pau, belonging to private charity, was one of the oldest hospitals in the Catalonian capital.[18] During the nineteenth century, there were frequently complaints from doctors about the poor functioning of this institution, which was the only noteworthy hospital available in the city of Barcelona. These complaints were noted during municipal inspections.[19] In 1903 the hospital treated more than five thousand sick people and by 1918 the figure was now over six thousand.[20] Building work was initiated at the start of 1902 to erect a new hospital, a project that was possible thanks to the legacy of the banker Pau Gil, and its inauguration took place in 1930 (Venteo, 2016). Nonetheless, the *Molt Il·lustre Administració* (MIA, Very Illustrious Administration), the managing body of this hospital, controlled by the bishopric and the city council, was radically and repeatedly opposed throughout the 1920s to the introduction of new scientific criteria and the professionalisation of the medical staff due to "fear of losing power, fear of losing control and fear of scientific innovation".[21]

[16] For a study on military hospitals in Spain, see Gutiérrez (2018, 367).
[17] A compilation of historical data on the creation of hospitals in Catalonia can be found in Aragó (1973, 57-74) and a study on hospitals in Barcelona, taking into account the business management, in Fernández and Sabaté (2019).
[18] Arrizabalaga (2006, 203-309). On its origins, see also Hospital de la Santa Creu i Sant Pau (2016).
[19] The shortcomings of the old building are noted in many sources from this time, for example, *Anuario Estadístico de la Ciudad de Barcelona* (1903, 376).
[20] *Anuario Estadístico de la Ciudad de Barcelona* (1918-1920, 449).
[21] As revealed in hospital records from the 1920s, see Fernández Pérez (2018, 146).

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In 1879, a draft was started for the project of the future Hospital de Nostra Senyora del Sagrat Cor, as a charitable initiative of a group of women belonging to the local bourgeoisie and under the auspices of the Church (Agustí, 1991). It was funded with public and private donations, care of the sick was left in the hands of the Daughters of Charity of Saint Vincent de Paul and the hospital's governing board was presided by an ecclesiastic. The success of the initiative prompted the purchase of some land in the neighbourhood of Les Corts in order to build their own facilities; the new hospital started operating in 1883 under the control and management of a private trust. According to the figures of the *Anuario Estadístico de la Ciudad de Barcelona* (Statistical Yearbook of Barcelona), in 1903, the hospital treated 777 sick people (men and women) with general medicine, surgery, gynaecology, urinary tract treatment and ophthalmology.

It is also worth noting that during this period Hospital Sant Joan de Déu was founded in Barcelona in 1867 by l'Orde Hospitalari de Sant Joan de Déu (Brothers Hospitallers of Saint John of God).[22] It was the first children's hospital in Spain, and originally treated sick children for rickets and scrofula. It changed sites several times as earlier premises became too small. The Hospitaller Order also founded a mental health and psychiatric hospital in Saint Boi de Llobregat (Barcelona) in 1895 and a general hospital in Manresa in 1932.[23] Meanwhile, new initiatives linked to doctors were implemented. This was the case of the clinic and dispensary for poor children run by the doctor of Cuban origin Francisco Vidal Solares (1854-1922). This doctor founded a hospital for poor children in 1886, with care provided by sisters of the

[22] For a more detailed account, see SJD (2020).
[23] See Plumed (2009, 503).

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Daughters of Charity of Saint Vincent de Paul.[24] This hospital had a laboratory for microbiological and chemical analysis and also distributed free medicines to the city's poorest children. More than 44,000 cases were treated in this hospital in 1903.[25]

The inadequate hospital provision in Barcelona became even more evident in the first decades of the twentieth century. In this respect, a significant milestone was the founding of Hospital Clínic i Provincial de Barcelona in 1906, the first publicly managed hospital in the city. Its work was initially focused on providing healthcare to the poorest, but it had very limited financial resources. Thus, for example, the doctors working at this hospital were not paid and nursing tasks were carried out by nuns. The situation was so abject that sometimes the first directors had to use their own money to buy basic supplies.[26] Some years later, in 1923, Hospital Dos de Maig was inaugurated by the Spanish Red Cross.[27] The work of the small Hospital del Mar, inaugurated in Barcelona in 1905, also deserves a mention.

Another significant novelty lies in the fact that in 1913 the statistics now clearly distinguished between institutions devoted to care for the sick that were classified as belonging to private charity, those of religious associations and private clinics.[28] Despite the predominance in this field of private institutions, both profit-making and not-for-profit, it should not be overlooked that municipal councils actually bore the main burden of family medical care at this time. This responsibility was not reflected in a significant budget allocation, as the portion destined to

[24] See Álvarez-Uría (1986). This experience is considered by some authors to be a forerunner of the paediatric institutions *Gotas de Leche*, which were organised in Spain as from 1902 (Rodríguez Ocaña 1986, 236).
[25] Data obtained from the *Anuario Estadístico de la Ciudad de Barcelona* for the year 1903 (Ayuntamiento de Barcelona 1905, 378).
[26] For further details, see: http://www.hospitalclinic.org/es/el-clinic/100-anos-de-salud (accessed in October 2016) and Corbella (2006). See also Broggi (2006).
[27] Data obtained from Consorci Sanitari Integral (2019).
[28] See Vilar and Pons (2020, in press), Table 1.

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charity barely accounted for 3-5% of total municipal spending (Table 1). Even so, the municipal services became the key link in treating the sick, either through subsidies to charitable establishments via municipal budgets (more than 40 institutions subsidised in 1903) or through direct municipal medical services. In the latter case, the municipal medical corps stood out, the council's main item of expenditure on charity and a fundamental element of these services. In fact, after paying the municipal doctor's salary, as required by law, the ability to spend on any other charitable cause was almost non-existent (Esteban 1992, 123).

TABLE 1. Charitable expenditure in the municipal budget of Barcelona, 1903, 1913 and 1918

Item	**1903 (Pesetas)**	**Item**	**1913 (Pesetas)**	**1918 (Pesetas)**
Municipal Medical Corps	415,345.14	Municipal Medical Corps	718,535.60	1,143,302.16
Charity	329,040.00	Domiciliary aid	8,730.00	6,230.00
Subs. charitable establishments	110,000.00	Charitable aid	427,663.17	449,400.00
		Aid and transport for poor non-residents	2,000.00	2,000.00
		Aid to poor emigrants	500.00	500.00
		Subsidies charitable establishments	204,800.00	255,800.00
		Municipal asylums	199,362.00	260,615.00
		Hospitals for the infectious		47,652.50
Charitable expenditure	854,385,14	Charitable expenditure	1,561,590.77	2,165,499.66
Total budget expenditure	27,825,873,86	Total budget expenditure	42,695,342.40	43,287,955.90
% charity	3.07%	% charity	3.66%	5.00%

Source: Ayuntamiento de Barcelona (1905, 311), (1915, 309) and (1925, 532).

The municipal medical corps was created in Barcelona in 1885 and from then comprised twenty doctors, ten designated primary and ten secondary, one of each category being destined to each of the ten districts that made up the city (Ayuntamiento de Barcelona 1905, 321). This first team was fundamental in tackling the cholera epidemic that ravaged the city at this time. One year later, the microbiological laboratory was set up and then, in 1891, the municipal medical corps

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was reorganised, increasing the number of members and dividing the services into four sections: medical attention and health policy, practical hygiene, laboratory and special hygiene. By 1913 the municipal medical corps in Barcelona had grown considerably, but was still insufficient to meet the health and medical care needs of a city of over half a million inhabitants (Table 2).

TABLE 2. Municipal Medical Corps, Barcelona 1913

Director: Dr. D. José Macaya y Gibert	
BUDGET	**Pesetas**
One Director	5,000
One Assistant Doctor	2,000
A Keeper of Dispensary Materials	1,860
FIRST SECTION	
Staff: 12 doctors (Dispensary Heads); 80 permanent staff doctors; 30 assistant doctors; 2 intern assistant doctors; 4 stretcher-bearers for ambulances; 1 caretaker; 52 dispensary assistants and 24 midwives	337,180
Free breastfeeding service: 1 director, 1 paediatrician sub-director; 1 obstetrician-gynaecologist; 1 domiciliary service inspector; 1 assistant in charge of statistics; 1 chemical analysis laboratory director; 1 administrator-inspector; 1 machinist; 1 caretaker; 4 junior assistants and 1 woman in charge of cleaning service	31,045
SECOND SECTION	
1 Chief Director of urban sanitation; 3 Sub-directors-Heads of Section; 3 doctors; 5 foremen; 1 night foreman; 4 machinists; 7 coachmen; 1 storekeeper; 73 operators and 1 electromechanical machinist	160,725.6
THIRD SECTION	
Chemical Analysis laboratory subsection: one director; one assistant; two interns and one junior assistant	10,100
Vaccination subsection: one director; one sub-director; one assistant; one intern; two junior assistants and one stable boy	13,530
Bacteriology subsection: one director; two assistants; one intern; one junior assistant and one caretaker	12,395
FOURTH SECTION	
Health Demographics, Statistics and Census; one medical technical director; seven assistants for demographic work; four Auxiliaries and one assistant	23,440
Otorhinolaryngology section: one medical director; one secondary doctor; one intern auxiliary and one medical assistant	6,750
OTHERS	129,500

Source: Taken from the Ayuntamiento de Barcelona (1915, 336).

Overall, Barcelona had thirteen municipal medical dispensaries and a first-aid post in 1903; six were located in the old municipality of the city and the rest in neighbouring towns that had recently been incorporated into the city limits. The dispensaries offered a permanent medical

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service, organised by duty shifts. Their multiple functions included providing emergency care to any injured or accident victims; expert medical attention at home; daily consultations for the poor; a nursing service; medical check-ups for children before attending schools or asylums sponsored by the municipality and vaccinations. Moreover, all the dispensaries ran a stretcher service, mainly using the old models with arms and only a few already had more modern services using stretchers with wheels. Each of these dispensaries had a staff of auxiliaries or junior assistants to deal with the so-called "mechanical services" (cleaning, porter duties, transfer of the injured, medical reports, etc.). Meanwhile, the first-aid post was located in the neighbourhood known as Casa Antúnez and was only manned by a doctor's assistant. The lack of resources made it necessary for private charitable actions to be undertaken intermittently and selectively.[29]

The main work of the municipal medical corps, however, was the provision of domiciliary medical care to the sick. This service had grown substantially in recent years. In 1892, municipal doctors in Barcelona carried out almost fourteen thousand home visits; then there were over one hundred and twenty thousand visits in 1897; and by 1903 this figure was now approaching one hundred and eighty thousand (Ayuntamiento de Barcelona 1905, 331). In some of these cases, when the social or medical conditions of the patient required admission to hospital for medical or surgical treatment, the doctor had to issue an admission certificate and the municipal stretcher-bearers went to pick up the individual in question, if necessary. When the doctors prescribed some medicine, the patient had to acquire it obligatorily from one of the registered pharmacies authorised to supply the medicines prescribed by the municipal charity

[29] The Royal Order of 27 October 1908 denounced the state of abandonment of many of these private foundations which did not even keep files due to the lack of resources or competent staff. *Gaceta de Madrid*, 302, October 28, 1908.

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services. These establishments, through their official professional association, had a contract for this service with the city council, which also established the prices that were to be charged. Details of medicines and their maximum doses were provided in the same leaflet that indicated the price rates. Only anti-diphtheritic serum and vaccine lymph were prepared and supplied directly by the municipal microbiological laboratory.

As well as these direct services, the city council used its budget to subsidise a large number of public and private charitable organisations. Many of these also provided medical care. Worthy of note was the work of the four charitable establishments in Barcelona in 1903 known as *Casas de Socorro* (San Beltrán, San Pedro, Palacio and Gracia), under the auspices of the *Asociación de los Amigos de los Pobres* (Association of Friends of the Poor). They had four main objectives (Ayuntamiento de Barcelona 1905, 360): a) a medical-surgical service to cover all accidents or urgent medical or surgical cases; b) a free public consultation for those that could prove that they were poor; c) vaccinations for all who requested them; d) provision of all the services that directors and doctors considered appropriate in particular cases and that were normal in this type of establishment. Their medical staff was made up of a president (the most senior director), and a director and three permanent staff doctors in each *Casa*, and the supernumeraries that were available in accordance with budgets and needs.[30] Each *Casa* also had a caretaker, a nurse and two stretcher-bearers. The medical attention provided in the *Casas de Socorro* for accidents were free for all, but home visits were only free for *pobres de solemnidad* (the officially

[30] The body of supernumeraries was made up of doctors without a salary whose main job was to cover any absences and illnesses of the permanent staff and they had the right to fill any vacancies that came up in the municipal medical corps, which was done by turn according to both seniority and merit (Ayuntamiento de Barcelona 1905, 345).

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registered poor). Many more of the establishments subsidised by the city council also had a medical care service (Ayuntamiento de Barcelona 1905, 364).

On the other hand, the data available for Barcelona confirm that very few changes were introduced into provincial charity services provided by the provincial authorities, known as *diputaciones*, in the early twentieth century (Table 3). It should be noted that, after the passage of the *Reglamento General de Beneficencia* (general charity regulations) in 1822/1836, each province was required to have a *Casa de Maternidad y Expósitos* (maternity and foundling home), another charitable institution known as a *Casa de Socorro y Misericordia* and a publicly owned hospital (Esteban 1992). The insufficient spending on provincial charity in the first decades of the twentieth century was limited to care provision for the oldest, most traditional sectors of the poor in a precarious manner. Their main efforts were concentrated on providing the poorest families with food, clothing and hospital treatment, and on the confinement of the old, vagrants and foundlings in hospices and children's homes. Their income came from their own sources; bequests, alms, and donations from individuals and aid from the state and local authorities (water rates, cemeteries, etc.). The income that came from some of those who were taken in by these charitable institutions, either in money or in kind, from the mid-nineteenth century onwards, should also not be overlooked, (Marín de la Bárcena 1909, LXV). In this case, the meagre resources also limited spending possibilities, which was naturally detrimental to the quality of the charitable services offered. With regard to Barcelona, the *Casa Provincial de Caridad* (a provincial "House of Charity"), the *Casa Provincial de Maternidad y Expósitos* and the *Hospital de Dementes Pobres* for poor mental patients absorbed almost all provincial charity expenditure (Table 3).

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TABLE 3. Budget of provincial charity expenditure in Barcelona, 1913

General Treatment	**Pesetas**
- Spending of the Provincial Charity Board	4,750.00
- Casa Provincial de Caridad	150,000.00
Casas De Misericordia	
- Casa Provincial de Caridad	1,058,718.52
Casas de Maternidad y Expósitos	
- Casa Provincial de Maternidad y Expósitos	511,384.10
Hospitals	
- Hospital Clínico	127,000.00
- Dementes Pobres	447,500.00
- For the medical examination of the mentally ill	3,000.00
Private Charitable Establishments	
- Subsidies	79,000.00

Source: Ayuntamiento de Barcelona (1915, 309).

Overall, healthcare and public hospital services in Barcelona during the period under study were synonymous with traditional charity: free for the poor and to be paid for by those considered to be comfortably off. The attention and coverage for both groups was clearly insufficient for a growing population and with limited financial means. The city council, rather than Barcelona provincial council, made the greatest effort in this area, despite having an even more limited budget. Hence, the data for 1913 reveal how the provincial council's maternity home had a similar budget to that for the city's entire municipal medical corps. Both municipal and provincial institutions, however, devoted a significant part of their spending on charity to subsidising private charitable institutions, where they did not control either the management or the results.

So where were the main changes in Barcelona's public hospital provision during this period? The concentration of companies and workers also stimulated the creation of employers' mutuals, private clinics and other forms of protection based on workers' associationism. The *Anuario Financiero y de Sociedades Anónimas* yearbook published in 1935 includes at least

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fourteen private clinics created as joint-stock companies in the province of Barcelona at this time. There was also one in Lleida and another in Tarragona.[31] It is also important to highlight the important role played by friendly societies in a city housing one of the country's main concentrations of workers.[32] According to the data available, most friendly societies (not dependent on any company) in Spain at this time were concentrated in Catalonia, where 73.39% of these entities and 56.26% of members were to be found in 1915 (National Welfare Institute, INP 1927, 99). In the meantime, the employers' industrial accident mutuals, created from 1900 onwards, were very numerous in Catalonia and especially in Barcelona. They created small dispensaries and some clinics: Mutua General de Seguros; Mutua Catalana de Accidentes e Incendios; Mutua Sabadellense and Mutua de Seguros de Terrassa. Finally, it is also important to note the role of private insurance companies in the industrial accident branch, for example, Hispania (Pons and Vilar 2019b). Within this context, the foundations of a hospital structure in Catalonia were laid, much conditioned by the "Barcelona factor" and relying mainly on a constellation of small private clinics and hospitals of varying origin.

2. The work of the Mancomunitat, the devolution of responsibility for healthcare to the Republican Generalitat and the debate on the Catalan hospital system before the Civil War

As seen above, the shortage of hospital beds and their unequal distribution among the provinces and districts of Catalonia were problems that were already evident at the turn of the twentieth century to professional doctors such as Francesc Puig i Alonso and his colleagues participating

[31] *Anuario Financiero y de Sociedades Anónimas de España 1935*, Madrid (p. 967). For more details on these joint-stock companies see Pons and Vilar (2019a, Table 2).
[32] This aspect has already been analysed in previous works, see for example Pons and Vilar (2012). The friendly societies also maintained an important presence in rural Catalonia, see Arnabat (1994).

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in the first *Congrés de Metges de Llengua Catalana* (Congress of Catalan-speaking doctors) in 1913 and in subsequent encounters organised by medical professionals (Sabaté 1993, 118, and Sabaté 2020). During this period, there were some initiatives launched by public institutions aimed at improving existing infrastructures. Examples include the transformation of the old maritime lazaretto into Hospital Nostra Senyora del Mar, promoted by Barcelona city council, or the inauguration of the new Hospital Clínico Provincial in 1906. Under these circumstances, the foundations of a model centred on the coexistence of private business with a limited development of public hospital institutions were gradually established. This was a result of the rejection of the model of provincial hospitals controlled by the provincial councils and a commitment to developing health districts and district hospitals. This strategy was accompanied by a significant change of approach towards a comprehensive system characterised by coordination between medicine and health, between public and private healthcare, and progressing from the charitable function of hospitals to the provision of a public service. This process began, according to Sabaté (1993, 118), with the setting up of the Mancomunitat de Catalunya. This author also highlights the "Pla de Regionalització Sanitària", the regional healthcare plan drawn up by Dr. Cinto Raventós (1917), as a fundamental precedent for hospital development. This was the basis for plans for the organisation of healthcare and hospitals in Catalonia at regional and district levels throughout the twentieth century.[33]

The Mancomunitat de Catalunya was an institution that encompassed, from 1914 to 1925, the four Catalan provincial councils in a single regional body.[34] It was promoted by the leader of the *Lliga Regionalista* (Catalan Regionalist League) Enric Prat de la Riba and constituted by

[33] For more information on this doctor, see Reventós (1984).
[34] For further details, see Mancomunitat de Catalunya (1923).

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royal decree by the Spanish government in March 1914. From the outset, the Mancomunitat assumed responsibility for all the charitable services that had previously been run by the Catalan provincial councils. Thus, the four Catalan *diputaciones* handed over their competencies to the Mancomunitat but, contrary to what the Regionalist League expected, the state did not relinquish any of its own competencies. A number of institutions were dependent on the Mancomunitat, including the charity, maternity and foundling homes in Barcelona; the maternity home, hospital and *Casa de Misericordia* in Girona; the maternity home, hospital and *Casa de Misericordia* in Lleida; and the *Casa de Beneficencia*, which incorporated a maternity home and a *Casa de Misericordia*, in Tarragona. The governing boards retained wide powers and their presidents continued to serve as directors of the establishments.

When the Mancomunitat started functioning, only Girona had a provincial hospital, due to the process of transformation into charity hospitals at the end of the nineteenth century, explained above in the first part of this paper. In the provinces of Barcelona, Lleida and Tarragona, the sick in the charge of provincial institutions, now taken over by the Mancomunitat, were attended by officially approved municipal hospitals. Meanwhile, the Mancomunitat, following the tradition already established by Barcelona provincial council, kept an item in its budget to subsidise charitable institutions, whether private initiatives or of a municipal nature. Furthermore, there were nine institutions that maintained an item reserved in the budget, a right that they had inherited from the four preceding Catalan provincial councils. These were Hospital Clínic de Barcelona; Montepío de l´Associació de la Premsa Diària de Barcelona; Patronat de l´Institut Català de Sords-Muts; City Council of Reus by Casa de Beneficència; City Council of Tortosa by Casa de Beneficència; City Council of Valls by Casa de Beneficència; Associació La Caritat de Lleida; Germanes dels Pobres de Lleida and Refugi

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Bressol de Girona. Apart from these institutions, others could apply for assistance in accordance with the basic provisions established by the Permanent Council of the Mancomunitat in the session of 18 August 1921. The following had priority with regard to an application for aid: first, those establishments that performed charitable functions that were responsibilities of the Mancomunitat; second, those charitable institutions that performed functions different to those assigned to provincial charity. The application had to be accompanied by a report justifying objectives and accounts. The Mancomunitat subsidised 28 public and private hospitals (Table 4), 34 charity homes and asylums and another 33 institutions of various types located in the four Catalan provinces during the financial year 1921-1922.

TABLE 4. Hospitals subsidised by the Mancomunitat in the financial year 1921-1922

Hospital de Balaguer	Hospital d´Olot
Hospital de Balsareny	Hospital de Pobla de Lillet
Hospital de Cardona	Quinta de Salut La Alianza
Hospital de Caldes de Montbuy	Hospital de Sabadell
Hospital d´Esparraguera	Sanatori Maritim de Sant Josep, per a nens tuberculosos (Barceloneta)
Hospital L´Esperit Sant per a tuberculosos	Hospital de Seu d´Urgell
Hospital de Figueres	Hospital de Sitges
Hospital de Granollers	Hospital de Terrassa
Hospital d´Igualada	Hospital de Tremp
Hospital de Manlleu	Hospital de Valls
Hospital de Mataró	Hospital de Vich
Hospital de Nens Pobres de Barcelona	Hospital de Vilafranca del Penedès
Hospital de Nostra Dona del Sagrat Cor	Hospital de Vilanova i Geltrú
Hospital d´Olesa de Montserrat	Hospital de Vilassar

Source: Mancomunitat de Catalunya (1923, 90-95).

In view of the inherited situation, the Mancomunitat considered optimising services with the cooperation of existing healthcare facilities. Once the transfer of powers had been completed, two strategies were implemented with respect to intervening in healthcare matters: a) rationalise subsidies b) initiate a programme of building provincial hospitals. With regard to the former,

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some guidelines on subsidies to private institutions were laid down in the form of "*Bases de repartiment de subvencions a establiments particulars de beneficència*" during the period 1920-1924, with the aim of eliminating arbitrariness and giving priority to hospitals. Moreover, there was the paradoxical situation that many hospitals subsidised by the Mancomunitat kept operating thanks almost exclusively to these contributions, but the government body was not directly represented and had no authority over the functioning of these hospitals. In order to improve this situation, an experiment was carried out by means of getting more directly involved in the hospital at Ripoll in 1922. In this case, the Mancomunitat, which provided 80% of the hospital's budget, started to intervene in the governance of the hospital, and the experiment was a success. The Mancomunitat then took action along similar lines with Hospital Civil de Reus in 1923 and Hospital d'Arenys de Mar in 1924 (Sabaté 1993, 126). As for the second strategy, building provincial hospitals, in 1922 the councillor Dr. Estadella once again picked up the thread of the "Pla de Regionalització Sanitària" proposed by Dr. Raventós and submitted a motion advocating the creation of district hospitals, an initiative that was not implemented until five years later, and once again under the guidance and supervision of Barcelona provincial council. What was actually implemented at this time was the building project for a hospital in Lleida (1923) and another project for building a hospital in Tarragona (1924).

As a result of these measures, a significant change in the weight of charity and healthcare in the expenditure of the Mancomunitat can be seen at this time. In 1915, the charity item accounted for 47.46% of total spending, to which could be added 0.52% for "Health Services and Social Action" (out of a total expenditure item of 1,546,170.64 pesetas). By 1922-23, charity and healthcare jointly accounted for 23.78% of expenditure, half of the percentage of 1915, although

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of a much larger item (26,051,390.30 pesetas of total expenditure).[35] After functioning for barely a decade, the Mancomunitat, which had assumed the functions of the provincial councils, was dissolved in 1925 by the dictatorship of Primo de Rivera. From 1925 to 1932, control of hospitals was given back to the provincial councils and some district hospitals were developed. Nevertheless, by the end of this period, Barcelona and Tarragona continued without any publicly owned hospitals dependent on the provincial institutions.

At the start of the 1930s another significant step was taken towards the creation of a hospital model in Catalonia, linked to the Second Republic and the passage of the Statute of Catalonia in 1932. The inclusion of the transfer of responsibility for healthcare led to a serious controversy among medical associations throughout Spain, which was countered by their Catalan counterparts who defended their position. On 25 May 1932, a letter addressed to the head of government and the parliamentary representatives debating the Statute was published. In this letter the inclusion of competencies for healthcare was defended, with arguments referring to the training of the medical professionals, the precedent of institutions created and the work carried out by the medical union *Sindicat de Metges de Catalunya i Balea*rs.[36] Finally, the Statute (Article 12 c and d) granted the Generalitat responsibility for charity and healthcare. Hervás (2004) establishes different phases in the Generalitat's health management in accordance with the stages of autonomous government. In the initial stage, from 14 April 1931 until the passage of the Statute in December 1932, key steps were the creation of the *Consell Tècnic de Sanitat* (Technical Health Council) in 1931, the *Comissió Parlamentària de Sanitat i Assistència Social a la Diputació Provisional de la Generalitat* (a parliamentary commission

[35] For further details, see Mancomunitat de Catalunya (1923).
[36] *La Vanguardia*, May 25, 1932.

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into health and social care under the Catalan government) in 1932 and the creation of a nursing school*, the Escola d'Infermeres de la Generalitat* attached to Hospital Clínic, in the same year. This author highlights as a decisive event, at this time, a series of talks prepared by professionals of the *Sindicat de Metges* analysing the hospital situation and making proposals to improve the state of affairs. Of these talks, one that was especially influential was that presented by Enric Fernández i Pellicer and Cristià Cortes i Lladó, which was expounded by Fernández i Pellicer at the *Academia i Laboratori de Ciències Médiques* (Medical Science Academy and Laboratory) in Barcelona on 16 March 1932 and subsequently published (Hervás 2004, 20).[37]

Fernández i Pellicer (1932) summarised the evolution of the debate on hospital organisation in Catalonia from the first Congress of Catalan-speaking doctors held in 1913 to the Second Republic. Below, we extract a series of elements that we consider essential to understand the formation of the Catalan hospital model.

First, the need for decentralisation and the location of specific centres for the chronically ill and incurable. With regard to the first aspect, the move towards decentralisation, his thesis was based on data that revealed that of the 12,500 sick treated by the most important hospitals in Barcelona (Santa Creu i Sant Pau and Hospital Clínico), more than 3,000 came from other parts of Catalonia. This meant that a quarter of the sick admitted and treated were not residents of Barcelona. In view of this situation, Fernández Pellicer (1932) proposed the creation of a Catalan Charity Committee made up of technicians, experts and people qualified to take on the job of drawing up a new charity law. This new law should include certain basic elements such as a strict delimitation of the obligations of municipal councils and the Generalitat in terms of

[37] A biography of Enric Fernández i Pellicer can be found at EFS (2020).

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social welfare. For the author, the functioning of hospital care should depend on the municipality, above all because the municipal councils were best able to know the needs of their population and identify the people who most needed care. The Generalitat, nevertheless, should take responsibility for surgical treatment. Ultimately, however, under this philosophy, it is understood that the hygienic-sanitary or public health function corresponds to the central state or regional authorities, due to its peculiar complexity, and the hospital function, actual hospital admission and care, corresponds to the municipal services. This project included both privately and publicly owned hospitals, which should all adapt to a plan of joint and harmonious planning and organisation. In cases where municipalities did not have the capacity to run a hospital in accordance with modern, scientific method, the idea was to promote collaborative measures by means of grouping municipalities into larger associations in order to create and maintain a district hospital. In this respect, Fernández i Pellicer continued the tradition initiated in the nineteenth century of opposing organisation on a provincial basis and recommended a division of Catalonia based on the *comarca* (a district comprising a group of municipalities). There were several reasons for this preference, including sentimental, cultural, legal and linguistic factors, while, on the contrary, the province was considered to be an "artificial concept".

The other great underlying debate was the question of the ownership of the district hospitals. In the context of the Second Republic, Fernández i Pellicer acknowledged various possibilities. One was district hospitals that were the property of the Generalitat or the municipalities. Another was privately owned district hospitals but subsidised by the official agencies in line with their social and charitable function. Finally, he thought that all hospitals should be considered as institutions of public utility, and should therefore be supervised by the public authorities and subject to regulations inspired by modern norms of social welfare; scientific,

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economic and moral. However, and this was a key aspect, he defended the idea that each hospital should be developed according to its own means and initiative. In other words, what was being proposed was the creation of hospitals as autonomous institutions where, principally, the municipalities, (and the Generalitat in the form of subsidies) would provide their economic base; private individuals or entities were to offer their support and also economic assistance; and the technical personnel, who constitute the spirit of the hospital function, would contribute their scientific know-how.

With respect to the healthcare organisation of these hospitals, he suggested a hierarchical organisation of care centres in three categories: primary, secondary and tertiary. The primary centres would be staffed by qualified doctors. The secondary centres would serve to support rural doctors. In this case, all the sick requiring hospitalisation should be sent to or admitted into the district hospital. Finally, the tertiary centres would provide specialised surgery and physiotherapy, undertake complicated laboratory research, etc. These tertiary centres would simply be some district hospitals enlarged depending on their capacity and means, and they would simultaneously act as secondary centres for a district and as a supplementary resource for the secondary centres of neighbouring districts.

Overall, Fernández i Pellicer's work encompassed the approach and included the proposals of the majority of medical professionals, and were intended to create the foundations of a Catalan model based on the coexistence of private and public hospitals supervised by a higher institution and the division of the territory into health districts with a hierarchical system of hospital care. It is important to recall that an essential part of the large hospitals in the provincial capitals had gone from public status to private charity ownership in the late nineteenth century, and their management, recruitment practices and the work of their healthcare personnel were all free

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from public control, despite receiving subsidies and reaching agreements with public institutions. This could explain the complaints of health workers at Hospital de la Santa Creu i Sant Pau just after the Second Republic had been proclaimed. On 7 May 1931, prestigious doctors issued a public letter denouncing the lack of control, incompetence and arbitrariness of the hospital's managers with respect to the medical staff. They also complained about the shortage of beds and a legislative framework based on nineteenth-century royal orders and regulations that did not correspond to the majority of demands of the medical personnel. Finally, they launched an appeal for urgent public intervention.[38]

Some of the ideas proposed by Fernández Pellicer and the *Sindicat de Metges* were implemented in the Generalitat's second stage from 29 December 1932 to the temporary suspension of the Statute in October 1934. A series of laws that laid the foundations of the model were passed at this time. These established the organisation, coordination, control and division of the Catalan health service, and were: "*Llei de bases per a l'organització dels serveis Sanitaris i Assistència Social a Catalunya*" (22 March 1934), "*Llei de coordinación i control Sanitaris Publics*" (13 June 1934), "*Llei de Divisió Sanitària de Catalunya*" (10 July 1934) and "*Llei de Carta Sanitària de Barcelona*" (19 July 1934) (Hervás 2004, 26). Within this legal framework in the dividing up of Catalonia's health system, the following health districts were established: Sabadell, Berga, Figueres, Girona, Granollers, Igualada, Lleida, Manresa, Mataró, Olot, Reus, La Seu d'Urgell, Solsona, Tarragona, Tortosa, Tremp, Vic and Vilafranca del Penedés.

[38] *La Vanguardia*, May 7, 1931, p. 7. Also worthy of note was a proposal to create 1,500 beds, made by the councillor Mr Huguet, *La Vanguardia*, September 23, 1932, p. 6. A book by Fargues and Tey (2015) provides details about these struggles between doctors and administrators in Hospital Santa Creu. The book of Comelles (2006), and the article by Fernández and Sabaté (2019) also provide evidence in this regard.

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As well as the legislative task of regulating the hospital system, the Generalitat also introduced changes in the district hospitals, replacing members of the hospital trusts by others who included representatives of the Generalitat itself and some of the municipal councils involved. On 24 August 1933, it passed a decree suspending the trustees from their posts at the district hospital of Vilafranca del Penedés and named another interim board of trustees.[39] On 21 September, the dissolution of the board of trustees of Hospital de Sant Antoni de Viella, which had been constituted by a royal order of 13 February 1928, was authorised. Moreover, a list of subsidies and subscriptions was demanded, as well as an inventory of building work carried out and a record of the management of Antonio Abadía's bequest of 50,000 pesetas.[40] The Generalitat's commitment to developing the model of district hospitals was confirmed with an order approving a building project for the construction of a new wing at the district hospital in Lleida. This was linked to a contract between this institution and the state for the establishment of a military infirmary, with the state agreeing to defray an important part of the cost.[41]

Concern for the district hospitals continued after the suspension of the Statute in October 1934. During 1935, the Catalan regional minister for health, Mr Huguet, made a number of visits to district hospitals such as that in Lleida and the inter-district hospital in Reus,[42] and the district hospital in Viella where building work had been suspended,[43] and then visited the one in Vic in 1936.[44] Building work on district hospitals actually continued during the period of the Civil

[39] *Butlletí Oficial de la Generalitat de* Catalunya, (Official Gazette of the Government of Catalonia), 83, August 24, 1933.
[40] *Butlletí Oficial de la Generalitat de* Catalunya, 95, September 21, 1933.
[41] *Butlletí Oficial de la Generalitat de* Catalunya, 312, November 8, 1934.
[42] *La Vanguardia*. June 18, 1935, p. 22
[43] *La Vanguardia*, September 17, 1935. This hospital was inaugurated on 23 September 1937. *La Vanguardia*, September 23, 1937, p. 3.
[44] *La Vanguardia*, January 14, 1936, p. 11.

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War.[45] During this conflict, a decree was passed by the Catalan regional ministry of the Interior and Social Assistance declaring the following district hospitals: Reus, Tortosa, La Seu d'Urgell, Vic, Olot, Figueres, Mataró, Granollers, Manresa, Berga, Solsona, Igualada and Vilafranca del Penedés.[46]

As well as its policy of promoting district hospitals, the Generalitat had to intervene specifically in Barcelona's hospital system, crucial due to the capital's demographic weight. It did so by regulating the role of hospitals in the city, extending their function as a public service beyond medical care for the poor sick, as well as providing financial support over and above the traditional subsidies. With regard to regulation, it established basic rules for the functioning of hospitals of the district that comprised Barcelona's metropolitan area. As well as care for the destitute, the decree also established admission on payment of a fee (5 pesetas a day) equivalent to 15 days for patients who paid privately, including foreigners, or were paid for by municipal councils. It is very interesting in this case to confirm that the fees established provisionally for services and surgical operations were those of a private insurance institution, Hospital de La Quinta de Salut l'Aliança, in this case reduced by 10%. On the other hand, as for financial support, this was extended beyond the traditional subsidies. In 1934, a law was passed authorising Hospital Clínic in Barcelona to arrange a credit transaction with the *Caixa de Pensions* for two million pesetas, with the Generalitat undertaking to provide an annual subsidy of 80,242.60 pesetas for twenty years (from 1935 to 1954). The only condition laid down was that Barcelona city council committed itself to paying the same amount and in the same way.[47]

[45] In 1938, the district hospital in Berga was under construction. *La Vanguardia*, January 25, 1938.
[46] *La Vanguardia*, October 14, 1938, p. 2.
[47] *Butlletí Oficial de la Generalitat de Catalunya*, 208, July 27, 1934.

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Generally speaking, during this period, the Generalitat continued the process initiated in the nineteenth century of rejecting provincial public hospitals, favouring a distribution of hospital care that took into account the interests of the economic elites, the owners of private hospitals (whether profit-oriented or in the form of private charity) and a significant part of the medical professionals who worked for, or were partners in, these institutions. The basic philosophy was to establish hospital organisation in terms of the healthcare function rather than on the basis of ownership and to follow a strategy of decentralisation based on public and private district hospitals. It is significant that some of the people to hold the post of regional health minister at this time were prestigious doctors linked to the private hospital system. This was the case, for example, of Josep Dencàs i Puigdollers, minister during the government of Francesc Macià from January 1933 to June 1934, who along with his father-in-law, the doctor Cararach i Mauri, founded the private Clínica Sant Jordi in the Torre Boades in the neighbourhood of Sant Andreu[48] and Manuel Corachán i García, minister of health in 1936, a very prestigious doctor who became head of the surgery service at Hospital de la Santa Creu i Sant Pau.[49] From this perspective, the convergence of public and private interests seemed evident.

Conclusions

The Catalan hospital model is based on a greater prevalence of the private provision of beds and a greater participation of the private sector in coverage of the public demand compared with the Spanish average. There were three key moments in the historical development of this model. First, in the late nineteenth century, when the elites who sat on the boards of trustees of the large public hospitals linked to the proprietorship of provincial or municipal councils

[48] His biography at Brugera (2020).
[49] His biography at Hervàs (2020).

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wanted to break these links with public ownership and supervision by transforming them into privately owned hospitals in the form of "private charity hospitals". With this strategy the sale of the property of these hospitals in exchange for public debt was prevented, but in return this property was now under the control of the economic and medical elites and the Church. The privatisations are a fact. However, the hypotheses as to why the elites sought this option are open to interpretation and other elements, such as the type of documentation used, from private hospital archives or public documents consulted, also have an influence on this interpretation. In the end, it is a matter of discerning whether decisions were taken in the public interest or controlled by and in the interests of certain groups, or perhaps due to a mixture of both factors. In this way, these private charity hospitals continued to treat the poor sick and receive subsidies from public institutions, from the provincial or municipal authorities, but these were now unable to control the destination, spending and investment of these funds. Second, the creation of the Mancomunitat de Catalunya in 1914 and its strategy gave rise to a new stage in this process. The Mancomunitat was able to revert the situation described above by taking over the hospitals linked to the provincial authorities at a time when there was a chronic shortage of public beds, above all in the provinces of Barcelona, Lleida and Tarragona, which did not have a provincial council hospital as a result of the previous phenomenon. Within this context, the creation of new public hospitals in the provincial capitals that did not have one was proposed, and there was an attempt to audit and exert a minimum of control over the destination of the subsidies granted. However, the dissolution of the Mancomunitat in 1925 barely allowed enough time to start building work on the projected hospitals in Lleida and Tarragona. Third, in the years prior to the Civil War, the idea of providing the provincial capitals with a public hospital dependent on the provincial authorities or the Generalitat was abandoned (after the transfer of healthcare

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responsibilities), and the idea of creating hospitals that were to function at a district level, regardless of the ownership of the hospital property, prevailed. Influenced by the weight and leverage of the private hospitals, the idea of creating a network of public utility hospitals, which were not exclusively under public ownership, also gained currency. The idea was that both publicly and privately owned hospitals would participate to cover hospital demand. In the end precedence was given to the criterion of mixed coverage of the public demand for hospital services, which was a boost to privately owned hospitals. This philosophy was taken up again at the start of Spain's democracy, after the devolution of responsibility for healthcare to the Generalitat de Catalunya in 1981.

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