The genesis, growth and organisational changes of private health insurance companies in Spain (1915-2015)

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Abstract

The crisis of welfare states in Europe has offered a growing market share to private health insurance companies. Health insurance is currently one of the fastest growing branches of private insurance business in developed countries. However, much remains to investigate the origin and evolution of the companies in this sector. This paper analyses the genesis, growth and organisational changes of health insurance companies in Spain from the creation of the first medical associations in the 1930s to the modern health insurance companies of today. Spain represents an interesting case study to investigate how changes in the public health model for the long period under study allowed private companies to maintain a changing relationship competitive & partnership with the state.

Introduction

By the end of the twentieth century most European Union countries were already providing auniversal compulsory health insurancescheme as part of a broader social protection system.[1] However, private health insurance has become increasingly importantwithin this system in recent decades, in a context of cutbacks, waves of privatisationsand a crisis of the welfare state.[2] As a result of this process, some Member States have a private health insurance market that supplements public coverage (e.g. Sweden, Spain, Ireland and the United Kingdom). This means that the private sector offers services already provided by the compulsory system,but with extra advantages such asshorter waiting lists, and other benefits and comforts. In other countries,private health insurance plays a more important supplementary role by covering services or specialties excluded from the basic state package (e.g. Denmark, Hungary and the Netherlands). Finally, in some Member States private insurance provides substitute cover for people excluded from some aspects of the statutory health insurance scheme due to various factors, such as level of income or type of work activity (e.g. Germany). Overall, the causes behind private health insurance are very heterogeneous and a result of historical evolution, the power of different interest groups and the public policies implemented. Its increasing importance, however, is a common trend in all European countries.[3]

Bearing in mind this typology, the population covered by PHI (private health insurance) in 2000 varied notably in OECD countries. Among the highest percentages, we find the case of the United States, where PHI covered 71.9% of the population (primary and supplementary); while in Europe, the case of Holland stands out with 92% (28 as primary, that is, principal and 64 as supplementary). The lowest percentages correspond to Spain with 13% (2.7 primary and 10.3 duplicate or supplementary) and the UK with 10% (essentially duplicate or supplementary).[4]

With regard to the case of Spain, between 1908 and 1940, the premiums obtained in sickness insurance were never in excess of 6% of the total annual premiums obtained in private insurance business. Later, in 1950, 1960 and 1970, this branch accounted for 10.4%, 6.25% and 8.2% respectively. Overall, these are very low figures, especially if one takes into account the very high number of companies operating in sickness insurance. In 1950, they comprised 24% of the total number of insurers operating in the market; in 1960 it was 30.7% and by 1970 it had reached 52.1%.[5] From 1987 to 1997, health insurance premiums grew by an average of 16% annually, driven by middle class demand and also boosted, among other factors, by: a) the deterioration of Social Security services within a context of cutbacks; b) the growth of group insurance in companies and c) the mutual insurance funds for civil servants and other public employees which allowed two million people to choose an insurance.[6] All in all, private health insurance accounted for 3.9% of total health expenditure in 2000.[7] In recent years, the growing interest of insurers and the banking sector in acquiring this segment of insurance business has led to them increasing their participation in the insurance industry. In,the percentage of total premiums accounted for by PHI rose from 7.2% in 2001 to 10.8% in 2011at a time of serious economic crisis.

Despite this trend, the development of health insurance companies has hardly been studied from a historical perspective.[8] Little is known about the origin, management and organisation of these companies; there is also a lack of studies from a business history point of view on their progressive increase in scale, their internationalisation process and the important mergers that have taken place in the sector over recent decades.[9] Thus, the main aim of this paper is to study, from a business history perspective, private health insurance companies in Spain before and after the belated introduction of state compulsory health insurance at the beginning of the Franco dictatorship in 1942. This

analysis takes into account the fact that their evolution has been different from the development of other insurance companies. These discrepancies are based on three aspects: 1) in most cases, their foundation was not linked to entrepreneurs in the insurance sector, but rather to members of the medical profession; 2) their dual regulation imposed joint control of health insurance companies by a health care supervisory body and an insurance sector supervisory body, and 3) their marginal development within the insurance business until increasing demand attracted the interest of general insurers and the banking sector in recent decades.

Bearing in mind these key aspects, and with the proposed objectives, this paper is divided into four main sections. In the first, the foundation, typology, location and financial resources of the first insurers that covered health insurance from 1915 to the Spanish Civil War (1936-1939) are analysed. Here, their minimal weight in the insurance market can be seen and the first entrepreneurs from the world of medicine are studied. The difficulties to grow in a market with little demand, which started to be transformed due to the growing interest of large companies in providing the benefits of health care coverage for some of their employees, are also examined. In the second section, the collaboration between insurers providing health insurance and the Franco dictatorship in the management of compulsory health insurance, from its passage in 1942 until its withdrawal with the Basic Law of Social Security in 1963, is studied. The obligatory abandonment of this important part of their business led insurers to initiate processes of conversion into stock companies and to increase their mutual collaboration and associationism in order to increase the scale of their coverage from local or regional to national level. The third section focuses on the Spanish transition to democracy, when health insurance companies obtained a market share in the coverage of public servants. This prompted different growth strategies ranging from cooperativism and mergers to the

creation of pools to increase the geographical scope of health care services. The fourth section analyses the growing interest of general insurance companies in the health branch, the concentration of business and the arrival of international and bank capital. All in all, this historical evolution makes it clear how private health insurance companies went from being marginal to being much coveted in the Spanish insurance market.

1.The marginal market: local and provincial initiatives (1915-1941)

The state was incapable of implementing compulsory health insurance in Spain in the first decades of the twentieth century. Industrial accident insurance, retirement pensions, maternity and unemployment were all legislated for, to a greater or lesser extent, but not health care coverage. During this first stage, the private insurance sector was very weak and showed little interest in this branch.[10] Consequently, and as had happened in other European countries, private companies did not compensate for the shortcomings of the state and friendly societies.[11] As regards demand, the low standard of living of the population, the high percentage of rural population and the low employment rate explain, among other factors, the slow development of the sector. As for supply, the private insurance law of 1908, which regulated the sector during this period, made minimal demands on companies in this branch with respect to share capital or deposits, which effectively determined their small size and high geographical concentration.[12] Both factors were the result of a fragmented market, made up of companies with scant capital and premiums, which operated at local level in the large cities (above all Barcelona and Madrid) and, in most cases, covered the risk of sickness in return for a monetary fee (*iguala*). Altogether, the premiums collected in the branches of health and burials (combined in the statistics of the time) accounted for 5.18% of the premiums collected by the entire insurance sector in 1915; 4.97% in 1925 and only 2.87%

in 1935.[13] The health branch, therefore, had a small and decreasing relative weight in the private sector as a whole during this period. However, while there were 45 companies registered in the branch of health and burials in 1915 (31 in Catalonia, 11 in Madrid, 2 in Zaragoza and 1 in Vigo), the number had risen to 70 by 1925. In 1915, the top 10 companies concentrated 71.83% of premiums, while in 1925 they only accounted for 57.56% (Table 1). It was, therefore, a fragmented branch with few companies of a significant scale in terms of premiums, managed in most cases by the doctors and specialists themselves, who were funded by the monthly fees or *igualas* paid by families.

Little is known of the founders of these companies started up by doctors' associations (known as *igualatorios médicos*), which were the first initiatives in the private health sector. We assume that the initial capital for these associations was provided by the doctors themselves, who saw a business opportunityin view of the backwardness of public health care coverage and the lack of interest of private insurance in the sickness branch. In fact, large companies did not start operating in the branch of health insurance until after the Civil War. If they did so earlier, they did not intervene directly but instead promoted specialised companies.[14] Overall, the typical corporate forms were professional associations and general partnerships, although they were progressively obliged to become joint-stock companies. The increase in the number of companies and the growing complaints received for breaches of contract drove the government to control their health care activity, through the creation of a Health Office (*Comisaría Sanitaria*) dependent on the Directorate General of Health (*Dirección General de Sanidad*), by the Royal Order of 31 March 1925. From this point on a certain bipolarity was created, as private health insurance companies were audited by the Directorate General of Insurance (*Dirección General de Seguros*), but controlled in terms

of health provisions by the Directorate General of Health, something which was to have important consequences in the future.

Some of these companies had been founded in the late nineteenth century and gradually offered medical specialties to the upper middle class in the main Spanish cities. This was the case of La Equitativa in Madrid, founded in 1896 by José García de la Serrana and which, in 1929, covered around 30,000 families who paid the monthly fee. The company had a team of medical practitioners and two clinics, one in the north of the capital and one in the south, where they offered routine consultations, general medicine, general surgery, and covered the ear, nose and throat, digestive system, ophthalmology, gynaecology and dermatology specialties. The two clinics had X-ray equipment, diathermy, phototherapy, an analysis laboratory and other modern facilities. In this year, 1929, it opened a clinic for surgical operations, equipped with a surgery and 30 rooms, run by Doctor Mariano Cardona.[15]

Generally speaking, private health insurance made little progress in terms of premiums and relative weight within the sector, although this mediocre trend was similar to that of other European countries. This performance was due to the inability of the sector to offer premiums and services that were affordable for most of society and also because of certain misgivings among the population about taking out health insurance with companies whose main goal was to make a profit.[16] These factors can be added to those already mentioned above for the Spanish case. But, who promoted the first private health insurance companies? Health care provisions introduced by companies and employers started in the late nineteenth century in those branches with the highest accident rates and nearly always linked to industrial accidents (mining and railway companies) and, in many cases, obliged by thelaw on industrial accidents of 1900.[17]

Later, during the aftermath of the First World War, with the spread of corporate capitalism linked to large companies, employers showed an increasing interest in providing other types of coverage apart from compulsory insurances, a process that was accelerated due to the increase in industrial disputes.[18] However, there was no homogeneous stance among employers in favour of voluntary insurance and, as it was not obligatory, the results were very inconsistent, both in terms of the insurance offered by employers and the coverage of workers.[19] In the case of Spain, the notable pioneers in providing complex programs of health care coverage were electricity companies, banks and railway companies of a certain size.[20]

2.Health insurance companies and the start of strategies to increase scale in private business (1940-1975).

The post-Spanish Civil War period was marked by a profound economic crisis, characterised by shortages and scarcity, and accompanied by a climate of repression and harassment. Being fully aware of the dreadful health care situation and the population's desire to have health care coverage, the Franco dictatorship used the introduction of compulsory health insurance for propaganda purposes.[21] Compulsory health insurance was passed by the law of 14 December 1942 and established the provision of general medical and pharmaceutical care in the event of sickness or maternity, but with clear limits: it was not universal, the coverage available was temporary and economically precarious, and benefits were very low. Compulsory health insurance was first introduced without a basic health care infrastructure and without any plan for state funding; both of these factors were serious obstacles to implementing a complex and expensive insurance.

What was the role of private companies in this new context? Their role was crucial for a state with the serious limitations commented above. The companies, for their part,

encountered an opportunity to collaborate with the state, which desperately needed doctors and health care infrastructures, and thereby increase the scale of their operations.[22] The Decree of 2 March 1944 established the implementing rules for the special agreement between the National Welfare Institute (*Instituto Nacional de Previsión*), the body given the responsibility for introducing, managing and administrating state insurance, and the private entities. The private entities that collaborated in managing compulsory health insurance were the leaders in terms of the percentage of companies covered, and the number of members and beneficiaries, until 1966, the year in which they abandoned their collaboration with the state definitively.[23]

In spite of their participation in the management of public insurance, the private companies continued to operate in a market that was fragmented during the 1940s and 1950s, divided into a multitude of medical *igualatorios* of registered medical practitioners and health care associations, providing specialties at local or provincial level, and clinics, whose partners or associates were doctors and other medical staff. The insurance law of 16 December 1954 determined that insurance policies and health care provisions were to be subject to this law and obliged all insurers (of any branch)to operate under the legal form of mutual society or stock company.[24] Meanwhile, a joint order from the Ministries of Finance and the Interior obliged all insurers in the branch of health and burial insurance to enrol in a special Ministry of Finance register of insurers. However, the law maintained very low demands with respect to deposits, although the deposit required was increased: rising from between 5,000 and 50,000 in 1927 to between200,000 and 600,000 in 1954, depending on the type of benefits offered. Furthermore, the required capital (a million pesetas) remained lower than in other branches (fire, transport, theft, etc.). Consequently, the market continued to be fragmenteddue to the presence of a multitude of local firms, even though 75% of business was concentrated in the hands of around twenty companies,

and the majority of these firms did not even operate at national level. Nevertheless, the new regulations entailed a radical change in the branch of health insurance, since a number of insurers came to light due to the register (121 registered in 1950, and 475 in 1960), while at the same time there was a wave of insurers that became stock companies (Table 2). Overall, we find that during this period there were diffuse and indistinct boundaries between the provision of health insurance by social welfare mutuals, state insurances, *mutualidades laborales* (workers' friendly societies created during the Franco regime) and private insurance companies and mutuals, which contributed to the opacity of the sector. On the other hand, the state needed these insurers in order to implement its health insurance project, yet even so it acted very warily in the signing of special agreements and maintained a posture of seemingly applying a temporary solution. Finally, collaboration with the state in managing public insurance came to an end with the Basic Law of Social Security of 1963, which terminated all collaboration with private insurers.

Apart from the termination of the agreements as collaborating bodies of compulsory health insurance, the private insurance companies in the branches related to health, sickness (benefits and health care provision) and burials were faced with two main problems that required reforms at the end of the dictatorship: the small scale of business and its dependence on two ministries (Finance and Interior), which put a break on legislative changes and reforms. Meanwhile, two changes were underway within the sector, with a growing focus on health care insurance rather than cash benefits, and also a growing weight of health care provision compared to burials in the branch as a whole.

Generally speaking, insurance companies operating in the health branch were not run as genuine insurance companies during the 1960s and 1970s. The dual control (dependent on two ministries) and the lack of business organisation, insurance techniques

and financial means justify this assertion. These factors explain why the evolution of health insurance companies in Spain was so slow and the market remained static, in spite of the transformations taking place in the socio-economic sphere and in medicine.[25]In the 1950s, the creation of stock companies by the doctors and specialists participating in the *igualatorios* and Specialty Centres proliferated. Thus, for example, Sanitas was formed in Madrid and Asistencia Sanitaria Colegial in Barcelona, and associations such as Igualatorio Médico Quirúrgico in Bilbao were transformed. However, the sector was largely comprised of a plethora of small-scale insurers, and there was an excessive number of companies, with very limited share capital and practically no reserves or deposits, even though these were now obligatory in other branches, and in most cases they only operated on a local or provincial scale.

In 1970, the branch of health insurance had by far the largest number of companies (347), followed at some distance by the fire branch. Very few of these insurers were general insurance companies, almost all of them operated exclusively in the health branch, and only exceptionally extended the insurance provided to include burial insurance. Comparing the rankings from 1960 to 1970 shows a curious return to an extremely fragmented business as the *Federación de Mutualidades de Cataluña*, which had accounted for 43% of premiums in 1960, had disappeared from the statistics by 1970 due to a change in classification.

In the 1960s and 1970s, however, there was a change in the demand as a result of the progressive implementation of state health insurance and increases in the cost of health care coverage due to medical advances, especially in surgery and medical specialties. Insurers had a growing clientele among the upper classes, who had previously used private medicine by means of direct payment and who started to take out policies with private insurance companies or mutuals. The friendly societies lost part of the

working and middle classes as these registered for state health insurance. This situation was further aggravated in the 1970s with the economic crisis, when inflation affected premiums due to the increased costs of services, benefits and health care provisions.

One of the most noteworthy transitions was related to the strategy of territorial expansion of companies in the sector. The increase in scale, from local or provincial to national, was accompanied by an increase in their financial capacity through the growth of their share capital. This process has been accredited in the two leading companies in the ranking: Igualatorio Médico Quirúrgico in the province of Biscay and Sanitas. In the first case, the Basque *igualatorio*, founded by a doctors' association in 1934, became a *montepío* (similar to a friendly society) in 1952 and then became a stock company in 1959. Starting from the 1940s, it grew in the province of Biscay and then expanded to the rest of the Basque Country, thanks to taking on the collective insurance of large companies. This growth was sufficient to make it the branch leader.

Sanitas provides another example of territorial growth, in this case due to successfully managing to sell premiums to the middle classes and its participation in organisations such as UNEAS (*Unión Nacional de Entidades Sanitarias*), a national union of healthcare organisations. This association, led by Sanitas (a company presided by Marcial Gómez Gil), was created to reach agreements with medical *igualatorios* and health care associations operating at local or provincial level in order to conclude reciprocal agreements for providing the services of collective policies that covered the patients of the association's members. UNEAS was founded in 1959 and was composed of 41 provincial and local insurers, mainly medical *igualatorios*. Their participation in this association enabled them to contract collective policies with important companies. Sanitas' expansion strategy was complemented by the full payment of its capital in 1967 and with the increase of this capital to ten million pesetas in 1968.[26] Thanks to this

process, by 1973 it occupied first place in the ranking of a branch with 366 operators and 42nd position in the general branch of the entire private sector (Table 3).

In Barcelona, a doctor called Espriu founded the company Asistencia Sanitaria Colegial, S.A. in 1954. Originally, each associated doctor had three shares. The company was run by fifteen directors chosen by a meeting of shareholders, all of them doctors. The company consolidated in the 1960s, while the number of share holding doctors increased and an administrative and accounting infrastructure was created.[27]

In the 1960s the sector urgently needed legislative changes and a new form of management that would lead to its modernisation. During the second half of the Franco period, the progressive visibility of the insurance companies that had been operating clandestinely and without control in the branches of health and burials was achieved, although pressure from doctors prevented these from becoming exclusively dependent on the supervisory institutions of the insurance sector. This made it more difficult to enforce the increased demands regarding solvency, actuarial techniques, guarantees and deposits that were required of companies operating in other branches. The weight of health insurance in the form of benefits and health care had recovered somewhat during the last decade of the Franco regime from 6.25% of private insurance premiums to 8.2% in 1970.[28] Nevertheless, insurance companies were faced with the considerable challenge of how to technically modernise the sector and concentrate business, and in fact very few companies were able to achieve this.

3.The demand generated by mutual insurance funds for public servants and the growth in the scale of health insurance companies (1975-1986)

From 1975 to 1986 Spanish politicians were incapable of reaching an agreement to establish the country's health care model in the new democratic era. The new General

Health Law was not passed until 1986. However, Spain's public health care expenditure quadrupled between 1976 and 1986 in circumstances where health care coverage was democratised with measures that brought about its universalisation, the standardisation of medical staff and their salaries, and initiatives aimed at modernizing infrastructures and incorporating new technologies.[29] Private insurance companies, for their part, were also awaiting the reform of the sector during Spain's political transition. In the mid-1970s private insurance was still regulated by the insurance law of 1954. The preliminary draft laws promoted by the Directorate General of Insurance aimed at introducing reforms did not come to anything until the private insurance law passed in 1984.[30]

Private health insurance companies took advantage of the delay in reforming public health insurance to obtain a share of a market with great potential: the mutual insurance funds for public servants. Law 29/1975, of 27 June, on the social security scheme applicable to public servants (*Seguridad Social de los Funcionarios Civiles*) led to the creation of a mutual fund for state public servants, the *Mutualidad General de Funcionarios Civiles del Estado* (MUFACE). Meanwhile, Law 28/1975, of 27 June created a mutual fund for the armed forces, the *Mutualidad de lasFuerzas Armadas*. These were joined by similar funds for civil servants in the judiciary, the *Mutualidades de Funcionarios de la Administración de Justicia* (MUGEJU) and in local administration, the *Mutualidad de los Funcionarios de la Administración Local* (MUNPAL). These mutual funds were able to provide health care provisions either by direct coverage or by establishing agreements with public and private entities.

The majority of public servants chose private insurance companies. At one stage during this period (1976-1985) private companies covered 94% of all public servants.[31] Thanks to the above-mentioned agreements with mutual funds, health insurance companies expanded and increased in scale. Moreover, the growth in the number of

insured and premiums gave rise to significant changes in how they were managed, which in turn led to providing improved and more complete services while reducing costs. Not all the effects, however, were positive. The contract with the mutual funds established fixed payments that limited profit margins. This meant that few companies decided to maintain the annual agreements on a regular basis. On the other hand, insufficient premiums led some companies to decapitalisation and degradation of their services, and even to annual deficits.[32]

Within this context, one of the main problems of the health insurance market was still its fragmentation and the small scale of coverage of companies managed, in the majority of cases, by doctors and medical specialists. A total of 297 companies were operating in the branch in 1979 and 279 in 1980; figures that accounted for almost half of the 640 private insurance companies in Spain.[33] However, during the 1970s, the groups, *igualatorios* and local companies initiated projects of integration via associations and cooperatives with the aim of meeting the demand at national level resulting from the agreements with the public servant mutual funds. ADESLAS is the most noteworthy case.

ADESLAS (*Agrupación de Entidades de Seguro Libre de Asistencia Sanitaria*), a grouping of private health insurers, was not constituted in the 1970s as a commercial company, but rather organised as an association made up of companies of a local and regional scope. They shared the objective of providing health care provisions at national scale in order to be able to participate in the agreements with the different public servant mutual funds. ADESLAS collected a total of 5,370 million pesetas in premiums in 1981 and was comprised of around thirty companies that were included in the official statistics on an individual basis. The continuance of the regulation of 1954 had enabled the survival of these groups thanks to an ambiguous legal situation. After a complaint of irregularities

by one of the associates, Previsión Médico Quirúrgica, in 1981, ADESLAS carried out a legal restructuring that led to it becoming a stock company in 1983.

Another example of collaboration between local and provincial companies was the stock company ASISA, created in Barcelona in 1973, with similar objectives of mutual cooperation. This insurer, promoted by the company Asistencia Sanitaria Interprovincial, was constituted as a medical *igualatorio* although all its shares were the property of Lavinia, a cooperative of registered doctors. In 1984, 18,000 doctors were members of the cooperative and shareholders of ASISA, each one of them holding one share. This company had a delegated committee in each province, comprising doctors elected by assemblies of cooperative members. There were sometimes offers to buy the company, but it continued as a doctors' cooperative with a 15% market share of health insurance from 2006 to 2010.[34]With this format, it provided care for public servants affiliated to their particular mutual funds throughout Spain.[35]

Few companies used mergers as a way to expand before the private insurance law was passed in 1984. One exception was the Sociedad Interprovincial Española de Seguros, S.A. (INTESA). This company took over at least ten small local firms in the region of Catalonia between1972 and 1983.This cycle of concentration ended with a change of business name as it became Aresa, S.A. a year later[36].

In a second phase of expansion, health insurance companies attempted the internationalisation of their operations, with varying degrees of success, and established a strategy of either creating their own clinics or signing preferential agreements with hospitals for the care and treatment of their insured. An example of the former strategy was Sanitas which, always under the leadership of the doctor Marcial Gómez Gil, created Sanitas Internacional (1980). As an example of the second strategy, since its constitution Sanitas, S.A. had maintained preferential agreements with Organización Ceyde, S.A.,

belonging to the same Gómez family, and with Instituto de Cirugías Especiales, S.A. Meanwhile, the Igualatorio Médico Quirúrgico of Bilbao had acquired the Clínica Vicente in San Sebastián, and Asistencia Sanitaria Colegial, S.A. converted a recently-acquired hotel in the Avenida Diagonal in Barcelona into the Hospital de Barcelona which was opened in 1989.[37] These are just a few examples of a process that was really quite complex.

4.Private versus public health insurance (1986-2015)

The General Heath Law was finally passed in 1986, but it was a piece of legislation that satisfied virtually no one, as its contents were more a set of principles and long-term objectives than a plan for health care reform that could be implemented immediately.[38] The legislative status quo established with regard to private health insurance in the previous stage barely changed in general terms. In Spain, in 2001, of all the public servants who belonged to three of the state's mutual funds (MUFACE, ISFAS and MUGEJU), the vast majority, 84%, chose to insure themselves with private insurance companies, compared with the 16% who chose the Social Security or the health services managed by the autonomous regions.[39] Meanwhile, along with these groups, consumers of health insurance turned increasingly to private health care for a different reason, and with a complementary function. This demand was aimed at avoiding the waiting lists of the public system, receiving specialised care without first having to go through the primary health care services and obtaining dental healthcare services for adults, which were not included in the public health insurance.[40]

The increase in individual clients contributed to the introduction of tax reforms in the 1990s that allowed a 15% tax allowance for medical expenses, including insurance company premiums.[41] This tax measure, despite the opposition of the insurance

employers' organisation UNESPA, was repealed in1999although, in exchange, tax deductions for company insurance were incorporated.[42] This double health coverage, compulsory public and complementary private, was defended by employers within the sector and studies were published supporting this option, most of them based on the savings in health care expenditure that would ensue.[43] In 2012, health insurance premiums (covering sickness and health care) rose to 6,720 million euros, 11.5% of total premiums in the insurance sector (life and non-life). 1,400 million euros came from the agreements with the mutuals MUFACE, ISFAS and MUGEJU, 21% of the total income of private health insurance.[44]

Along with the growth in this demand, the adaptation of the sector to Spain's incorporation into the EEC led to numerous mergers and takeovers that reduced the number of companies in the health insurance sector. Between 1985 and 2013, there were other important changes that modified this branch. Health insurance companies went from being operators in a marginal branch, with little weight in the sector, to occupying the leading positions of non-life branches of the insurance business by 2013. The health branch grew from 2000 to2012, initially with an annual growth rate of 9-10% untilit sloweddown in 2008 due to the effects of the economic crisis and competition over prices. In 2012 the growth rate was 3.08%. The factors influencing this growth included the introduction of new types of coverage, tax incentives established in the reform of 2002, the development of group insurance in companies and the marketing of products for certain segments of the population.[45]

In 1973, the leading company operating in the health branch, Sanitas, S.A., was in the 42nd position in the general ranking of the sector, comprising 687 entities. By 2013, we find several health insurance companies in the top twenty places of the ranking by volume of business in the non-life branch, comprising 200 companies.[46] As regards the

ranking of companies by premiums in the health care branch, we find the same companies in the first three places both in 1993 and in 2013. However, by 2013 ASISA had fallen from first to third place, while ADESLAS (now in the hands of SegurCaixa) had risen from third place to leading the sector with 30.3% of premiums. Together, ASISA, Sanitas and ADESLAS (under the name SegurCaixa-Adeslas in 2013) accounted for 52% of total premiums in 1993 and 65% in 2013 (Table 4).

This new situation for the sector was due to important changes in the last thirty years: a) waves of mergers and takeovers that increased business concentration in the health branch, driven by the new solvency requirements after the 1984 law and incorporation into the EEC; b) the increased demand that stimulated the interest of general insurance companies and the banking sector in this business; and c) the entry of multinationals into health insurance.[47]

With respect to business concentration, the number of insurers operating in the health branch fell from 243 to 128 between 1984 and 1993 (Table 5). In this period the companies were still financed by national capital, and were mainly stock companies, which now controlled 97.5% of business (only 5 mutuals remained). The top twenty companies collected 85% of premiums in 1993, which shows the greater concentration. ASISA led this branch with 23.76% of premiums, followed by Sanitas with 14.77% and ADESLAS with 13.96%. The top three together accounted for almost 52.5% of business. If we add Asistencia Sanitaria Colegial (6.56%) and Previasa, S.A. (5%), this percentage rises to 64.05%. It must be remembered that in 1970, the top five in the ranking only accounted for 28.42% of premiums. The level of concentration increased between 2000 and 2012. In the former year the top ten companies concentrated 77.86% of premiums while in 2012 this figure had reached 82.15%.[48]

Two phases can be detected in the merger process of health insurance companies. In the first, small provincial insurers were absorbed, whereas in the second foreign capital and the banking sector now participated. The first waves of concentration processes were initiated in the second half of the 1980s, when the larger companies (ADESLAS, Aresa and Aegon) took over others that only operated on a local or provincial scale. This phenomenon accelerated in the insurance sector between 1990 and 1996, when 143 entities were involved in mergers or takeovers. Three important conclusions can be drawn regarding this trend:[49] a) most of these operations were undertaken by stock companies (92% of total insurers); b) 51 companies acted as the absorbing company another 88 firms; c) the waves followed this pattern: the largest number of agreements were concluded in 1991 and then there was another wave in 1994 and 1995. In this second phase, the entry of foreign capital, linked to incorporation into Europe, and the recent acquisition of health insurance companies by general insurance companies, were crucial factors. General insurers became very interested in the expansion of a branch which they had largely ignored during the entire twentieth century.[50]

With these two phases, the large health insurers consolidated their position. This was the case of ADESLAS and Aresa. The former acquired Madrid Salud, S.A. and Previsión Médico Social de Huelva, S.A. (1989). Later on, starting in 1991, it initiated the merger of almost twenty insurers that operated at local level throughout Spain. In 1991, the French group Médéric acquired 45% of its capital, while the remaining 55% was in the hands of Aguas de Barcelona. By 2006, thanks to this process, ADESLAS had become the leader in the health branch with 23.69% of premiums. This distribution of shares changed in October 2009 when one of the largest Spanish financial institutions, La Caixa, acquired ADESLAS through its own company SegurosSegurCaixa. For its part, Aresa (Interprovincial Española de Seguros, S.A. before 1984) absorbed dozens of small

provincial and regional insurers between 1991 and 1999 until it was taken over by Mutua Madrileña in 2005. By 2014 this company enjoyed a market share of 27.4% with 3.2 million customers.[51]

The interest of foreign capital in the health branch led to other shares changing hands. The Dutch Aegon was one of the first multinationals interested in Spanish health insurance. It acquired Seguros Galicia in 1988 and, later, Labor Médica de Seguros and La Sanitaria, S.A. in 1996 and 1997. Also in 1988, 40% of the capital of Sanitas was acquired by COFIR (*Corporación Financiera Reunida*), linked to Carlos Benedetti. Differences of opinion between the new shareholders and the Gómez family led to the sale of the shares of the founder's heirs to the British mutual company BUPA (British United Provident Association).[52] By 1989 BUPA had acquired almost all the shares of Sanitas.[53] Meanwhile, the entry of the German multinational DKV into the Spanish insurance market was via the acquisition of Previasa, S.A., a company founded in Zaragoza by Publio Cordón. In 1990, the British company Scottish Widows acquired 10% of its capital. In 1997, after the kidnapping of its founder by the terrorist organisation GRAPO, its sale to DKV, the leading European health insurance company, was agreed. This insurer currently belongs to Munich Health of the Munich Regroup. It is the fourth insurer in the health branch with 6.8% of premiums. The sale of Clínicas Quirón, which formed part of the Previasa Group and had played a very active role in the provision of health care in Spain in recent years, was not included in the acquisition agreement.

The crisis of the public health care model over the last few decades, mutilated by budgetary adjustments and cuts, fuelled the trend towards the privatisation of health care services managed by central and regional governments within the framework of neoliberal ideology. This change in trend opened the way to the participation of health insurance companies in the management of hospitals and medical services or publicly

owned foundations. The development of this process coincided with the expansion of the private hospital network. Since 1990, almost all insurance companies have increased their medical centres, dental clinics, hospital groups and health care staff with the aim of giving preferential treatment to their policyholders and beneficiaries (Table 5). This is the case of ADESLAS, ASISA, DKV and Sanitas, companies which already had hospitals and clinics and took advantage of these resources to offer their services to insurers or to sign agreements with the public health service with the intention of reducing waiting lists for certain provisions.

The latest step in this process is the policy of privatizing hospital management, which has been accelerated over the last decade. This model is based on a system of public private partnerships through which the public ownership of hospitals is maintained, and these also remain under public control and funding, but their management is privatised. This formula was introduced in 1999 at Alzira Hospital (Valencia). Insurance companies soon opted to participate in this system. Sanitas (BUPA) was one of the first companies to collaborate. Its first intervention was specifically in running the Manises Health Department, comprising 2 hospitals and 14 primary health care centres in the Autonomous Region of Valencia. Sanitas purchased all Ribera Salud[54] shares in Manises Hospital and took over its management in 2012. In the same year it acquired the Ribera Salud shares for the management of Torrejón Hospital in the Autonomous Region of Madrid.[55]

Sanitas was joined by other insurance companies attracted by the private management of public hospitals. The partner of the insurance companies in most cases was Ribera Salud. ASISA acquired 35% of the shares of the management company running Torrevieja Hospital, which opened in 2006, while Ribera Salud was the holder of the other 65% of the shares. DKV, always in partnership with Ribera Salud,

collaborated in the management of Denia Hospital from 2009 with 65% of shares. ASISA also shares the management of Elche Hospital. This model has been the subject of debate in the last three years and, currently, private insurance companies are still conducting a strategic review of their participation.[56]

Conclusions

In recent decades, private health insurance has experienced an increase in activity in Europe, especially in its supplementary role to public health care coverage. The reduction in public expenditure, the privatisation of public health services and tax incentives to private insurance, along with changes in the population's consumption patterns and diversification of the offer, have fostered this process. Health insurance companies, founded by doctors themselves in their infancy, operated in a marginal market for years in Europe, until becoming an object of desire for banks and general insurance companies in recent decades, thanks to their attractive growth.

This process is evident in the case of Spain. Before the Spanish Civil War, private companies in the health branch had very little weight in the insurance sector. Although they multiplied in number throughout Spain, promoted by doctors, they were small, with very little capitalisation and concentrated in Madrid and Barcelona. We would highlight, among other obstacles to their growth, the minimal demands of legislation governing the sector (the laws of 1908 and 1954) and the dual control (Directorates General of Insurance and Health), factors that certainly did not favour modernisation.

The dictatorship managed to overcome the obstacles that hindered the introduction of a state health insurance, which required the collaboration of the private sector in its management through special agreements, a key manoeuvre to address the lack of adequate funding and public infrastructures. The first agreements concluded with the private sector

(1944-1954) enabled the progressive implementation of coverage of an increasing number of beneficiaries. Basically, the state offered business to the private health care sector, and this responded by facilitating its reorganisation. In 1954, many of the agreements with mutuals and private insurance companies were not renewed in the light of new and more stringent demands. Consequently, private companies tried to increase their existing market niche (upper and middle classes) in a context of limited coverage by state insurance and the rising costs of surgical and pharmaceutical provisions. The basic law of 1963 put an end to the private management of state health insurance and insurance companies focused their strategy on the growth of the private market. Between 1960 and 1975, territorial growth processes were initiated through the organisation of associations, doctors' cooperatives and collaborative mechanisms that enabled the treatment of those insured with small local and provincial companies via networks of broader geographic scope. This process led to the creation of health insurance companies at national and regional level (for example Sanitas andIgualatorioMédicoQuirúrgico).In fact, insurances played a major role in the formation of health business systemsin many countries (particularly in continental Europe, including Spain) because they contributed to regulating competition through the adoption of fixed fees and prices (so that hospitals, doctors, producers of drugs and equipment, etc., could benefit from minimal prices). This was important to ensure the long-term growth of the system.

There was an impasse from1975 to 1984/86 while awaiting the passage of a law to modernise public and private insurance and it was necessary to define a public health care model within the new democratic framework. Additionally, there was also the need to meet the demands of integration into the EEC and the transfer of health care competencies to the autonomous communities. In this situation, health insurance companies progressed,

aided considerably by providing coverage for the mutual insurance funds for public servants, whom the state gave the right to choose between public or private health care.

The market for health care coverage has undergone a profound transformation in Spain since 1986, characterised by business concentration and increasing demand. Under these circumstances, the interest in providing private health insurance in Spain has grown significantly among general insurance companies, bancassurance companies and the multinationals of the sector. Meanwhile, the mutilation of the public health care system, with budgetary adjustments and the approval of formulas for the private management of public hospitals, increased the business opportunities for a growth sector in all European Union countries, and Spain is no exception.

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[1]In Europe, from a historical point of view, and although with significant variations in each case, public systems of health insurance coverage generally prevailed. These models contrast with the one that consolidated in the United States, where the population's health care has mainly been covered by private insurance companies; a system considered to be more expensive in the long term. Chapin, in *Ensuring America's Health*, examines from an institutional standpoint the management and consolidation of the model based on insurance companies, which determined the characteristics of the health system in the United States: its high cost, fragmentation and an anti-democratic corporate structure. The private interest groups involved in this process gained ascendency over the medical professionals and the politicians in government consolidating a system of private coverage. In a similar fashion, Thomasson, *From Sickness to Health*, analyses the creation of the model, although in this case he highlights the role of tax incentives and the fact that private insurance favoured hospitals.

[2]More details on these aspects in Thomson and Mossialos, *Private health insurance*. Since the 1980s, public health insurance has suffered cuts and privatisations and opened up to management by private insurance companies in most developed countries. See Hassenteufel and Palier, "Towards neo-Bismarkian"; Cabriedes and Guillén, "Adopting and adapting managed competition"; Mossialos and Allin, "Interest group"; and Palier, *A long Goodbye to Bismark?;*Aguilar, Waitzkin and Landwehr, *Multinational Corporations.*

[3]Different forms of health care coverage took precedence in these countries depending on the period and the model adopted. The so-called mixed economy of welfare (coexistence of forms of solidarity, state action and private companies) was a preliminary step towards the creation of two basic models of health insurance by the mid-twentieth century; see Harris and Bridgen, *The origins*. After the Second World War, state insurances prevailed in Western Europe, whilst private insurance companies took precedence in the United States. For more on these aspects, see Van der Linden, *Social Security Mutualism;* Beito, *From Mutual Aid;* Glenn, "Understanding mutual"; Harris, *The origins;*Gorsky, "The Growth and Distribution"; Murray, *Origins of American;* and Dreyfus, *Les assurances socials*,among others.

[4]Information taken from Table 2.7 of the OECD Health Project 2004, *Private Health Insurance (*http://www.oecd.org/health/privatehealthinsuranceinoecdcountries-theoecdhealthproject.htm), p. 51. Definition of functions of private health insurance in Box 2.2, 29.

[5]The data from 1908 to 1940 in Pons, *Las estrategias de crecimiento*, and for 1950 to 1970 in Pons, *The difficulties of Spanish*.

[6]Tortella (dir.), *Historia del Seguro*, 344-47.

[7]Public expenditure on health accounted for 71.7%, out-of-pocket payments 23.5% and all other private funds 0.9%. In Table 2.4 taken from OECD, *Private Health Insurance (*http://www.oecd.org/health/privatehealthinsuranceinoecdcountries-theoecdhealthproject.htm), 41.

[8]There are a few exceptions, although outside the field of business history. These are works such as Murray, *Origins of American* and Vonk, "In it for the Money?" that analyse the behavior of private health insurance companies in the United States and the Netherlands, respectively, but tangentially within their broader research that focuses on friendly societies. For his part, Chapin, "The American Medical Association" studies the role of insurance companies in the creation of a health insurance system with a high-cost model in the United States. As for the impact of health insurance on private insurance business, the works on the twenty most important insurance markets in the world compiled in Borcheid and Hauter, *World Insurance*…, highlight its emergence since the 1990s in countries such as Germany, France, Italy, and Japan, and also in emerging countries such as China and Brazil.

[9]The interest of economists has certainly increased, and in some cases they include a brief history of the sector in their introductions, such as in Hurley and Guidon, *Private Health* for the case of Canada and in Buchmueller and Couffinhal, *Private Health* for the case of France.

[10]We find cases of some advanced projects in health coverage for women coming from the world of friendly societies, such as the Montepío de Santa Madrona founded in 1900 for health care provision for women, mainly maternity care. From 1920, the foundation of the Caixa de Pensiones integrated the *montepío* into the Institut de la Dona que Treballa which, as well as this friendly society, also encompassed dispensaries and clinics, a maternity service, a nursing school and housing for poor families. http://www.memoriaesquerra.cat/publicacions/3/52_1934317/IGUALADI_19340317_11.pdf. This example may be seen as indicative of Spain's participation in a trend of European specialisation in social maternity (Nash, *Maternidad y Construcción).*

[11]The local and fragmented offer of sickness coverage provided by mutuals and friendly societies may, from the point of view of supply, be seen as an obstacle to the rationalisation of the sector; nevertheless, some studies have also demonstrated the advantages that these societies offered to the population in general and to the working class in particular by introducing a culture of insured people which provided health care coverage, security and citizen identity (Harris, Welfare and old age). Other works such as Cordery, *Friendly societies* and Gorsky, *Mutual Aid*, reinforce the idea that the friendly societies offering sickness coverage,

founded on the basis of worker solidarity, also created a sense of identity and respectability in the fight against social exclusion and division.

[12]During much of the twentieth century there were different legal demands for private insurance companies in terms of minimum and subscribed capital, deposits and reserves depending on the branch of insurance. The demands for the health branch were lower (Pons and Vilar, *El seguro de salud*, 68). In particular, the 1908 law established a paid-up capital of 25%, but with no minimum capital; the Royal Decree-Law of 18 February 1927 introduced a minimum capital, but very low (50,000 pesetas with an exiguous outlay of 15,000 pesetas or payment of 15% when the subscribed capital was 60,000 pesetas or more). In 1920, only three of the 22 insurance entities in the branch of health and death insurance that appear in the yearbook *Anuario Financiero y de Sociedades Anónimas* (1921) had a share capital of more than 60,000 pesetas. Pons and Vilar, *El seguro de salud*, 67 (Table 1.11); Frax and Matilla, "Centenario de la Ley".

[13]Pons and Vilar, "Friendly Societies", 81.

[14]This was the case of FomentoNacional. This health insurance company was founded on 3 April 1912 with a share capital of 50,000 pesetas, of which 12,500 were paid up. One of its first executives was Antonio Cabrer Sagauas manager, a position he combined with the vice-presidency of La Unión y El Fénix Español in Barcelona until his death on 21 October 1918 (*La Vanguardia* newspaper, 13/11/1918). This situation seems to be a clear indication of the connection between Fomento Nacional and the leading company in the sector at this time. *AnuarioFinanciero y de SociedadesAnónimas*, 1921, 311.

[15]ABC newspaper, 04/06/1929, p. 12.

[16]This is Vonk's argument in "In it for the Money?" to explain the limited development of private health insurance before the Second World War.

[17]Some mining companies created hospitals that also treated sick workers (Martínez Soto and Pérez de Perceval, "Asistencia sanitaria", 99; Pérez Castroviejo, "La asistencia sanitaria", 139; Menéndez Navarro, "Hospitales de empresa", 334-335). For more on the medical infrastructure of the employers' industrial accident mutuals, see Pons, "El seguro de accidentes".

[18]For the case of the large German companies, see Hilger, "Welfare Policy in German".

[19]In 1924,the Board of Directors of Mutua General de Seguros, created in 1907 as an employers' industrial accident mutual, decided to offer associated employers health insurance coverage for their workers, which would allow them to cash in on their considerable health care infrastructure of clinics and hospitals. This

branch of insurance, however, did not generate very high profits, see Pons, "El Seguro Obligatorio de Enfermedad", 230-231.

[20]Aubanell, "La elite de la clase trabajadora".

[21]Pons and Vilar, "Labor repression"; Vilar and Pons, "The introduction of Sickness insurance".

[22]To this end, many commercial insurance companies created mutuals in order to collaborate in the provision of compulsory health insurance. The company Hispania created the Mutualidad de Previsión Hispania (MUTUANIA) on 2 June 1944. By 1945 this mutual covered the health insurance of 8,090 companies, 60,979 workers and 174,338 beneficiaries (Pons, *130 años de promesas*, 99).

[23]They were also leaders in terms of premiums collected, see Pons and Vilar, *El seguro de salud*, Table 2.4, p. 131. On 31 December 1954, the Minister of Labor terminated all the agreements signed with the collaborating bodies since 1944, and most of them were not renewed. Greater demands made by the Ministry in terms of deposits and reserve funds, and the reduction of profit margins, did not favor the continuity of this collaboration.

[24] Pons and Vilar, *El seguro de salud,* 170.

[25]In line with the arguments of Guerrero, "Salud. Situación del ramo", 217.

[26] Pons, "Biografía de Marcial Gómez Gil", 430.

[27] Rodríguez, "Sanidad, Farmacia, 32-35.

[28] Pons, "El Seguro Obligatorio de Enfermedad", 71.

[29]For more on the healthcare reform during the transition to democracy, see the works of Ortega and Lamata, *La década de la reforma sanitaria;* Elola and Navarro, "Análisis de las políticas sanitarias"; and Pons and Vilar, *El seguro de salud,* 293- 313.

[30] Pons and Vilar, *El seguro de salud,* 325-327.

[31] Guerrero, "Salud. Situación del ramo"; Sáez, "Las prestaciones y servicios".

[32] Guerrero, "Salud. Situación del ramo", 226.

[33] Pons, "Spain: International influence", 204.

[34] Pons and Vilar, *El seguro de salud*, 413.

[35] Carreño, "La intercooperación", 167.

[36]For a complete list of the firms absorbed, see Pons and Vilar, *El seguro de salud*, 338.

[37] Pons and Vilar, *El seguro de salud*, 335; Rodríguez, "Sanidad, Farmacia", 35.

[38] Muñoz et al, *Las estructuras del bienestar*, 224.

[39] Guerrero, "Salud. Situación del ramo", 15.

[40] Uri, "Seguros de salud en España", 2.

[41]This tax deduction was maintained until the passage of Law 40/1998 which abolished the 15% deduction related to medical services and private health care insurance. Freire, *La nueva fiscalidad* defends doing away with the deduction as it was detrimental to the national health service. In the United States, tax subsidies led to an increase in the purchase of insurance, not only reducing its relative price but also stimulating the growth of group insurance (Tomasson, *From Sickness to Health*).

[42]Thanks to this tax change the premiums for this product increased 30%. Companies extended this social benefit to their workforces. "Un buen momento para el negocio colectivo de salud", *Aseguranza: revista de los profesionales del seguro*, 73 (2003): 16-27.

[43]See, for example, López Nicolás, "Seguros sanitarios", 28; Guerrero, "Salud. Situación del ramo", 16.

[44]Herce et al, *Rol de las aseguradoras,* 53.

[45]Tortella(dir.), *Historia del seguro*: 424-426.

[46]For 1973, Anuario Español de Seguros, 1973-1974, 24-25. The data for 2013 from the Directorate General of Insurance at

http://www.dgsfp.mineco.es/sector/documentos/Informes%202014/Memoria%20Estad%C3%ADstica%20Anual%20de%20Entidades%20Aseguradoras%202013.pdf Accessed on 20/09/2015.

[47]The concentration of the sector through mergers and acquisitions may introduce positive aspects in terms of the scale of companies, but the result may be different if the process is analysed from the consumer's point of view. Ethnographers such as Narotzky, *"El lado oscuro"*, have evaluated the learning costs for families when it came to facing the disappearance of mutuals or small local and regional firms as they were replaced by large companies, with complex information and marketing systems.

[48]Tortella (dir.), *Historia del Seguro*, 426.

[49]In line with Serra et al, "Resultados de las fusiones", 1001.

[50]In the 1980s the era of strictly-regulated and isolated national insurance markets came to an end, with the liberalisation of markets, especially in the European Economic Community, Borscheid, Europe Review, p. 59-60. Spain's incorporation into the EEC obliged an opening up and liberalisation and encouraged the entry of foreign capital.

[51]Herce et al, *Rol de las aseguradoras,* 7.

[52]For the role of this mutual in British health insurance, see Doyle and Bull, "Role of private sector, 563-565.

[53]For an exhaustive list of the mergers, see Pons and Vilar, *El seguro de salud*, Table 4.41, 419-420.

[54]According to the information it provides itself, Ribera Saludis is the leading health care management company in the sector of health care administration licenses in Spain. It was founded in 1997 to develop initiatives in public private partnerships, see http://www.riberasalud.com/ accessed on 27/09/2015.

[55]For more on the health care networks of the main insurance companies, including the administration of public hospitals in 2008, see Pons and Vilar, *El seguro de salud*, p. 423, Table 4.42.

[56]http://www.elconfidencial.com/espana/comunidad-valenciana/2015-05-29/asisa-y-adeslas-venden-a-ribera-salud-su-participacion-en-los-hospitales-modelo-alzira_863642/Accessedon 27/09/2015.