The long shadow of charity in the Spanish hospital system, c. 1870-1942

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Abstract

One of the key historical changes related to the increase in overall welfare for the population of Europe was the provision of sickness coverage. Public and private hospital charity was focused almost exclusively on the poor and marginalized until well into the nineteenth century. In the late nineteenth century, in most industrialized countries, the coverage of social risks in general and the risk of sickness in particular came from four basic sectors with different weighting according to country: the state, the market, the traditional family network (which was less robust in urban areas), and solidarity among workers. Historians have shown that, across time, hospital systems tended to be created in developed countries where at least one of these public or private elements was prominent. Spain provides an excellent case study of how a country in Western Europe made modest progress with respect to its hospital system between the 1880s and 1930s in a context of low coverage capacity in all four of the areas that comprise the mixed economy of welfare. Changes to the hospital map occurred above all during the 1920s and 1930s with the emergence of new actors responding to new demands: companies that created hospitals for workplace victims; friendly societies; insurance companies; and medical specialists who set up clinics and polyclinics to attend to an emerging middle class. Despite this, the majority of the working population lacked hospital coverage due to the state's inability to establish a health insurance scheme in a country with a predominance of agricultural workers without regular work or wages.

Keywords: Charity, welfare, sickness, hospital, Spain, nineteenth and twentieth centuries

Health coverage, along with diet, has historically been an essential component of the life-chances and welfare of a country's population and economy.[1] For a long time, the treatment and care of the sick was restricted to the family. Better-off families paid private doctors who treated the sick in their homes with limited knowledge and resources. Most of the working population was excluded from the coverage provided by state charitable institutions and religious establishments that only treated the marginalized poor. Only part of the population could resort to the protective network of guilds. In most cases, under the *Ancien Régime*, hospitals were institutions of internment with minimal healing capacity, where the poor and overcrowded sick were isolated from society for security reasons, to prevent contagion or simply out of Christian charity. The first industrial revolution increased worker demand for health care services within a framework of urbanization, breakdown of the traditional family, dependence on wages for subsistence and an increase in occupational risks. On the other hand, prohibition of the guilds (and the Church's loss of power in some countries) dismantled one of the population's traditional means of support.

The liberal states of the nineteenth century continued to treat the social and health care needs of their populations as marginal matters, which prolonged the stigmatizing charity system of previous centuries. Poor relief can be considered as both a control strategy of the elites and a survival strategy for the poor;[2] the former aimed to guarantee social peace and to control the risks related to the availability of labour, whilst the latter accepted a stigmatizing system as a means of survival. The ideological model of health care defined by the Poor Laws was common to most Western European countries regardless of their pace of development, although there were some specific traits with regard to periodization or the influence of the Church.[3]

This system, based on a kind of theological pact between rich and poor, gave rise to a period associated with a mixed economy of welfare.[4] By the late nineteenth century in most industrialized countries the coverage of social risks in general and the risk of sickness in particular came from four basic sectors with different weighting according country: the state, the market, the traditional family network (less robust in urban areas), and solidarity among workers. The work of historians on a wide range of periods and places has shown that, across time, hospital systems were created in developed countries where at least one of these public or private elements was prominent.[5] This process was neither linear nor homogeneous across different countries and the balance or preponderance of each of the components of the mixed economy of welfare changed over time.[6] In this respect, some historians have also suggested that any increase in the state's role was not necessarily seen as a panacea, since workers may have preferred to have better working conditions and improved pay because this enabled financial independence and direct control over their own welfare spending in relation to personal need.[7] However, during much of the twentieth century, the position and role of the state became more central in most Western European countries, although to a different degree and at a varying pace in each case. The passage of state health insurance legislation serves as a useful indicator of state involvement in the field of health coverage, enabling chronological comparison across European countries (see Table 1), with Germany the first in 1883 and Spain a late adopter in 1942.

[INSERT TABLE 1 HERE]

Thus Spain provides an excellent case study in Western Europe to illustrate how a hospital system functioned in a context of low coverage capacity in the four areas that comprise the mixed economy of welfare. Firstly, with regard to the state, Spain

accumulated a legislative backlog in two fundamental areas: the failed attempts to establish a basic legislative framework for health care (given that state insurance legislation was not passed until 1942) and the maintenance of a regressive tax system exacerbated by a high level of fraud that hindered the state's financial capacity. Indeed, it must be taken into account that Spain maintained a regressive tax structure until 1977. It had been designed back in 1845 (through the Mon-Santillán tax reform) and was based on indirect taxes, which resulted in low fiscal pressure, a high level of fraud and very limited public spending capacity. Under these circumstances, the state concentrated its low social expenditure on maintaining a charity system inherited from the nineteenth century. Overall, the historiography suggests that the Spanish state's limited involvement in the area of health care was almost always the result of an outside stimulus: such as the government's commitment to establish social insurance (in 1922) after the 1919 Washington Conference (where a Maternity Protection Convention organized by International Labour Organization took place), or following international intervention linked to the actions of the Rockefeller Foundation (which assisted with the assessment of problems in Spanish healthcare).[8]

Secondly, during the period on which we focus here – from around 1870 to 1942 – the Spanish population was mainly rural (given that only 42% lived in urban areas in 1930), with more than half of the working population tied to the country as day labourers without regular work or wages. Within this sphere, the family network acted as the main source of health coverage in a situation where rural doctors pursued their professional activity in very precarious conditions controlled by local caciques.[9] As for wage earners in the country's industrial centres, they had low purchasing power, restricted to covering the needs of the household budget, and lacked a family network.[10] Under these circumstances, their attempts to stand up for their rights were focused on

improving their working and pay conditions in order to achieve economic independence, whereas the demand for health coverage only arrived belatedly in the 1930s. It should be noted that anarchist unions had significant weight in Spain at this time. These unions opposed state intervention, even in health care, and concentrated their demands on improving working and pay conditions. It was the Socialist Trade Union (*Unión General de Trabajadores*, UGT) that started to call for state social welfare programmes in the 1930s, with health coverage as one of their main demands.[11] In the more industrial regions of the country, such as Catalonia and the Basque Country, and also in Madrid, where some of the country's large companies (electricity and railway sectors) were located, friendly societies and company mutuals played a key role in providing health and hospital coverage to working families with insufficient economic capacity to access the health services available on the market. Moreover, mutual coverage was often more favourable than that offered by the state. This was the case, for example, with the maternity allowance promoted by the state in 1923, which led to numerous strikes by women in Catalonia, as they were required to pay a higher subscription and receive lower benefits than they already received through mutual coverage.[12]

As regards the private sector, some innovative hospital projects can be found during this period, but they encountered serious obstacles to progress. One example was the case of Hospital del Niño Jesús in Madrid, established by a private foundation in 1876, which in the face of serious economic difficulties ended up in the hands of public charity in 1889. Other similar centres were fostered by private charity, with varying fortunes, between 1892 and 1910, in Barcelona (Hospital del Niño Dios and Hospital de Niños Pobres), the Balearic Islands, Tenerife, Zaragoza and Teruel.[13] It is also worth noting the case of Hospital Casa de Salud in Valdecilla, backed in Santander in 1927 by

the philanthropist Marquis of Valdecilla, which tried to implement the management methods and functions of a modern hospital by combining four aims: health care, teaching, research and a socio-medical approach (involving the treatment of the destitute sick as well as wealthy patients).[14] It was a private institution designed under a mixed funding model that received private donations, contributions from mutuals (through voluntary insurance contributions or from the hospital functioning as an insurance entity), payments for services and official contributions from the provincial council. Furthermore, its foundation project established a joint medical and administrative management, similar to that in US hospitals at the time, and proposed having qualified personnel in the nursing service and its own training school. The initial project was undermined and failed in the early 1930s for several reasons: the vagueness of the funding model, which led to a lack of commitment from the parties involved; the administrative inefficiency of the Board of Trustees, which undermined the medical and administrative management; the rejection of mutual methods due to the opposition of medical professionals in Santander, fearful of putting their private business at risk; and the control of the hospital's non-medical services, including management of the nursing school, by the Daughters of Charity of Saint Vincent de Paul. The weighty inheritance of the past ended up prevailing over the new, innovative initiative.

Despite all these obstacles, the Spanish case study enables us to see, during the period under study, a transition from an almost exclusively charitable hospital system, provided for the poor by public and private institutions, to a hospital system that started to extend its coverage to workers, and to the middle and upper classes, with the incorporation of other care providers in accordance with a mixed economy of welfare model (private hospitals owned by doctors, friendly societies, firms and insurance companies). The dual approach of public and private sectors in the creation of the

Spanish hospital system enables us to confirm the long shadow of charity in the hospital structure and late state action in this area (compared to other European countries).

The Spanish historiography available to date has come up with very little in the way of an overall and long-term interpretation that enables us to understand the obstacles hindering the development of both public and private hospital care in Spain.[15] One of the main reasons that explain this void is the lack of catalogues (or lists) of hospitals and of related statistics that make it possible to draw up a map of public and private hospitals in Spain before the passage of state sickness insurance in 1942. Research for this article has sought to overcome this difficulty by searching for information in statistical yearbooks, official gazettes, company directories and newspaper library archives that have been deposited in the National Library of Spain (*Biblioteca Nacional de España*). The compilation of this information has made it possible to create a statistical base to underpin an analysis of the public and private hospital infrastructure in Spain between 1870 and 1942.

To this end, the predominant classification used in contemporary statistical sources, based on the criterion of property ownership, has been adopted. This criterion enables, on the one hand, identification of publicly-owned hospitals in Spain during the period under study; that is whether they were in the hands of municipal, provincial (*diputaciones*) or state authorities. These basically comprise hospitals of a charitable nature, although hospitals specialized in infectious diseases and mental disorders can also be found. The private sector encompassed private charity hospitals, whether the property of the Church, the Spanish Red Cross (*Cruz Roja*) or privately owned (by companies or doctors). However, cataloguing each of these on the basis of finance and typology of patients is far from simple. Some public establishments accepted paying patients and some private ones maintained their quota of poor patients. Moreover,

publicly-owned institutions usually accepted donations and alms from private individuals and some private charity establishments received public money from municipal and provincial councils.

The hospital legacy of the *Ancien Régime*: public and private charity

During the first half of the nineteenth century, Spain experienced a stage of institutional discrediting and dismantling of hospitals, with respect to their managers, resources, hygiene and health care methods.[16] The hospital legacy of the *Ancien Régime* in Spain came from three basic institutions: municipal councils, the Catholic Church and the protective network of guilds, associations and corporations.[17] This theological social pact between rich and poor broke down in Spain from the late eighteenth century onwards. The political establishment dismantled this old system of religious and private charity associated with the *Ancien Régime* through a series of disentailment laws that cut off the sources of financing of religious charitable establishments.[18] This process obliged the sale of goods of religious corporations and the closure of many monasteries, convents, colleges and religious communities, which put an end to their tithes and other incomes. Meanwhile, the suppression of guilds was another facet of the new economic and social relationships that were developing in Spain during the first third of the nineteenth century. Liberal public charity intended to fill the gap that the disentailments and the breakdown of the *Ancien Régime* left in the charitable welfare system. Consequently, some religious hospitals were destined for public use and came under the control of civil authorities, above all municipal or provincial councils. Nevertheless, this transferral opened up the possibility for the Daughters of Charity of Saint Vincent de Paul and other sisters to continue to serve in charity hospitals (now public).

During this stage, limited state intervention concentrated on two health problems: the threat of catastrophic illnesses and epidemics coming from abroad, which led to the sanitary control of borders and ports, and the spread of social diseases within the country, which exacerbated what were already terrible living conditions for the proletariat and increased mortality. In this respect, individual and collective hygiene proved to be a necessary condition in order to guarantee a healthy workforce and to maintain social order.[19] We cannot overlook the fact that there were still very high mortality rates in Spain during the nineteenth century – between the years 1850 and 1900 it was never below 26.7% – accompanied by an average life expectancy of less than 35 years and a relatively low population growth. The high mortality was directly influenced by the social diseases, of epidemic origin and development, which affected lower-income social groups and the child population with greater virulence. In general, the periodic appearance of subsistence crises that weakened the population's natural defences, unhealthy living conditions in the cities, deficient preventive measures, and shortcomings in medical diagnosis and treatment processes had terrible social consequences.[20] Approximately 800,000 people died in Spain during the nineteenth century solely as a result of the four cholera pandemics that swept through the country.[21]

The state transferred the management of disentailed hospitals to provincial and local authorities through the passage of the general charity regulations in 1822 and 1836.[22] However, Spanish municipal councils had sparse resources during this period, a situation aggravated by the legal prohibition against dedicating more than 10% of their budgets to charity. Even this limit was remote in 1857, when town and city councils only allocated 6.4% of their paltry municipal budgets to charity, a percentage that was lower than that allocated for 'urban police' spending. The budgetary situation did not

improve in the following decades; it dropped to 5% in 1861 and then 2.5% in 1882 before returning to 5% in 1915.[23] In fact, after paying the municipal doctor's salary, as required by law, their spending capacity was exhausted.[24] Thus, their main efforts were concentrated on providing food, clothing and hospital attention for the poorest families, and on the confinement of the old, vagrants and foundlings in hospices and children's homes. Under these conditions, those classified as municipal charity hospitals (22 in provincial capitals and 525 in towns) cared for around 70,000 sick people in 1859, and those classified as provincial charity hospitals (there were 63 of them) only treated 80,000 sick, a small percentage of the population.[25] Most of these institutions were small with limited technological and professional resources. In most cases the doctors did not charge a fee, and the tasks of nursing were undertaken by nuns.

Overall, and even without denying their traditional role in health care in the new liberal order, hospitals had legally been considered as agencies for maintaining public order.[26] The new charity law of 20 June 1849 consolidated this trend, as hospitals became institutions dedicated to caring for the sick from the more vulnerable sectors of the population and maintaining and controlling social order. This law classified charitable establishments as general, provincial or municipal. Hospitals for the sick, hospices, maternity homes and children's homes were all basically incorporated into the provincial group, controlled by civil governors, the main law enforcement agents in nineteenth-century Spain. In this respect, relations between medical faculties and provincial hospitals, which obliged the latter to provide rooms for teaching after the Royal Orders of 15 August and 16 September 1846, were nearly always a source of controversy. Those responsible for running the teaching centres resented their subjugation to the provincial councils in terms of the allocation of staff and patients and

their scant interest in investing in material infrastructures, diagnostic devices or new treatments.

The reinforcement of these economic and political aspects of nineteenth-century charity in Spain to the detriment of purely health-related aspects led to growing criticism of the hospital infrastructure from different spheres, especially from hygienists and philanthropists. A report on Hospital Provincial de Madrid drawn up by Ángel Pulido in 1889 indicated two basic requirements for reforming the country's hospital structure.[27] Firstly, he claimed that improving the professional hierarchy was imperative, in terms of both professional categories and medical specialities. Secondly, it was necessary to acquire medical and healthcare equipment, not only of the most basic kind (disinfection and facilities) but also technical resources and surgical equipment for operating theatres. Testimonies from this time reveal the deplorable state of hospital services in general, which were basically like an extension of municipal domiciliary medical services. The public charity hospital project was finished and the rise of private charity was a clear indication of the failure of the state's negligence in health matters and the lamentable state of public hospitals.[28] However, private charity hospitals also experienced problems of a lack of resources.

Co-existing with these public charitable institutions were others of a private nature and of religious, philanthropic-charitable (hospitals founded by patrons or local dignitaries) or political origin. Although they were financed with private funds, in most cases their management was theoretically under the supervision of the public authorities. In practice, these public authorities did not provide any funding and left the task of supervision in the hands of local elites. Their work was quite modest as they usually had very limited budgets funded by private charity. The origins of the financing of these charitable institutions were diverse and enterprising over time. In the case of

Catalonia, most of the local hospitals functioned as health care foundations, regulated by private Catalan law from the nineteenth century. Their funding was based on the capitalization of lifetime donations, benefaction and testamentary bequests of property and derived income. These incomes could be supplemented at times by municipal aid, government subsidies and other types of income coming from middle-class sources.[29] For example, the construction of Hospital Homeopático de San José, which started in Madrid in 1873, was financed by its main philanthropist the Marquis of Núñez, but funding also came from private alms, monthly subscriptions, donations in kind and a bed foundation (with an annual income of 3,000 *reales* for adult beds in exchange for a marble slab with the benefactor's name).[30]

However, the most remarkable source of financing of many private, and even provincial and municipal, charitable hospitals in Spain was revenue from bullfights. In the eighteenth century, the Crown granted an exclusive licence to certain hospitals to organize bullfighting events to finance themselves. In the nineteenth century, Spanish political leaders persevered with the idea that programming bullfights was a magnificent system of subsidizing some charitable institutions. This was the case with Santo Hospital Civil, built in Bilbao in 1879. As well as important benefactors and backing from institutions such as the city council, the provincial council and the hospital's charity board (*Junta de Caridad*), this hospital raised funds by organizing bullfighting events. In fact, its charity board took control of the Vista Alegre Bullring in 1900.[31] Bullfights for the benefit of hospitals, which were often the owners of the bullrings, were held all over Spain from the eighteenth to the twentieth century. Thus, Hospital General de Madrid, run by the provincial council, managed the revenue from the Alcalá bullring, although this was reduced to an annual charity bullfight in the mid-eighteenth century (which is still held today).[32] There was a similar case regarding the Valencia

bullring, property of Hospital General de Valencia, which was granted the perpetual privilege to hold bullfights by King Philip V in 1739.[33] This fund-raising method spread throughout Spain and for different types of hospital. For example, the construction of the Almadén bullring was to meet the needs of building Hospital para Mineros de San Rafael for workers at the mercury mines.[34] In the meantime, the Misericordia bullring in Zaragoza (the second oldest in Spain) was built in the eighteenth century to meet the financial needs of the city's hospital and the Casa de Misericordia (hospice).[35]

Generally speaking, legislation and the efforts of the authorities were focused more on public health than on building hospitals and providing hospital care. The legal basis for Spanish public health care was the Organic Law on Health Care of 1855 which consolidated the centralization of health policy under the Directorate General for Health (*Dirección General de Sanidad*) attached to the Ministry of the Interior (*Ministerio de la Gobernación*).[36] In fact, this law promoted domiciliary medical care rather than hospital attention, backed up by two basic arguments: the lower cost (for the system and for the families when they had to pay for it) and also the consideration that hospitals were places of social stigmatization, overcrowding and sources of infection and contagion.[37] In the last decades of the nineteenth century, some old hospitals in Spain underwent extensive architectural reforms and many others were transferred to new buildings in the outskirts of cities in the developing suburbs.[38]

The first transformations of publicly and privately owned hospitals, 1870-1920

In the last quarter of the nineteenth century, the limited scope of health care in Spain was a fact that was accepted in contemporary publications and which was illustrated even more clearly with three health-related disasters: the colonial war in Cuba (1898), the influenza epidemic (1918) and the colonial war in the Moroccan Rif (1920-1926).[39]

Health conditions in the country left much to be desired: some of the symptoms of this neglect were terrible water supply and sewerage services, no organized collection of health statistics and a widespread presence of infectious diseases with high mortality.[40] In the first years of the twentieth century alone, smallpox killed more than 11,500 Spaniards and measles took 30,500, while 21,000 succumbed to typhoid fever, 8500 to malaria and 7500 to tuberculosis.[41]

Nevertheless, the 1870s witnessed a change in the concept of hospital at the international level thanks to advances in research that influenced the construction of a large number of hospitals and their architectural structure, with one-storey wings, small wards and better ventilation systems.[42] Hospitals combined their surgical specialization with the care of contagious diseases, promoted by the wealth of bacteriological discoveries (tuberculosis, cholera, diphtheria and malaria). These advances required laboratories, new diagnostic techniques and the observation of illnesses. Within this context, the function of hospitals changed. In Spain in the late nineteenth century, social medicine and hygienists started to consider the water supply to cities, construction of public sewers and vaccination campaigns as basic needs. Under these circumstances, a modest transformation of the hospital system was initiated. Lack of statistics prevents an in-depth analysis of the hospital map in Spain, but a detailed charting of the hospitals of the country's two main cities, Madrid and Barcelona, can be provided (see Table 2).

[INSERT TABLE 2 HERE]

In the case of Madrid, we found 22 hospitals in the year 1883, eight of which were publicly owned: four under the afore mentioned general charity of the Ministry of the Interior which focused on confinement and the incurably sick (Hospital de la

Princesa, Hospital de Jesús Nazareno, Hospital de Nuestra Señora del Carmen and the Instituto Oftalmológico); one belonging to the Ministry of Public Instruction and associated with the Faculty of Medicine (Hospital Clínico); one under the War Ministry which only treated members of the military (Hospital Militar); and two managed by the provincial council (Hospital Provincial de Madrid and Hospital San Juan de Dios).[43] The rest were privately owned (one in the hands of the Church and 13 considered as dependent on private charity).

Private charities also sought resources to create new facilities during this period. Some achieved this aim. Thus, Hospital del Buen Suceso, founded in 1489, was transferred to a new building in 1902; Hospital de los Italianos, founded in 1583, moved to a newly-constructed hospital that was completed in 1885; and Hospital de San Luis de los Franceses, created in 1615, was relocated in 1881. In the meantime, others were doomed to disappear. This was the case of Hospital de La Latina, founded in 1499 and demolished in 1904. Some more recently constructed hospitals also participated in this process, such as Hospital de la Princesa, which was built in 1857 and then enjoyed the benefits of a new building from 1888.[44]

Apart from the architectural reforms, which were plentiful, there were few initiatives from the private sector. One notable exception was Hospital Homeopático de San José, between 1873 and 1878.[45] The hospital belonged to private charity and was used both to care for the poor sick and for public teaching of the theory and practice of homeopathy. It was the first hospital with these characteristics to be built in Spain, thanks to two royal orders in 1850 and 1865 which allowed for its foundation on an experimental basis.[46] Also worthy of mention is the Instituto de Terapéutica Operatoria, founded in 1880 as a department (with two wards of 20 beds for men and women) within the building of Hospital de la Princesa in Madrid (and operative until the

outbreak of the Civil War in 1939) with the aim of promoting the teaching of surgical specialities.[47] Its founder, the surgeon Federico Rubio y Gali, was a pioneer in operations on the ovary (1860), uterus (1861) and larynx (1870) and was a key figure in the training of postgraduate doctors and the foundation of the first nursing school in Spain in 1896. The Institute's motto was *todo para el enfermo, y cuanto más necesitado más atendido* (everything for the sick, and the greater the need, the greater the care). In spite of all this, the medical testimonies from the late nineteenth century offer a very negative picture of the hygiene and sanitary situation in Madrid, describing it as the 'city of death' due to its high general and infant mortality rates.[48]

The city of Barcelona had 12 hospitals in 1898. Unlike Madrid, however, none of them belonged to public charity, although it did have Hospital Militar, and Hospital Clínico (attached to the Faculty of Medicine) was in the construction stage. The rest were privately owned: three belonging to the Church, one to the Red Cross and six classified as private charity, although they were run by foundations in which, in some cases, municipal institutions participated. Some of the oldest hospitals in this city would be reformed over time, such as Hospital de Santa Cruz. In parallel, new proposals appeared linked to doctors as well as to some religious congregations. One example of this was the case of the dispensary for poor children run by the doctor of Cuban origin Francisco Vidal Solares (1854-1922). This dispensary became a hospital for poor children in 1886 with care provided by sisters of the Daughters of Charity of Saint Vincent de Paul, whose participation was in the context of the introduction of religious congregations with a health care vocation in Spain from the early nineteenth century onwards. Many of the sisters from these religious congregations worked in charitable hospitals, including mental hospitals, hospices and *casas cuna* (orphanages).[49] The Red Cross was constituted in Spain under the Royal Order of Isabel II of 6 July 1864, where

it was declared ‘an organization in the public interest’ under the auspices of the Hospitaller Order of Saint John of Jerusalem. At the end of the nineteenth century it had sanatoriums and dispensaries in several Spanish cities such as Barcelona. Nevertheless, the 'modern' hospitals of the Red Cross took a long time to build, due to a lack of funds. In the case of Madrid, Hospital Central de la Cruz Roja San José y Santa Adela was not opened until 1913 due to lack of funds, even though the initial project was for 1890.[50] In the case of Barcelona, the construction of Hospital Dos de Maig de la Cruz Roja was initiated in 1920 and the hospital opened in 1924.[51] This hospital was consolidated over time into a general hospital, maintaining a significant private part as well as a part reserved for charitable care. These initiatives were followed by other similar ones in other urban centres around the country.

Urban growth – often associated with migratory flows resulting from industrial development in sectors such as typography and railways in Madrid, mining in Andalusia, and textiles in Catalonia – brought to light a greater shortage of health care infrastructures in these regions.[52] Under pressure from this increasing demand, the authorities in some of these areas made a special effort to collaborate with employers in order to increase hospital capacity. This was the case in Bilbao, where Achuri Hospital was incapable of meeting the growing demand for services in the late nineteenth century.[53] Although extensions were added to its facilities, in the end the city council, the hospital board and the provincial council approved the project for a new hospital in 1895. Construction work was initiated in Basurto in 1898 and completed in 1908. Its design was modelled on modern hospitals, with a horizontal structure, separate wings, large windows and a garden area. The number of patients treated in this hospital almost tripled between 1909 and 1935, while the proportion of deceased fell.[54] Overall, these new hospitals together with the advances in bacteriology, infectious disease prophylaxis

and surgery enabled a transformation away from the traditional conception of the hospital as a house of death. Although we do not have detailed information, it seems that during this period there were important advances in the availability of better facilities, diagnostic devices and medicines, and above all in private coverage in some provincial capitals, where medical specialists associated together to form clinics and polyclinics. Such facilities were still exceptional in 1884, but grew in number and in specialization in the first decades of the twentieth century. The work of specialist doctors mainly consisted of home visits whose payment was made in accordance with the patient's economic capacity: the most common payments were between 5 and 10 pesetas for wealthy families and 2.5 pesetas for middle-class patients.[55]

The lack of catalogues of hospitals for the entire Spanish territory prevents more detailed knowledge of hospital coverage on a national scale. Nevertheless, new indirect sources can help to outline the system. The pharmaceutical company Burroughs, Wellcome & Co., founded by two Americans in London in 1880 and specializing in medicines using a novel form of standardized pills, carried out a publicity campaign for its medicines in Spain in 1884.[56] In the Wellcome Foundation Archives in London there are 350 letters offering testimonies from doctors all over Spain who had tested the effects of the tablets and who, at the request of the pharmaceutical company, sent reports to the agent on effectiveness, convenience and ease of use.[57] Using this documentation, it is possible to produce an outline of the Spanish health care and hospital network based on: qualified municipal doctors working in charity; general, provincial, municipal, military, and also university, hospitals; a few private clinics and others funded by private charity; and a broad network of doctors with private practices. This source confirms that by the end of the century the medical and hospital network remained anchored in private and public charity. The archive documentation reinforces

the idea of the decisive role played by provincial hospitals. Moreover, it confirms that the greatest concentration of hospitals was located in Madrid, where a significant number of general charity hospitals (Hospital de Jesús Nazareno and Hospital de la Princesa), provincial hospitals (Hospital San Juan de Dios and Hospital General de Madrid)[58] and private charity hospitals (Hospital del Niño Jesús and Hospital de Montserrat) were all located.

On the whole, public and private charity had many deficiencies, in terms of both facilities and services, and was insufficient to meet the health care requirements of the population. Limited and unreliable resources made it necessary for charitable actions to be undertaken in an intermittent and selective fashion.[59] Charitable medical care had even fewer repercussion in towns and villages of less than 5000 inhabitants, where 70.7% of the population lived in 1900.[60] In rural areas, health care remained linked to doctors who had established practices in these areas, and for a long time was financed by municipal councils. These doctors, besides taking responsibility for the medical care of those included in the census of the poor, also offered private cover to the rest of the population in return for payment by means of a system of *igualas*.[61] The system of *igualas* consisted of a kind of private insurance that neighbours contracted with the local doctor and pharmacist, by virtue of which the clients paid a modest periodic fee and, in exchange, the doctor and pharmacist agreed to provide them with their services when needed. This system, however, did not include monetary compensation or care in relation to medical and surgical specialities. Although the *igualas* have traditionally been considered as a typically rural phenomenon, there is also evidence of their functioning in some urban municipalities of the industrial zone of Biscay province.[62]

The incorporation of the initiatives of medical specialists: changes in the hospital system during the 1920s and 1930s

The influenza pandemic of 1918-1920, which occurred in several outbreaks, aggravated the country's health situation and led to a temporary increase in the mortality rate.[63] The pandemic made it evident that Spain lacked an administrative organization and modern hospital infrastructure capable of isolating and treating the sick. In fact, not even Madrid, the capital, had a hospital for infectious diseases. Indeed, at the beginning of the twentieth century, some hygienists had already denounced Spain's lamentable health situation, while simultaneously pointing out the need to undertake a complete health reform that should begin with the promulgation of a new health law adapted to the principles of modern medical science.[64] After four failed attempts at getting Parliament to pass legislation of this kind, all that was achieved was the implementation of an insufficient *Instrucción General de Sanidad* (set of general public health guidelines) in 1904. In view of these repeated failures, the most influential doctors in Spain at this time focused their efforts on the battle against infectious diseases, which constituted a serious social problem exacerbated by the outbreak of the influenza pandemic.

In the following decade, Spain's industrial and urban growth was accompanied by the public authorities assuming a more active and responsible role in health protection for the population.[65] However, no sickness insurance was legislated and no noteworthy structural changes were implemented in the organization and functioning of the hospital system. The unreliable figures available indicate a growth in the number of public institutions for the care of the sick: 755 hospitals in 1844 and 1529 in 1915.[66] These figures conceal institutions of very different natures, ranging from mental hospitals to asylums and including hospitals and small dispensaries. Once again,

statistical limitations prevent us from making a more detailed classification. We can only point out that at the beginning of the twentieth century there were only 183 provincial charitable institutions in Spain, and 363 municipal ones that offered 66,014 beds, which was the equivalent of an average of 302 inhabitants per bed.[67] The official figures for this period recognized the existence of 813,815 poor families (around 3.25 million inhabitants), a figure that was equivalent to 16.33% of the census.[68] Meanwhile, there was a total of 7769 municipal doctors, which was equivalent to 419 poor people per practitioner.[69]

The sparse data available reveal that free care for the sick improved during the first decades of the twentieth century. Thus, in 1927 municipal charity provided free domiciliary care for 595,132 families – approximately 2.38 million people, equivalent to 10.10% of the population – with a service of 7,555 doctors and 3,458 pharmacists, and 315 poor people corresponding to each doctor.[70] In addition to domiciliary care, during the 1920s provincial charity provided 35 civilian hospitals located in provincial capitals, 5 combined civilian-military hospitals and 12 auxiliary or district centres, all of them dealing with common illnesses (see Table 3). This development was possible due to the increasing budget allotted to health care. In 1900 this accounted for 0.08% of state expenditure (738,652 pesetas); in 1921 it accounted for 0.24% (6.62 million); in 1930 it rose to 0.27% (10.3 million); in 1932 there was a 50% increase, with which it reached 0.36%; and in 1933 there was a further 100% increase to 0.72% of state expenditure (31.43 million pesetas).[71] In general, in the period 1900-1935, the transformations in state budget expenditure for health care were modest but significant.[72] Modest transformations can also be seen in the structure of municipal expenditure, where not only did the amount allotted to charity increase (from 6.8% in 1926 to 8.6% in 1933) but so too did expenditure on salubrity and hygiene (from 10.1%

in 1926 to 8.1% in 1933) and on social welfare (from 0.7% in 1926 to 2.1% in 1933).[73] This change reveals the social function taken on by town and city councils during this period, alongside their traditional charitable aid. However, the poor financial capacity of most publicly-owned hospitals made the incorporation of the scientific and medical advances of the time (including the introduction of laboratories, X-rays, electric light in operating theatres, adequate ventilation and aseptic wards) very expensive and difficult to implement.

[INSERT TABLE 3 HERE]

It is important to note here that military hospitals remained outside the public hospital network, only providing care for professional military personnel and their families and members of the military reserve (soldiers and sailors), which meant that they had a much higher bed and hospital ratio than the rest of the population.[74] There were 45 hospitals in the 1920 Spain Handbook (*Guía Oficial de España*) distributed in accordance with military regions.[75] Of all these military hospitals only twelve received both civilian and military patients; and, as Tables 3 demonstrates, only five were supported through provincial charity and two through sustained municipal charity.

As in other European countries, friendly societies spread among workers in Spain at this time as a mutually supportive way of fighting against sickness and the costs incurred by funerals.[76] However, only a few of these societies managed to construct their own health care facilities because they concentrated their limited resources on providing primary health care. From a territorial point of view, mutual insurance coverage in Spain was very unequal. It was basically concentrated in the more industrialized regions with a greater weight of urban population and wage-earners

(Catalonia, the Basque Country and Valencia). According to the figures available, the majority of friendly societies (not dependent on any company) were concentrated in Catalonia, which was home to 73.39% of these societies and 56.26% of their members in 1915.[77] In particular, there was a total of 641 friendly societies federated in the province of Barcelona in 1923 and offering medical care, with a total of 166,894 members.[78] In Madrid, these societies were obliged to include obstetrics and gynaecology, paediatrics and ophthalmology amongst their health provisions, although other complementary services such as radiodiagnosis or laboratory techniques were always excluded.[79] More than 60% of the benefits offered by these societies were in the form of medical care and major and minor surgery. Benefits for disability and death were some way behind. The average daily cost of sickness of a member was almost 4 pesetas at a time when the average daily wage of an industrial worker in Spain was only 2.88 pesetas in 1910 and 6.33 pesetas in 1920. These figures give an idea of the important work carried out by these societies.

To date it has not been possible to quantify the number of clinics and hospitals linked to these friendly societies in Spain. Nevertheless, qualitative data leads us to suspect they were significant. One of the best-known cases is that of Quinta de la Salud La Alianza, which was first established as a friendly society to cover the risk of sickness for waiters in Barcelona. Its first clinic had been set up in 1904 with a very modest nine beds, but subsequently its network expanded. The society also broadened its social base to include other groups of workers, traders and the petty bourgeoisie. Palacio de la Mutualidad, its Barcelona headquarters, opened in 1917 and during the 1920s it admitted 1200 patients, of whom 964 were operated on.[80] In 1930 it was enlarged to provide more than 600 beds, with 40 doctors, 40 nurses and 12 assistant nurses working there.

Meanwhile, in the country's other industrialized zones such as Asturias, Biscay, Gipuzkoa and Madrid, we find a greater number of societies linked to large companies typical of the second industrial revolution (and associated with large-scale iron and steel, electricity, textiles, paper and transport industries). This phenomenon has originated at the end of the nineteenth century in areas such as Biscay province, where employers' *montepíos* (similar to friendly societies) were created in the iron and steel and transport industries.[81] The model of company mutuals also spread to public companies such as the tobacco factories and railway companies, which were sometimes located in less industrialized areas.[82] The functioning of company mutuals had some special characteristics, as the majority were controlled by the firms and were funded by fees deducted from the workers' wages (around 2% of the wage) supplemented by contributions from the company itself.[83]

In general, health care promoted by companies and employers had begun in Spain in the late nineteenth century in the sectors with the highest accident rates and almost always linked to industrial accidents (leading, in particular, to orthopaedic and trauma specialities). The mining and railway companies were pioneers in the creation of private hospitals and dispensaries to treat their workers; the former were obliged to do so, in the first instance, by mining laws, whilst both sectors were later required to do so by the law on industrial accidents of 1900.[84] Meanwhile, many insurance companies that operated in the area of industrial accidents carried out similar processes of creating health care networks, first in relation to dispensaries and later by setting up their own clinics. In 1932 legislation made industrial accident insurance obligatory for all industries (although agriculture and services were excluded), forcing the National Welfare Institute (which was the administrator of the first public sector social insurance

schemes) to create a hospital facility to enable the functional re-adaption of injured workers.

In 1933, the Clínica del Trabajo (inspired by clinics in Vienna and in German industrial areas such as Westphalia) was opened in Madrid, with the aim of reducing workers' disabilities.[85] It was not an emergency clinic although it could deal with emergencies since the injured were taken to the hospitals run by the mutual societies, the *Caja Nacional* or the insurance companies through which they had been insured by their employers. The official controlling body *Caja Nacional de Accidentes del Trabajo* had agreements with 52 provincial clinics and 52 provincial dispensaries and more than 4000 doctors throughout Spain, where workers insured by this institution received treatment.[86] The number of workers treated at the Clínica del Trabajo grew, with 784 in the period 1933-1934 and 506 in 1935, although this was a very low figure compared with the total number of injured (239,695 in 1935 according to the statistical yearbook).[87]

Finally, within the private hospital provision of this period, it is also important to mention the medical *igualatorios* (doctors' associations) and private insurance companies. With respect to the latter, some of the most important were created in the 1920s and 1930s. The majority were small-scale companies, with a reduced geographical area of operations, little capital and run by professional doctors and non-professionals from the insurance sector. The non-application of actuarial techniques and the exiguous demands for capital, reserves and deposits in the sickness branch did not favour either the capitalization of these companies or their concentration. Within this group, we also find other health care facilities founded by private institutions such as the Church and the Red Cross.

Private initiatives promoted by medical specialists were especially significant in Catalonia and the Basque Country, where medical teams created a constellation of small clinics.[88] In 1906, a group of specialist doctors founded Clínica San Ignacio, the first medical and surgical centre in Gipuzkoa. Many of these initiatives are little known and they were not very formally organized as companies, although in some cases they eventually became joint-stock companies. Other medical specialists (some linked to university teaching and having received some training abroad) opened private clinics in Barcelona in the 1920s, taking advantage of the demand from the social classes with greater purchasing power and the incapacity of the public sector to provide adequate surgery, new treatments and diagnostic tests. For example, Clínica Corachán was founded in 1921, and in 1925 Clínica Platón, Clínica San Jorge and Clínica Bretón were opened, among others.[89]

In Madrid in 1935 the supply of hospital infrastructure was substantially modified as a result of phenomena that were similar to those in Barcelona (see Table3). The first changes had taken place between the late nineteenth and early twentieth centuries, when the first doctors' associations appeared (*igualatorios* and mutuals), such as La Positiva, La Esperanza, El Buen Orden, La Legalidad and El Progreso.[90]As a consequence of all these transformations, hospitals such as Los Irlandeses and La Latina disappeared and the San Juan de Dios and Montserrat hospitals were demolished. In the meantime, new centres were founded, such as the hospitals of San José y Santa Adela, San Francisco de Paula (for day labourers), San Nicolás (for convalescents), the Hospital de Epilépticos de Carabanchel and the Hospital Asilo San Rafael (run by the Brothers Hospitallers of Saint John of God). Moreover, centres linked to foreign communities had also sprung up, such as the Hospital Alemán (1913) and the Hospital Evangélico (1921). As well as this maze of hospitals, there was also a notable

proliferation of polyclinics. These were specialized establishments equipped with modern diagnostic techniques – especially X-ray– and which enabled the sharing of costs. The press of this period published information about the many specialists who advertised their work in clinics equipped with innovative technologies (Table 4).[91]

In Spain in the 1930s religious orders still carried out most of the work related to health care provision in these hospitals. Faced with the possibility of the dissolution of these orders with the establishment of the Second Republic in 1931, voices of alarm were raised and concerns expressed about the negative effects this would have on the hospital system. It was not only a matter of a shortage of qualified staff but also a potential rise in personnel costs. In the province of Girona, for example, four charity establishments treated 1500 patients who were cared for by 86 religious personnel who only received 25 pesetas a month each to cover living and accommodation expenses. This amounted to a total annual cost of only 25,800 pesetas in 'fees'. Their administrators pointed out that their substitution by lay nurses with a monthly salary each of no less than 100 pesetas would increase personnel costs to 160,000 pesetas a year.[92]

The outbreak of civil war once again demonstrated the precariousness of public and private hospital infrastructures, as in both camps health care facilities had to be dedicated first and foremost to military needs. The lack of better infrastructures led to several civilian buildings in Madrid such as the Palace and Ritz luxury hotels being converted into blood hospitals.[93] The army that supported the *coup d'état* of 1936 initially organized its hospital coverage from Salamanca (its first capital), headed by two military doctors, General Carrión and Colonel Rubio.[94] Later, as the Spanish Civil War (1936-1939) progressed, it set up its military health care operational centre in Zaragoza. According to its documents, during the war campaign this army established

447 hospitals with capacity for 97,000 beds; it maintained 243 operative surgical teams and had 5,000 doctors available (only 500 of whom were military) with the help of 15,000 nurses, most of them not professionals. Furthermore, they used 23 trains for health care, and the ship Ciudad de Palma as a hospital ship.[95] Meanwhile, data relating to the Republican army indicate that health services at the front line had only 60 ambulances and other vehicles available for evacuation purposes.[96] A total of 70 blood hospitals, set up to care for the injured, can be discerned (20 under the Ministry of War and the other 50 dependent on other institutions such as provincial councils, workers' committees and the Spanish Red Cross), whilst many convents as well as public and private buildings were converted into provisional hospitals to treat the sick on the Republican side.

At the end of the Spanish Civil War and during the initial post-war period, the epidemiological situation worsened, causing a severe health crisis which led to a significant increase in mortality from infectious diseases. The health situation in Spain was on the verge of collapse. In 1948 a United Nations report identified the Spanish diet as one of the poorest in Europe and highlighted the critical situation of shortages and hunger in the country.[97]

Conclusions

For most of the nineteenth century the Spanish hospital system was characterized by the legacy of forms of public and private charity that were almost exclusively focused on the poor and whose function was confinement rather than therapy. From 1870 onwards certain changes can be observed, resulting in part from urban transformations (social, economic and spatial) that led to the construction of new facilities influenced by the most modern designs in hospital architecture. New generations of specialist doctors

fought in many cases against old structures and conventions to establish semi-public institutes that pioneered modern medicine as well as new specialities such as paediatrics and new trends such as homeopathy.

The persistence of infectious diseases and the impact of influenza in 1918 once again brought to light the shortcomings of the Spanish public hospital system. Yet, in the more industrialized areas of the country employers themselves looked for alternatives in order to provide coverage for their workers. In some cases, for example the Basque Country, they collaborated with public institutions such as provincial and municipal councils to increase the number of hospital beds available. Meanwhile, in other regions such as Catalonia private hospital activity and mutualism were promoted. The great transformation before the Civil War began in the 1920s when new private players entered the scene. The initiatives of companies were joined by friendly societies and private insurance companies. Hospital companies were launched by medical specialists who created small clinics and polyclinics in order to share costs and investment in new diagnostic techniques, and to meet demand from both the working classes and the better off. This all substantially increased the number of hospital beds available in urban and industrialized areas especially, while provisions in the rural world remained totally inadequate. Agricultural workers lacked stable, long-term contracts and regular wages.

However, two key elements put a brake on any greater progress for the hospital system in Spain. One was the low level of both public and private financing, which forced hospitals to seek such surprising and curious sources of funding as the income obtained from bullfights, to prolong the use of obsolete buildings or to use non-professional nurses. The other was the absence of public health insurance, which led to less state involvement in health care coverage in general and hospital provision in

particular, especially in agricultural areas. The state's lack of commitment in this respect was illustrated by the devolution of responsibility for hospitals to provincial and local authorities with precarious budgets. As a result of these two elements, the number of hospital beds per inhabitant remained low and Spain continued without an adequate system of health and hospital coverage, not only for the majority of workers but also for the rest of the population. As this study has tried to demonstrate, all the different providers who participated in the mixed economy of welfare during this period encountered significant obstacles to development, which led to a slow transformation of the Spanish hospital system, subsequently aggravated by the heavy pressure it was subjected to during the Spanish Civil War (1936-1939).

Funding

This work was supported by the European Union, European Regional Development Fund (ERDF) & Spain's Ministry of Economy and Competitiveness, under the project entitled 'Management and construction of the Spanish hospital system from the perspective of economic history: between public and private sectors', Ref. HAR2015-66063-R.

[1]As shown in the works compiled on various European countries in O.P. Grell, A. Cunningham and R. Jütle (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe* (Aldershot, 2002).

[2]In fact, they were not formally abolished until the National Assistance Act of 1948 in Britain, see L.H. Lees, *The Solidarities of Strangers: The English Poor Laws and the*

people, 1770–1948 (Cambridge, 1998). For more on the Poor Laws before the welfare state, see P.H. Lindert, 'Poor relief before the welfare state: Britain versus the continent, 1780- 1880', *European Review of Economic History*, 2 (1998), 101–40.

[3]For the influence of the Church on health care in some Catholic countries in Europe see D.S. Lucey, *The End of the Irish Poor Law? Welfare and healthcare reform in a revolutionary and independent Ireland* (Manchester, 2015).

[4]See B. Harris and P. Bridgen (eds), *Charity and Mutual Aid in Europe and North America since 1800* (New York, 2007); M. Lengwiler, 'Competing appeals: The rise of mixed welfare economies in Europe, 1850–1945', in G. Anderson *et al*., *The Appeal of Insurance* (Toronto, 2010), 173–200.

[5]The peculiar functioning of the Spanish hospital system in the early twentieth century is evident if compared with the British and French systems. For the British case, see, for example, S. Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900-1939', *Economic History Review*, 50 (1997), 305-26; M. Gorsky, J. Mohan and M.A. Powell, 'The financial health of voluntary hospitals in interwar Britain', *Economic History Review*, 55 (2002), 533-57; B. Doyle, *The Politics of Hospital Provision in Early Twentieth-Century Britain* (London, 2014); V. Berridge, *Health and Society in Britain since 1939* (Cambridge, 1999). For the case of French hospitals, see P.Y. Domin, *Une Histoire Économique de l'Hôpital (XIXe-XXe siècles). Une analyse rétrospective du développement hospitalier, Tome I (1803-1945)* (Paris, 2008) and C. Chevandier, *L'Hôpital dans la France du XXe siècle* (Paris, 2009). An interesting compilation of articles on the history of hospitals in the Mediterranean, Northern Europe and America over centuries (300-2000) can be found in J. Henderson, P. Horden and A. Pastore (eds), *The Impact of Hospitals 300-2000* (Bern, 2007).

[6]As shown by J. Lewis, 'The voluntary sector in the mixed economy of welfare', in D. Gladstone (ed.), *Before Beveridge: Welfare before the Welfare State. Choice in Welfare*, 47 (London, 1999), 10-17; P. Thane, 'The working class and state 'welfare' in Britain, 1880-1914', in Gladstone (ed.), *op. cit.*, 86-112.

[7]For the British case, see the considerations of Thane, *op. cit*., 112.

[8]E. Rodríguez-Ocaña, 'El informe sobre la sanidad española (1926) de C.A. Bailey, enviado de la Fundación Rockefeller', *Cronos*, 4, 1-2, (2001), 63-79.

[9]R. Huertas, 'Fuerzas sociales y desarrollo de la salud pública en España, 1917-1923', *Revista de Sanidad e Higiene Pública*, 68 (1994), 45-55.

[10]M. Vilar-Rodríguez, 'La ruptura postbélica a través del comportamiento de los salarios industriales: nueva evidencia cuantitativa (1908-1963)', *Revista de Historia Industrial*, 25 (2004), 81-126.

[11]J. Pons and M. Vilar, *El Seguro de Salud Privado y Público en España. Su análisis en perspectiva histórica* (Zaragoza, 2014), 79.

[12]*Ibid*., 92.

[13]R.M. Medina and E. Rodríguez Ocaña, 'Profesionalización médica y campañas sanitarias. Un proceso convergente en la medicina española del primer tercio del siglo XX' , *Dynamis*, 14 (1994), 77-94.

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[17]J. Pan-Montojo, 'Pobreza, exclusión y desigualdad', *Revista de Occidente*, CCXV (1999), 5-18; F. López Castellano, 'El buen samaritano no sabía economía política, de la primera ley de beneficencia al intervencionismo científico (1822-1920)', *Revista de la Historia de la Economía y de la Empresa*, IV (2010), 21-45; and R. Castel, *La Metamorfosis de la Cuestión Social. Una crónica del salariado* (Buenos Aires, 1997).

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[19]R. Huertas, 'El debate sobre la creación del Ministerio de Sanidad en la España del primer tercio del siglo XX. Discurso ideológico e iniciativas políticas', *Asclepio*, XLV-1 (1993), 89-122; E. Rodríguez-Ocaña, 'El concepto social de enfermedad', in A. Albarracín (coord.), *Historia de la Enfermedad* (Madrid, 1987), 341-9.

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[31]A. Fernández-Casado, *Bizkaia Taurina: Plazas de Toros Vizcaínas* (Madrid, 2014), 13 and 43.

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[33]BNE, Fondos históricos digitalizados, *Memoria sobre la Plaza de Toros de Valencia propiedad del Hospital General de la misma ciudad* (Madrid, 1861).

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[37]For the debate in nineteenth-century Spain on the advantages of hospital care over family care, see C. Barona, *Las Políticas de la Salud. La Sanidad Valenciana entre 1855 y 1936* (Valencia, 2006), 42-50.

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[40]E. Rodríguez Ocaña, 'La salud pública en España en el contexto europeo, 1890-1925', *Revista Española de Salud Pública*, 68 (1994), 11-27.

[41]C. Rico-Avello, *Historia de la Sanidad Española (1900-1925)* (Madrid, 1969), 84.

[42]M.T. MacEachern, *Hospital Organization and Management* (Chicago, 1946).

[43]Hospital Provincial de Madrid was founded in 1587 from the group of small hospitals with the name of *Hospital General Nuestra Señora de la Encarnación y San Roque*. From 1848 it was governed and administered by the provincial council (*diputación provincial*), and it was subsequently renamed *Hospital Provincial de Madrid*; see A.

Sáiz, 'Historia del Hospital General o Provincial de Madrid, cuna de un servicio de urología centenario', *Archivo Español de Urología*, LIX, 7 (2006), 663-73.

[44]*Ibid*., 663-73.

[45]*Revista Criterio Médico*, 25 March 1877.

[46]Institutional website of the *Instituto Homeopático y Hospital de San José*, http://www.hospitalhomeopatico.es/historia/el-hospital-de-san-jose (accessed on 2 October 2017). For the development of homeopathy in Spain from a historical perspective, see A. Albarracín, 'La homeopatía en España', in *Historia y medicina en España. Homenaje al Profesor. Luis S. Granjel* (Valladolid, 1994), 215-35; and P. León-Sanz, 'A homeopathic perspective on Tarantism and Music Therapy, Dr. Núñez (1864)', *Medicina and Storia*, XIII, 3 (2013), 89-112.

[47]BNE, Fondos históricos digitalizados, *Reseña del primer ejercicio del Instituto de Terapéutica Operatoria del Hospital de la Princesa* (Madrid, 1881) and F. Vázquez, *Médicos y Hospitales de Santander: 1930/1976* (Santander, 2005).

[48]M.I. Porras, 'Un acercamiento a la situación higiénico-sanitaria de los distritos de Madrid en el tránsito del siglo XIX al XX', *Asclepio*, LIV, 1 (2002), 219-51.

[49]See F. Álvarez-Uría, 'Los visitadores del pobre. Caridad, economía social y asistencia en la España del siglo XIX', in Seminario de Historia de Acción Social, *De la Beneficencia al Bienestar Social. Cuatro siglos de Acción Social* (Madrid, 1988), 117-46.

[50]Comunidad de Madrid, Hopital Central de la Cruz Roja, 'Historia', http://www.madrid.org/cs/Satellite?cid=1191579636288&language=es&pagename=HospitalCruzRojaSanJoseSantaAdela%2FPage%2FHCRU_contenidoFinal (accessed 14 January 2019).

[51]L'Hospital Dos de Maig fa 90 anys, 'Historia', https://www.barcelona.cat/barcelonablog/insolit/l%E2%80%99hospital-dos-de-maig-fa-90-anys (accessed 14 January 2019).

[52] L. German, E. Llopis, J. Maluquer and S. Zapata (eds), *Historia Económica Regional de España. Siglos XIX y XX* (Barcelona, 2001).

[53] P. Pérez-Castroviejo, 'La formación del sistema hospitalario vasco, administración y gestión económica 1800-1936', *Transportes, Servicios y Telecomunicaciones*, 3, 4 (2002), 73-97.

[54]For further details, see Esteban Rodríguez Ocaña, 'La asistencia médica colectiva en España, hasta 1936', in Ministerio de Trabajo y Seguridad Social (ed.), *op. cit.*, 321-61.

[55] J. Álvarez-Sierra, *La Medicina Madrileña al empezar el Siglo XX* (Madrid, 1967), 7.

[56]R. Wingate, 'Sir Henry Wellcome', *Journal of the Royal African Society*, XXXV, 141 (1936), 357-67.

[57]Wellcome Foundation, London, Archives and Manuscripts, WF/M/04/99, Folders 1-9, Spanish Testimonials.

[58]Although it was now officially called *Hospital Provincial de Madrid*; it continued to appear in the source with the old name of *Hospital General de Madrid*.

[59]The Royal Order of 27 October 1908 denounced the state of abandonment of many of these private foundations, which did not even have records due to a lack of resources or qualified personnel. *Gazeta de Madrid*, 28 October 1908, No. 302.

[60] The terms towns and villages are used to refer to population centres with less than 5000 inhabitants; see D. S. Reher, 'Ciudades, procesos de urbanización y sistemas urbanos en la Península Ibérica, 1550-1991', in M. Guàrdia, F.J. Monclús and J.L. Oyón (dirs), *Atlas histórico de ciudades europeas* (Barcelona, 1994), 1-29.

[61]E. Rodríguez-Ocaña, 'La asistencia médica colectiva en España, hasta 1936', in Ministerio de Trabajo y Seguridad Social (ed.), *op. cit.*, 321-61.

[62]P.M. Pérez-Castroviejo, 'La asistencia sanitaria de los trabajadores, mutualismo y previsión en Vizcaya, 1876-1936', *Revista de la Historia de la Economía y de la Empresa*,4 (2010), 127-52.

[63]For the impact of the influenza of 1918, which caused the deaths of more than a quarter of a million people in Spain, above all in urban areas, see I. Porras and R.A. Davis (eds), *The Spanish Influenza Epidemic of 1918-1919, Perspectives from the Iberian Peninsula and the Americas* (Rochester, 2010).

[64]M.I. Porras Gallo, 'La lucha contra las enfermedades 'evitables' en España y la pandemia de la gripe de 1918-19', *Dynamis*, 14 (1994), 159-83.

[65]R. Huertas, 'Política sanitaria de la Dictadura de Primo de Rivera a la IIª República', *Revista Española de Salud Pública,* LXXIV (2000), 35-43.

[66]The figure for 1844 is from Carasa, *op. cit*. This figure from the AEE (1915) does not appear to be particularly reliable when compared with other statistics. See P. Blanco, 'La asistencia hospitalaria en España', *Boletín Técnico de la Dirección General de Sanidad*, VI (1931), 589-606.

[67] Marín de la Bárcena, *op. cit.*, CI-CII and LXIV; and the AEE (1912). The population data correspond to the 1910 census from R. Nicolau, 'Población, salud y actividad', in A. Carreras and X. Tafunell (coords), *Estadísticas históricas de España, siglos XIX-XX* (Madrid, 2005), 77-154. We are sceptical about these figures, which we feel are overestimated; many of these institutions did not perform health care tasks but only supervised confinement of the sick.

[68]Marín de la Bárcena, *op. cit.*, CI-CII and LXIV; and E. Maza, 'El mutualismo en España, 1900-1941. Ajustes e interferencias', in S. Castillo and R. Ruzafa (coords), *La previsión social en la historia* (Madrid, 2009), 333-68.

[69]The special corps of qualified doctors and pharmacists of general charity (validated by Royal Decree of 23 February 1884) enabled charitable establishments managed by the central administration to be staffed with trained professionals chosen by competitive public examination. However, their salaries were so paltry that, generally speaking, they also had other jobs. See I. Fargues and R. Tey, *Sis segles d´assistència hospitalària a Barcelona, de Santa Creu a Sant Pau* (Barcelona, 2015).

[70]National Welfare Institute [INP], *La cuestión del seguro de enfermedad ante la X reunión de la Conferencia Internacional del Trabajo, Ginebra, mayo 1927* (Madrid, 1927), 22; the 1930 census has been used for the calculations; data from Nicolau, *op. cit*.

[71]Data obtained from P. Marset, J.M. Sáez and F. Martínez, 'La Salud Pública durante el franquismo', *Dynamis, 15* (1995), 211-50 and A. Mazuecos, 'La política social socialista durante el primer bienio republicano, trabajo, previsión y sanidad', *Estudios de Historia Social*, 14 (1980), 135-55.

[72]Comín, *op. cit.*, 43 and F. Comín and D., 'Sector público administrativo y estado del bienestar', in Carreras and Tafunell, *op. cit*., 873-964.

[73]Data obtained from Comín, *op. cit.*, 224.

[74] J.M. Massons, *Historia de la Sanidad Militar Española* (Barcelona, 1994).

[75] *Guía Oficial de España* (Madrid, 1920).

[76]M. Vilar, 'La cobertura social a través de las sociedades de socorro mutuo, 1839-1935. ¿Una alternativa al Estado para afrontar los fallos de mercado?', in J. Pons and J.

Silvestre (eds), *Los Orígenes del Estado del Bienestar en España, 1900-1945: los seguros de accidentes, vejez, desempleo y enfermedad* (Zaragoza, 2010), 85-122.

[77]National Welfare Institute [INP], *op. cit.*, 99.

[78]Percentage calculated on the basis of the average of the population census of the city of Barcelona for 1900 (533,000) and for 1920 (710,000). Figures come from the National Statistics Institute (INE).

[79]Rodríguez Ocaña, *op. cit.*, 334.

[80]For the history of this mutual society, see https://www.annalsdelsagratcor.org/hospihisto8.htm (accessed 14 January 2019).

[81] See Pérez Castroviejo, *op. cit*., 137.

[82]For more details, see A. Menéndez-Navarro, 'Hospitales de empresa, los primeros pasos de la medicina del trabajo', in Fundación Largo Caballero (ed.), *Trabajo y Salud, desde la Protección a la Prevención* (Madrid, 2010), 328-45**.**

[83]A. Aubanell, 'La elite de la clase trabajadora. Las condiciones laborales de los trabajadores de las eléctricas madrileñas en el periodo de entreguerras', *Scripta Nova. Electronic Review*, CXIX, 7 (2002); T. Martínez-Vara, 'Salarios y Programas de Bienestar Industrial en la empresa ferroviaria MZA (1915-1935)', *Investigaciones de Historia Económica*, IV (2006), 101-38.

[84]See the works included in R. Huertas and R. Campos (coords.), *Medicina Social y Clase Obrera en España (siglos XIX y XX)* (Madrid, 1992); A. Cohen (ed.), *El Trabajo y sus Riesgos en la Época Contemporánea: conocimiento, codificación, intervención y gestión* (Barcelona, 2012).

[85]National Welfare Institute [INP], *La Clínica del Trabajo del Instituto Nacional de previsión* (Madrid, 1933).

[86]National Welfare Institute [INP], *La Caja Nacional de Seguro de Accidentes de Trabajo* (Madrid, 1946).

[87] AEE (1935).

[88]For the case of Catalonia, see A. Zarzoso, 'Privatización de la medicina y profesionalización de la gestión hospitalaria en Barcelona, 1888-1980', in A. Zarzoso and J. Arrizabalaga (eds), *Al Servicio de la Salud Humana. La historia de la medicina ante los retos del siglo XXI* (Sant Feliu de Guíxols, 2017), 509-14. For the Basque Country, J. C. Garmendia, 'Urólogos Vascos (compendio biográfico)', *Osasunaz,* V (2003), 237-62.

[89]For the biography of its founders, see R. Casares and M. De Fuentes, *Història de la Clinica Plató. 75è aniversari* (Barcelona, 2001).

[90]For further details, see Álvarez-Sierra, *op. cit.*, 17, 31.

[91]*ABC* [newspaper], 23 January 1931, 28. It should be clarified that the term 'polyclinic' was commonly used to refer to a dispensary or community clinic, whereas the term 'clinic' actually referred to a small hospital facility. Nevertheless, the terminology of the sources at this time is confusing and does not allow for a comprehensive classification.

[92]*ABC*, 18 October 1931, 49.

[93] See P. Montoliú, *Madrid en la Guerra Civil. I «La Historia»* (Madrid, 2000).

[94]The documentation generated by these hospitals from 1936 to 1940 can be found in the Archivo Militar de Ávila. The documentary collection comes from the archives of Hospital Militar de Zaragoza and Hospital Militar de Valladolid, which were functioning during the Civil War. It consists of clinical records, admission files, book of admissions and discharges and military courts.

[95]*ABC*, 20 February 1940, 11.

[96]BNE, Ref. 3/118834, *El Rapport de la Mission Sanitaire de la Société des Nations en Espagne (28 Décembre 1936-15 Janvier 1937)*, a report drawn up by the Comité international de coordination et d'information pour l'aide à l'Espagne républicaine.

[97]Report published by the Food and Agriculture Organization of the United Nations (FAO), *La situation de l´alimentation et de l´agriculture en 1948*, September (1948).