


# From Abandonment to Hospitalisation: Evolution of Hospital Care in Rural Spain (1939–1975)

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**Summary.** The aim of this article is to explain the situation of the Spanish hospital system during the twentieth century and to analyse the reasons why the difficulties that a significant part of the Spanish population, resident in rural areas, had to access hospital services during the Franco dictatorship were perpetuated. The first section uses a conceptual perspective to discuss the repercussions that the new medical significance of the hospital had for the notion of ‘rural hospital’. The second section examines the projects for hospital modernisation that appeared before the Spanish Civil War (1936–39) and highlights what impeded the consolidation of these pioneering experiences in the country. The following section analyses the hospital situation in Spain’s rural world as well as the profound changes that occurred during the last decades of the dictatorship, just on the threshold of the health reform that was finally implemented in the democratic period.

**Keywords:** history of hospitals; modern hospital; healthcare; rural Spain; Francoism

The roots of the modern hospital cannot be dissociated from the medical education reform movement that groups of leading doctors, mainly formed in Central Europe, set in motion during the second half of the nineteenth century.<sup>1</sup> However, despite being essential, medical and scientific achievements only represent one of the characteristics of the modern hospital. Attention should also be drawn to the influence of all kinds of technological, economic and social elements which, as a whole in the immediate aftermath of

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<sup>1</sup>For the genesis of the modern hospital, see: Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York-Oxford: Oxford University Press, 1999), 399–462.

the First World War, ended up fostering 'the idea of the hospital as a social catalyst of all the resources of a (local, regional or national) community at the service of a good conjunction of the health-sickness dualism'.<sup>2</sup> In western countries, the creation of a modern and coordinated hospital system should be understood as a general phenomenon, whose materialisation in the USA could already be seen in the first decades of twentieth century, while in most European countries it had to wait until the interwar period and, in many cases, the process was not culminated until after the Second World War.

Focusing on the country under study in this article, this process did not take place systematically in Spain until the 1970s.<sup>3</sup> These almost three decades of delay with respect to what occurred in most European countries can be explained, at least partly, by the Franco regime's international isolation,<sup>4</sup> above all during its first two decades, and the absence of a tax reform, the implementation of which was delayed until 1977.<sup>5</sup> Both factors, and especially the latter, made it impossible to make the necessary investments to standardise and modernise the Spanish health system until the arrival of democracy. Moreover, this modernisation took place in a context of international economic crisis—oil crisis—whose main consequences in Spain were high inflation and an increase in the unemployment rate.<sup>6</sup>

In short, during much of the twentieth century, the Spanish health system was characterised by a chronic shortage of funding and a lack of coordination between different healthcare networks, whether publicly or privately owned.<sup>7</sup> This led to a very unequal territorial distribution of hospital services that made it difficult for a significant part of the population, especially those in rural areas, to access these resources. This absence of hospital modernisation and coordination also explains why, after the Spanish Constitution of 1978, the priority of the health reform undertaken in Spain was, above all, hospital reform.<sup>8</sup> Although it was intended to change the approach of the health system from a model based on curing sickness to another focused more on prevention and health promotion, the fact is that most healthcare expenditure was devoted to hospital and specialised services,<sup>9</sup> and this continues to be the case according to the latest data available.<sup>10</sup>

<sup>2</sup>Fernando Salmón *et al.*, *La Casa de Salud Valdecilla. Introducción del hospital contemporáneo en España* (Santander: Universidad de Cantabria, 1990), 14.

<sup>3</sup>For more on the health reform process in Spain, see: Enrique Perdiguero-Gil and Josep M. Comelles, 'The Defence of Health. The Debates on Health Reform in 1970s Spain', *Dynamis*, 2019, 39, 45–72.

<sup>4</sup>See: Carlos Barciela López, ed., *Autarquía y mercado negro: el fracaso económico del primer franquismo, 1939-1959* (Barcelona: Crítica, 2003).

<sup>5</sup>For the politics that originated the tax reform of 1977, see: Francisco Comín Comín, 'El desarrollo del Estado del bienestar en España', *Historia y Política*, 1999, 2, 7–38; Edurne Gandarias, 'La Política de la reforma fiscal: De la dictadura a la democracia' (unpublished PhD thesis, Universidad de Deusto, 1999).

<sup>6</sup>For the impact of the oil crisis in Spain, see: José M. Serrano, 'La Crisis del Petróleo', in A. Furió (coord), *Las crisis a lo largo de la historia* (Valladolid: Secretariado de Publicaciones e Intercambio Científico, 2010), 155–92.

<sup>7</sup>See: Margarita Vilar-Rodríguez and Jerònia Pons-Pons, 'Competition and Collaboration between Public and Private Sectors: The Historical Construction of Spanish Hospital System, 1942-1986', *The Economic History Review*, 2018, 72, 1384–408.

<sup>8</sup>See, for example: Margarita Vilar-Rodríguez and Jerònia Pons, eds, *Un siglo de hospitales entre lo público y lo privado, 1886-1986* (Madrid: Marcial Pons, 2018); Josep Barceló-Prats *et al.*, 'Las bases ideológicas y prácticas del proceso de regionalización de la sanidad en España (1955-1978)', in M. I. Porras, L. Mariño and M. V. Caballero (coords), *Salud, enfermedad y medicina en el franquismo* (Madrid: Los Libros de la Catarata, 2019), 146–67.

<sup>9</sup>See: Nolasco Acarín, 'Entre el deseo y la pérdida', *Quadern CAPS*, 1992, 17, 99–104.

<sup>10</sup>In 2019, according to functional classification, more than 60 per cent of the consolidated public health expenditure in Spain was devoted to hospital and specialised services. See: María del Carmen Rodríguez-Blas, *Estadística del gasto sanitario público*

On the contrary to what occurs in the British National Health Service (NHS), where the flow of money is proportional to the flow of patients, which not only rationalises health spending, but also creates an interesting level of competitiveness between hospitals to offer the best services and consequently attract the referrals of 'general practitioners',<sup>11</sup> in Spain it is the needs of hospitals rather than patients' needs that dictate economic investment.<sup>12</sup> Thus, despite the fact that the current Spanish General Health Law, promulgated in 1986, enshrined primary healthcare as one of its basic pillars, hospital centrism has continued to be preponderant in the drawing up of health policies in recent decades.<sup>13</sup>

The aim of this article is to analyse the hospital planning initiatives developed in Spain during the Franco dictatorship (1939–75). These proposals, which in many cases were not actually implemented, were intended to coordinate the Spanish hospital system, as a way of dealing with the shortcomings in healthcare and responding to a growing demand for medical care which could no longer be absorbed by the structures of nineteenth-century charity. However, before going into the details of our case study, we devote a first section to conceptually reviewing the repercussions that the new medical significance of the hospital had for the notion of 'rural hospital'. The second section, now focusing on the Spanish case, outlines the projects for hospital modernisation that appeared before the Spanish Civil War (1936–39). Finally, the third section analyses the least-known elements of the debates on hospital reform that took place during the Franco dictatorship and the transition to democracy, whose influence on the major reforms carried out during the 1980s was undeniable. For this reason, the third section also includes a series of qualitative and quantitative data that help illustrate the situation of the Spanish hospital system just before the start of the democratic period.

### The New Medical Significance of the Hospital and its Implications for the Concept of Rural Hospital

The evolution of hospitals in the western world, from charitable guesthouses to centres of scientific excellence, was obviously influenced by scientific and technological determinants, but also by others of a social and cultural nature which, in the late nineteenth and early twentieth centuries, transformed the significance of sickness—and the actual experience of being sick—and the health needs of populations.<sup>14</sup> Focusing solely on the emergence of the present 'dominant medical model',<sup>15</sup> its roots must be sought in the late eighteenth century with what Michel Foucault called the '*Naissance de la Clinique*'.<sup>16</sup> The

2019: *principales resultados* (Madrid: Ministerio de Sanidad, 2020), 5.

<sup>11</sup>Candelaria Ayuso *et al.*, 'La Práctica de la Medicina de Familia en el National Health Service', *Revista Clínica de Medicina de Familia*, 2011, 4, 57–68.

<sup>12</sup>See: Francisco Escobar, 'El hospitalocentrismo que corroe nuestro sistema público de salud', *Revista Clínica de Medicina de Familia*, 2006, 9, 250–58.

<sup>13</sup>For the historical evolution of hospital centrism in Spain, see: Josep Barceló-Prats and Deborah Bekele, 'Historical roots of hospital centrism in Catalonia, 1917–1980', *Journal of Evolutionary Studies in Business*, 2021, 6, 156–81.

<sup>14</sup>See, for example: George Rosen, 'The Hospital: Historical Sociology of a Community Institution', in E. Freidson, ed., *The Hospital in Modern Society* (New York: Free Press of Glencoe, 1963), 1–36.

<sup>15</sup>For the characteristics of the dominant medical model, see: Eduardo L. Menéndez, 'El modelo médico y la salud de los trabajadores', *Salud Colectiva*, 2005, 1, 9–32.

<sup>16</sup>For the birth of the clinic, see: Michel Foucault, *Naissance de la clinique. Une archéologie du regard médical* (Paris: Presses Universitaires de France, 1963); Erwin Ackerknecht, *La médecine hospitalière a Paris, 1794-1848* (Paris: Payot, 1967). For the

inception of this type of medicine, largely based on clinical experimentation,<sup>17</sup> the performing of autopsies and medical statistics, increased the interest of doctors and surgeons in the hospital institution.<sup>18</sup> This interest, which was also a result of the need for new medical education underpinned by the anatomico-clinical verification of diagnoses, accorded the hospital a new medical significance as a '*machine à guérir*'.<sup>19</sup> Overall, the consequences of this process led to the hospital being considered as the ideal scenario for training healthcare professionals and also as the hub of production and dissemination of new scientific knowledge within the field of practical medicine, both in its diagnostic dimension—chemical analysis, bacteriology and radiology—and in its therapeutic aspect—surgery, pharmacology and physical therapy.<sup>20</sup> Obviously, this also had an impact on the scope of the availability of medical care which led, irrevocably, to the creation of the first sickness insurances.<sup>21</sup>

Nevertheless, despite the fact that hospital practice was increasingly underpinned by clinical foundations, it should also be borne in mind that scientific development affected the perceptions of health workers more than their actual therapies, at least until the consolidation of laboratory medicine.<sup>22</sup> Likewise, in the collective imagination of populations, for most of the nineteenth century the hospital continued to be a synonym for a place that attended to the poor, the insane and the socially marginalised. Hence, when members of the bourgeois class or the aristocracy fell sick, their families cared for them at home. Medical practice and even certain types of surgery continued to be routinely performed in patients' homes. It was not until the late nineteenth century and above all the first third of the twentieth century, as western societies industrialised and medical treatment became increasingly sophisticated and complex, that the 'health-sickness-care' process started to be transformed.<sup>23</sup> The result was a gradual change towards the professionalisation of healthcare practices which, eventually, included the development of a complete and competitive commercial market for medical services that were increasingly provided in hospitals.<sup>24</sup>

inception of clinical medicine in Spain, at the beginning of the nineteenth century, see: Josep Danón, 'Sobre los inicios de la medicina clínica en España (1801-1850)', *Medicina e Historia*, 1986, 12, 3–26.

<sup>17</sup>For the consolidation of clinical observation in hospitals, see: François Steudler, *L'Hôpital en observation* (Paris: A. Colin, 1974); Isabelle von Bueltzingsloewen, *Machines à instruire, machines à guérir. Les hôpitaux universitaires et la médicalisation de la société allemande, 1730-1850* (Lyon: Presses Universitaires de Lyon, 1997).

<sup>18</sup>See: Guenter B. Risse, 'Before the Clinic Was "Born": Methodological Perspectives in Hospital History', in N. Finzsch and R. Jütte, eds, *Institutions of Confinement. Hospitals, Asylums, and Prisons in Western Europe and North America, 1500-1950* (New York: Cambridge University Press, 1996), 75–96.

<sup>19</sup>See: Michel Foucault, *Les machines à guérir, aux origines de l'hôpital moderne* (Paris: Ins. de l'Environnement, 1976).

<sup>20</sup>See: Teresa Huguet, 'Una reflexió historiogràfica sobre l'hospital com a espai de medicalització', *Gimbernat*, 2004, 42, 41–48.

<sup>21</sup>The first sickness insurance to protect workers in industry, on a mandatory basis, was approved on 15 June 1883 in Germany and was promoted by the chancellor at that time, Otto von Bismarck. See: Henry E. Sigerist 'De Bismarck a Beveridge. Desarrollo y tendencias de la legislación sobre seguridad social', in E. Lesky (comp), *Medicina Social. Estudios y testimonios históricos* (Madrid: Ministerio de Sanidad y Consumo, 1984), 187–210.

<sup>22</sup>See: Morris J. Vogel, *The Invention of the Modern Hospital. Boston, 1870-1930* (Chicago: The University of Chicago Press, 1979).

<sup>23</sup>For more on the 'health/sickness/care' concept, see Eduardo L. Menéndez, 'El modelo médico y la salud de los trabajadores', in F. Basaglia, ed., *La salud de los trabajadores. Aportes para una política de la salud* (México: Nuevo Imagen, 1978), 11–53.

<sup>24</sup>See: Barbra M. Wall, 'Healthcare as Product: Catholic Sisters Confront Charity and the Hospital

In the USA, a first fundamental milestone for the consolidation of the hospital as the centre of a community's medical and health issues was the creation of the American Hospital Association (AHA) in 1898.<sup>25</sup> However, the definitive emergence of the hospital as the centre around which research, teaching and medical care revolved dates from the 1910s due to a combination of various factors. We highlight the following three factors: the restructuring of medical training that resulted from the Flexner report<sup>26</sup>; the introduction of standardisation by Charles Moulinier and Franklin Martin,<sup>27</sup> which led to hospital accreditation<sup>28</sup>; and the consolidation of the modern conception of hospital administration with such relevant contributions as those of Malcolm MacEachern.<sup>29</sup> These and other criteria helped the hospital evolve from the 'domestic era' to the 'managerial era'.<sup>30</sup> All this ended up transforming American medical and folk cultures<sup>31</sup> and, subsequently, those of the rest of western countries.<sup>32</sup> The confidence and optimism concerning the potential of the hospital was clearly documented, for example, when Henry Hurd, of Johns Hopkins University Hospital, proclaimed in 1913 that 'the day of the home care of the sick can never return. Social conditions forbid that hospital care will become superfluous'.<sup>33</sup>

In sum, the 'old homelike hospital' gave way to the 'new temple of science'. However, this conversion was not instantaneous or automatic even in the USA. For several decades, the 'old' and the 'new' significance of hospital coexisted in apparently similar contexts. Undoubtedly, the most graphic example of this reality is found in the small and often isolated hospital located in a rural community. In the mid-twentieth century, in western countries, the concept of 'rural hospital' still conserved the stamp of a long past when its

Marketplace, 1865-1925', in S. Strasser, ed., *Commodifying Everything: Relationships of the Market* (New York: Routledge, 2003), 143-68.

<sup>25</sup>The AHA was the first national hospital association in the world, which was conceived as a discussion forum where the hospital was seen to be far more than the medicine that was practised within its walls. This kind of approach ended up converting the hospital into a subject for study and analysis from different disciplines.

<sup>26</sup>See: Abraham Flexner, *Medical Education in the United States. A report to the Carnegie Foundation for the Advancement of Teaching* (New York: The Carnegie Foundation, 1910).

<sup>27</sup>For more on standardisation, see: Franklin H. Martin, 'Hospital Standardization, Its Inception, Development, and Progress in Five Years', *Surgery Gynecology and Obstetrics*, 1922, 34, 133-42; Christopher J. Kauffman, 'The Push for Standardization: The Origins of the Catholic Hospital Association, 1914-1920', *Health Progress*, 1990, 71, 57-65.

<sup>28</sup>The system of hospital accreditation is based on external quality control undertaken by a national or regional commission, which annually draws up a list of hospitals which, due to the quality of their resources and functioning, deserve to be 'accredited'. It was the Joint Commission on Accreditation of Hospitals, created in 1952 on the basis of the union of the

American Medical Association, the American College of Physicians and the American Hospital Association, that drew up the famous document entitled 'Standards for Hospital Accreditation' which has subsequently been adopted by many countries around the world.

<sup>29</sup>See: Malcolm MacEachern, *Hospital Organization and Management* (Chicago: Physicians' record Co., 1935).

<sup>30</sup>See: Joan E. Lynaugh, 'From Respectable Domesticity to Medical Efficiency: The Changing Kansas City Hospital, 1875-1920', in D. E. Long and J. Golden, eds, *The American General Hospital: Communities and Social Contexts* (Ithaca: Cornell University Press, 1989), 21-39.

<sup>31</sup>See: Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Charles E. Rosenberg, *The Care of Strangers. The Rise of America's Hospital System* (New York: Basic Books, 1987); James H. Cassedy, *Medicine in America: A Short History* (Baltimore: Johns Hopkins University Press, 1991).

<sup>32</sup>See: Paloma Fernández-Pérez, *The Emergence of Modern Hospital Management and Organisation in the World, 1880s-1930s* (Bingley: Emerald Publishing, 2021).

<sup>33</sup>See: Henry Hurd, 'The Hospital as a Factor in Modern Society', *Modern Hospital*, 1913, 1, 32-33, 33.

only functions were to shelter travellers or provide very elementary medical care to the surrounding population. On the other hand, the trend of bringing the diagnostic and therapeutic capacity of hospital services to all citizens made the hospital, located in rural areas, an ideal institution, *a priori*, to solve the problem of access to this type of care. The former conceptualisation still included the care that the rural hospital could provide within the domestic era of respectable care, while the latter now assimilated it into 'the modern small hospital and community health centre'.<sup>34</sup>

Starting from this second premise, in 1955 Robert F. Bridgman defined the 'rural hospital' not only as the smallest curative unit serving a rural community, but also as a health centre which in its . . .

most comprehensive form should provide the surrounding district with preventive and curative services and, at the same time, should serve as an outpost for the hospitalization of confirmed cases of disease. The rural hospital may also cover health education in rural communities and serve as a demonstration center for general hygiene work.<sup>35</sup>

However, the implementation of these objectives ran into obstacles of an economic nature due, above all, to the disproportionate running costs of a hospital with such a small number of beds and their relation to the staff and technical equipment requirements. Years later, Bridgman himself affirmed that his idea of rural hospital had run into the insurmountable barrier of the cost of technical facilities. For example, in 'hospitals having between 25 and 50 beds, the price of treatment was prohibitive, and the care and safety of patients was called into question'.<sup>36</sup>

Fully aware that hospitals are the most expensive elements of health services, the World Health Organisation (WHO) always discouraged countries, especially less-developed ones, from planning a network of small rural hospitals that could end up being 'over-equipped and over-costly'.<sup>37</sup> Thus, the WHO preferred to use the term 'health centre' to define 'a unit providing the basic functions of curative and preventive medicine and hygiene necessary for the majority of the local population, either directly or in relation to other services'.<sup>38</sup> This strategy, which not only consisted in considering the health centre as a 'geographical unit' but also as a 'functional entity', would subsequently be ratified and expanded in the International Conference on Primary Health Care, held in Alma-Ata in 1978.<sup>39</sup>

<sup>34</sup>See: Alden B. Mills and Everett W. Jones, *The Modern Small Hospital and Community Health Center* (Chicago: The Modern Hospital, 1946).

<sup>35</sup>Robert F. Bridgman, *The Rural Hospital: Its Structure and Organization* (Geneva: World Health Organization, 1955), 9.

<sup>36</sup>Robert F. Bridgman, 'El hospital base reemplaza al hospital rural', *Jano: Medicina y humanidades*, 1971, 1, 5–7, 7.

<sup>37</sup>Richard Llewelyn-Davies and Hugh M. C. Macaulay, *Planificación y administración de hospitales* (Washington: Organización Panamericana de Salud, 1970), 7.

<sup>38</sup>World Health Organization, *Report of Technical Discussions on the Methodology of Health Protection in Local Areas* (Geneva: WHO, 1952), 27.

<sup>39</sup>In Spain, the first initiative that could be assimilated into this new conception of 'health centre' is documented in the city of Talavera de la Reina within the WHO project E30 OMS-España for the establishment of health demonstration areas. See: Esteban Rodríguez-Ocaña and Juan Atenza, 'El Proyecto E30 OMS-España para el establecimiento de una zona de demostraciones sanitarias en Talavera de la Reina, 1965-1976', in Porras, Mariño and Caballero, eds, *Salud, enfermedad y medicina*, 124–45.

In the 1970s, the concept of rural hospital was now in obvious decline. Its use was restricted to a health centre that had some beds for 'hospitalisation' due to being located in a population centre at least 60 min away from the nearest hospital and, moreover, situated in a mountainous area or a place difficult to access. Even in these cases, however, the trend was towards the suppression of these beds 'as they are inefficient and uneconomic, preferring to invest their budget in rapid and efficient means of communication'.<sup>40</sup> The following data confirm the 'process of extinction' that the rural hospital was undergoing:

In the United States, the proportion of admissions to hospitals with between 1 and 24 beds fell from 3.4% to 1.7% between 1953 and 1962. France prohibited the practice of surgery in these hospitals, turning them into centres of social medicine or of diagnosis for local doctors. In Great Britain, the closure of 1,300 of these establishments was planned.<sup>41</sup>

In any case, there was consensus in affirming that any type of hospital, including the smallest and even the equivalents to a health centre, had to be part of an organised healthcare network—according to the concept of 'regionalisation'—and have a minimum number of beds that ensured their efficient management and economic viability. Regarding the first requirement, 'regionalisation' should be understood as . . .

a complex mechanism of technical and administrative decentralisation that includes the establishment of levels of care ranging from the community primary health centre to the general hospital and speciality polyclinics.<sup>42</sup>

In relation to the optimum hospital size, recommended limits were established between a minimum of 250 beds and a maximum of 1,000.<sup>43</sup> A hospital with less than 250 beds was economically undesirable. On the other hand, one that exceeded 1,000 beds caused serious problems with regard to the human aspect, as it neither facilitated interpersonal relationships nor made for easy management. Within these parameters, for a population of 100,000 people, the ideal figure was calculated to be around 600 beds and, in any event, never less than 400.<sup>44</sup>

Finally, it should be noted that the debates on hospital regionalisation and the optimum size of hospitals need to be set, in western countries, within broader proposals of comprehensive reform of the health system. Nonetheless, it is also true that the evolution of these health systems never gravitated spontaneously towards primary healthcare values. In most cases, the medical dominance of the hospital with respect to all other

<sup>40</sup>Hèlios Pardell, 'Estudio de la dotación hospitalaria española' (unpublished PhD thesis, Universidad Autónoma de Barcelona, 1973), 51.

<sup>41</sup>Bridgman, 'Hospital rural', 5.

<sup>42</sup>Alfredo L. Bravo, 'Regionalización: organización y funcionamiento coordinado de los servicios de salud en zonas rurales y urbanas', *Boletín de la Oficina Sanitaria Panamericana*, 1974, 77, 231–46, 231.

<sup>43</sup>See, for example: P. Mauranges, 'Capacité optimale des hôpitaux', *La semaine des hôpitaux*, 1971, 47, Suppl. 8, 152–55.

<sup>44</sup>See: Paul Aourousseau, 'Conferencia inaugural del IV Congreso Nacional de Hospitales', in Asociación Española de Administración de Hospitales (coord), *El hospital de 100 a 300 camas* (Barcelona: Asociación para el Desarrollo Hospitalario de Barcelona, 1979), 5–10.

healthcare resources encouraged the development of the hospital-centric culture.<sup>45</sup> In conclusion, the consequences of the 'hospital-centric model', characterised by a disproportionate distribution of resources to hospitals, ended up favouring the fact, for example, that medical specialists only concentrated in hospitals, or that large outpatient departments were incorporated into hospitals and functioned, in detriment to primary care, as the first point of care for many patients.<sup>46</sup> Logically, this trend made access to health services even more difficult for rural communities, above all to those located far from any hospital.

### The First Attempts to Modernise the Hospital System in Spain

In modern states there have been—and still are—different strategies, from the most centralised to the profoundly decentralised, for managing what has commonly been called the Welfare State.<sup>47</sup> However, all the historical, social, political and cultural variables that have given rise to these strategies are embedded in the 'medicalisation process',<sup>48</sup> in the sense of availability of medical care, and it has been necessary to solve the problem of citizen access to health services by regulating admission criteria.

Spain, from the mid-nineteenth century, with the promulgation of the Charity Law of 1849 and the Health Law of 1855,<sup>49</sup> opted for a centralised model of health management that tended to concentrate hospital care in provincial capitals. This health policy, adopted due to a lack of resources more than for ideological reasons,<sup>50</sup> made access to these services difficult for most of the population which, at this time, was eminently rural.<sup>51</sup> This, added to the still preponderant concept of hospital as a 'charitable guest-house', explains why, during the second half of the nineteenth century, only between 1 and 2 per cent of the Spanish population was treated in hospitals.<sup>52</sup> Consequently,

<sup>45</sup>For the development of the hospital-centric culture in Spain, see: Josep M. Comelles, Elisa Alegre-Agís and Josep Barceló-Prats, 'Del hospital de pobres a la cultura hospitalocéntrica. Economía política y cambio cultural en el sistema hospitalario catalán', *Kamchatka: Revista de análisis cultural*, 2017, 10, 57–85.

<sup>46</sup>Note, by way of example, that from 1962 to 1969 the number of outpatients in American hospitals rose by 71 per cent and emergency cases, which already accounted for a third of all outpatients at the beginning of the 1960s, grew from an average of 5,664 per hospital/year in 1962 to 8,600 in 1969. Data taken from the monograph on health industries published by *Hospitals: The Journal of the American Hospital Association*, July–September 1970, 44.

<sup>47</sup>See: Martin Gorsky et al. (eds), *The Political Economy of the Hospital in History* (Huddersfield: University of Huddersfield Press, 2020).

<sup>48</sup>For the concept of medicalisation applied to historical research of the health culture, see: Enrique Perdiguero-Gil and M. Dolores Ruiz-Berdún, 'La medicalización: ¿un concepto útil? Reflexiones a propósito de la investigación histórica de la cultura de la salud', 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 Guixols: Sociedad Española de Historia de la Medicina, 2017), 247–52.

<sup>49</sup>For the development of charity laws in Spain, see: Elena Maza, *Pobreza y beneficencia en la España contemporánea, 1808-1936* (Barcelona: Ariel, 1999).

<sup>50</sup>Throughout the second half of the nineteenth century, per capita income in Spain was, *grosso modo*, barely half of that of the more prosperous Europe'. José L. García-Delgado and Juan C. Jiménez-Jiménez, 'Los problemas económicos del final de siglo', in P. Laín and C. Seco, eds, *España en 1898: las claves del desastre* (Barcelona: Galaxia Gutenberg Círculo de Lectores, 1998), 65–82, 66.

<sup>51</sup>Towards the end of the nineteenth century, the Spanish economy was still essentially agricultural. Almost 70 per cent of the active population worked in agriculture, a figure that helps envisage the percentage of the population that lived in rural areas. *Ibid.*, 69. In 1900, 50.8 per cent of the Spanish population lived in municipalities of less than 5,000 inhabitants. This percentage was still 40.2 per cent in 1930. Source: Spanish National Statistics Institute (*Instituto Nacional de Estadística*, INE).

<sup>52</sup>The diverse analyses that exist of the social make-up of those treated shows that, by and large, those



medical practice in Spain continued to be carried out predominantly in patients' homes. Nevertheless, as doctors, doctors' assistants (*practicantes*), midwives and apothecaries were not ubiquitous throughout Spanish territory, and even less so in small rural communities, many sick people, unable to find any possibility of being cured in their own localities or surrounding towns or villages, were obliged to travel to distant municipalities in order to receive medical attention.<sup>53</sup>

This precarious healthcare situation could not be extrapolated equally to all Spanish territory. In regions that industrialised earlier, such as Catalonia or the Basque Country,<sup>54</sup> the consequences of sudden demographic expansion led to the need to propose healthcare reforms and, in particular, to modernise and coordinate hospitals that could not continue to function under charitable parameters or in isolation. In these regions, with living conditions typical of the industrialisation of the late nineteenth and early twentieth centuries, the emergence of a new collective consciousness made health something desirable, as well as necessary, and this explains, for example, the appearance of the first compulsory sickness insurance for workers.<sup>55</sup> Likewise, the increased demand for medical attention, whether for common illnesses or due to accidents at work, was also influential in the proliferation of a flourishing private medical market.<sup>56</sup> As had happened in the USA, in the most industrialised Spanish regions 'medical care was no longer simply a societal function . . . , but instead had become a purchased commodity'.<sup>57</sup>

It is no surprise, therefore, that the first proposals to modernise and reorganise the hospital system in Spain were documented in Catalonia. The proposal that is considered to be the pioneer is the one drawn up by the doctor Jacint Reventós at the request of the regional Catalan government, in 1917.<sup>58</sup> Although it was never implemented, this project is considered to be the first attempt at hospital regionalisation in Spain. It was not until the advent of the Spanish Second Republic (1931–36) that, thanks to more favourable political conditions, the government of Catalonia could again try to address the healthcare needs of its population. On this occasion, the technical reports commissioned from

admitted to hospitals came from sectors of the urban population related to the new industrial pauperism. See, for example, Pedro Carasa, *El sistema hospitalario español en el siglo XIX. De la asistencia benéfica al modelo sanitario actual* (Valladolid: Universidad de Valladolid, 1985).

<sup>53</sup>For the evolution of rural medicine in Spain during the twentieth century, see: Josep M. Comelles *et al.*, 'Por caminos y veredas: la práctica médica rural durante el franquismo', in J. Martínez-Pérez and E. Perdiguero-Gil, eds, *Genealogías de la reforma sanitaria en España* (Madrid: Los Libros de la Catarata, 2020), 63–124.

<sup>54</sup>For the evolution of the Catalan hospital system during the nineteenth and twentieth centuries, see: Josep Barceló-Prats and Josep M. Comelles, *L'evolució del dispositiu hospitalari a Catalunya, 1849-1980* (Manresa: Publicacions de l'Arxiu Històric de les Ciències de la Salut, 2020). For the formation of the hospital system in the Basque Country, see: P. Pérez-Castroviejo, 'La formación del sistema hospitalario vasco, administración y gestión económica,

1800-1936', *Transportes, Servicios y Telecomunicaciones*, 2002, 3–4, 73–97.

<sup>55</sup>For the genesis of the first public and private sickness insurance in Spain, see: Margarita Vilar-Rodríguez and Jerònia Pons-Pons, 'Competition and Collaboration between Public and Private Sectors: The Historical Construction of the Spanish Hospital System, 1942-86', *The Economic History Review*, 2018, 72, 1384–408.

<sup>56</sup>For the development of the medical market in Spain in the early twentieth century, see: Alfons Zazoso, 'Privatización de la medicina y profesionalización de la gestión', in A. Zazoso and J. Arrizabalaga, eds, *Al servicio*, 509–14.

<sup>57</sup>Nancy Tomes, 'An Undesired Necessity, the Commodification of Medical Service in Interwar America', in S. Strasser, *Commodifying Everything: Relationships of the Market* (Oxfordshire: Routledge, 2003), 97–118, 100.

<sup>58</sup>See: Ferran Sabaté, 'Public Health in Catalonia between 1885 and 1939', *Catalan Historical Review*, 2017, 10, 43–57.

different experts, such as the doctor Enric Fernández-Pellicer,<sup>59</sup> enabled the Catalan government to promulgate the 'Framework law for the organisation of health services and social welfare in Catalonia' in 1934.<sup>60</sup> For the first time in Spain, a legislative initiative broke with the centralising structure of nineteenth-century charity and tried to rationalise the existing healthcare resources.<sup>61</sup> Unfortunately, the outbreak of the Spanish Civil War (1936–39) changed the deployment and implementation of this modern health model in Catalonia.<sup>62</sup>

However, the most ambitious project to introduce the modern hospital in Spain was not presented either in Catalonia, 'the factory of Spain', or in the Basque Country, 'the steel capital of the peninsula'<sup>63</sup> but rather in the current autonomous community of Cantabria.<sup>64</sup> Thanks to the patronage of Ramón Pelayo de la Torriente, Marquis of Valdecilla (1850–1932), and under the medical direction of Wenceslao López Albo (1889–1944), the reform project known as '*Casa de Salud Valdecilla*' was launched in the city of Santander in 1928. Conceived as a new hospital and different to those that had previously existed in Spain, it was designed to carry out the four characteristic functions of the modern hospital: healthcare, medical teaching, scientific research and preventive social action in the community in which the establishment is located. However, problems related to the vagueness of the chosen economic model for the management of the project, as well as obstacles of an ideological nature, ended up frustrating this pioneering experience.<sup>65</sup>

In conclusion, during the first third of the twentieth century, there was no type of project at state level aimed at modernising and reorganising the Spanish hospital system as a whole. Among other reasons, because the administrators of large public hospitals, under pressure from the different groups of political and religious elites with priorities related to local dynamics and aspirations, were never open to, or even directly blocked, the introduction of new ideas on hospital organisation and management.<sup>66</sup>

<sup>59</sup>See: Enric Fernández-Pellicer, 'Ordenació hospitalària a Catalunya, solucions pràctiques', *Annals de Medicina*, 1932, 7, 387–408.

<sup>60</sup>For the development of Catalan health legislation during the Spanish Second Republic, see: Manuel J. Peláez-Albendea, 'La Conselleria de Sanitat i Assistència social de la Generalitat republicana a través de la Ley de Bases de 5 de abril de 1934 y la Ley de Coordinación y Control Sanitarios Públicos de 26 de junio de ese año', *Revista de Política Social*, 1982, 134, 73–86.

<sup>61</sup>For further information on the design of the Regional Government of Catalonia's health policies during the Spanish Second Republic, see: Carles Hervàs, 'Sanitat a Catalunya durant la República i la Guerra Civil' (unpublished PhD thesis, Universitat Pompeu Fabra, 2004).

<sup>62</sup>For more on the health reforms in Catalonia during the Spanish Civil War, see: Carles Hervàs, *La xarxa hospitalària de Catalunya durant la Guerra Civil, 1936-1939* (Manresa: Publicacions de l'Arxiu Històric de les Ciències de la Salut, 2014).

<sup>63</sup>García-Delgado and Jiménez-Jiménez, 'Los problemas económicos', 74.

<sup>64</sup>Cantabria is a region in the north of Spain located between the Basque Country and Asturias. The Casa de Salud Valdecilla project was developed between two regions with an evident sectoral specialisation and whose industrial sector, along with that of Catalonia, contributed most to the early twentieth-century Spanish economy. For Spanish industrialisation during the nineteenth century, see: J. Nadal, *El fracaso de la revolución industrial en España, 1814-1913* (Barcelona: Ariel, 1975).

<sup>65</sup>An extensive and detailed monograph on the experience undergone in the Casa de Salud Valdecilla in Santander can be found in Salmón *et al.*, *La Casa de Salud*.

<sup>66</sup>See: Paloma Fernández-Pérez, 'Modelos de gestión hospitalaria en España (1900-1930). El Hospital de la Santa Creu i Sant Pau en perspectiva comparada', in M. Vilar-Rodríguez and J. Pons-Pons, eds, *Un siglo de hospitales entre lo público y lo privado (1886-1986)* (Madrid: Marcial Pons, 2018), 139–75.

This lack of a coordinated hospital policy does not mean that the scientific advances of the leading countries in matters of hospital care were unknown in Spain. Not only were they known, but during the 1920s and above all in the early 1930s, thanks to institutions such as the Rockefeller Foundation,<sup>67</sup> important novelties were introduced in the health-care model that the government of the Spanish Second Republic tried to implement. One notable aspect was the requirement for specialised training, which led to the creation of the National School of Public Health (*Escuela Nacional de Sanidad* (ENS)).<sup>68</sup> Other innovations were the establishment of a statistics service and the creation of a Social Hygiene and Propaganda section as the backbone of the Directorate General for Health (*Dirección General de Sanidad*),<sup>69</sup> which ran the internal organisation of the sectorised model of centres of rural hygiene, as well as being the inspiration of a regime of incompatible activities in relation to holding public offices.

After the Civil War, the Franco regime's lack of interest put an end to the most innovative aspects of the health model that the Republic had aspired to implement. Hence, the aforementioned strategic horizons of quality and service were not re-established until the final years of the Franco dictatorship, coinciding with the reforming intentions of the 1970s. It was from this time that the design and organisation of large hospitals started to be entrusted to young generations of doctors and architects, who were already trained in scientific and technical solutions developed on the basis of innovations introduced during the first third of the twentieth century.<sup>70</sup>

Thus, the few attempts mentioned in this section are limited to very particular cases which, precisely, could be originated due to being immersed in urban and industrialised contexts. Consequently, the development of these initiatives, finally cut short for economic, ideological or war-related reasons, never envisaged the need for extending hospital services to the rural population of these same territories. In short, medical practice in the Spanish rural context continued in its traditional form and the hospital continued to be, during this first third of the twentieth century, a very distant and exceptional resource for almost three-quarters of the Spanish population.<sup>71</sup>

<sup>67</sup>Esteban Rodríguez-Ocaña, 'La intervención de la Fundación Rockefeller en la creación de la sanidad contemporánea en España', *Revista Española de Salud Pública*, 2000, 74, 27–34.

<sup>68</sup>Gustavo Pittaluga, *La constitución de la Escuela Nacional de Sanidad de Madrid* (Madrid: Publicaciones de la Escuela Nacional de Sanidad, 1930). For more on the historical evolution of the ENS, see: Fernando Ruiz-Falcó, 'Escuela Nacional de Sanidad. Problemática pasada, actual y futura', *Revista de Sanidad e Higiene Pública*, 1983, 57, 359–72; Josep Bernabeu, 'La Escuela Nacional de Sanidad', *Eidon: revista de la fundación de ciencias de la salud*, 2009–2010, 32, 74–80.

<sup>69</sup>See: Enrique Perdiguerro-Gil et al., 'La propaganda sanitaria en España en la II República: la Sección de Higiene Social y Propaganda de la Dirección General

de Sanidad', in R. Campos, Luis E. Montiel and R. Huertas, eds, *Medicina, ideología e historia en España (siglos XVI-XXI)* (Madrid: Consejo Superior de Investigaciones Científicas, 2007), 303–16.

<sup>70</sup>See: Joel Howell, *Technology in the Hospital. Transforming Patient Care in the Early Twentieth Century* (Baltimore-London: Johns Hopkins University Press, 1995); Pierre-Yves Donzé, 'Les systèmes hospitaliers contemporains, entre histoire sociale des techniques et business history', *Gesnerus*, 2005, 62, 273–87.

<sup>71</sup>See: Josep L. Barona et al., 'Health Problems and Public Policies in Rural Spain (1854-1936)', in J. L. Barona and S. Chery, eds, *Health and Medicine in Rural Europe (1850-1945)* (Valencia: PUV, 2005), 63–82.

## Analysis of the Spanish Hospital System during the Franco Regime: Shortcomings and Challenges

At the beginning of the 1940s, the situation of the Spanish hospital system could be described as 'pathological', as if its hospitals were some kind of 'hunchbacked, sclerosed and scarce cells'.<sup>72</sup> Francoism meant the return of administrative centralism in terms of healthcare and the suspicion with which any 'regionalist' initiative was seen impeded all attempts at hospital planning based on the specific needs of different regions, or with their real participation, during the first two decades of the dictatorship. Furthermore, there was no coordinated health policy due to reasons related to the contradictory interests of the different 'families' that supported the Franco regime.<sup>73</sup>

Nevertheless, the early years of the Franco dictatorship should not be considered as a period of inaction in terms of health reforms. For example, one of the most representative pillars of the regime, compulsory sickness insurance (*Seguro Obligatorio de Enfermedad*, hereinafter SOE), was introduced in 1944.<sup>74</sup> Initially, the SOE adopted the functioning of a state mutual for paid workers. However, unlike public sickness insurance in other countries, whose services were planned on the basis of existing hospitals, it was decided to build a new network of hospitals for the SOE.<sup>75</sup> This insurance, promoted by the Falangist sector of the regime through the Ministry of Labour, was designed with industrial workers in mind (iron and steel industry, mining, etc.), as obtaining the consent of a group of workers considered to be disaffected was a political priority of the dictatorship.<sup>76</sup> This explains, in part, the delay and the marginalisation of the rural population in gaining access to the benefits and provisions of the SOE.<sup>77</sup>

This option entailed the acceptance of certain limitations. First, the state's economic weakness meant that the construction of this network was slow, and hospitals were built bit by bit. Second, despite having an architectural and functional aspect similar to that of American hospitals,<sup>78</sup> these hospitals did not meet the minimum requirements to fall

<sup>72</sup>Ignasi Aragó, *Els hospitals a Catalunya* (Barcelona: Imp. Altés, 1967), 11.

<sup>73</sup>For an overall view of the health system during the early years of the Franco dictatorship, see: Joan Serrallonga, 'El cuento de la regularización sanitaria y asistencial en el régimen franquista. Una primera etapa convulsa, 1936-1944', *Historia Social*, 2007, 59, 77-98; Daniel Lanero, '¿La salud es lo que importa? La O.S. 18 de Julio y la asistencia médica en Galicia (1940 - 1965)', *Historia Social*, 2010, 68, 47-67; Margarita Vilar-Rodríguez and Jerònia Pons-Pons, 'El sistema hospitalario público y privado en España en las primeras décadas del franquismo', in Vilar-Rodríguez and Pons-Pons, eds, *Un siglo de hospitales*, 179-261.

<sup>74</sup>For the inception of the SOE, see: Felip Solé-Sabaris, 'Apunte crítico del funcionamiento de la Seguridad Social en España', in H. Hatzfeld, ed., *La crisis de la medicina liberal* (Barcelona: Ariel, 1965), 197-221.

<sup>75</sup>The report that laid the foundations for the construction of a new hospital network for the SOE can be seen in: Primitivo de la Quintana and Joaquín Espinosa, *Seguro de Enfermedad. Estudio para un*

*plan de instalaciones de asistencia médica* (Madrid: Hijos de E. Minuesa, 1944).

<sup>76</sup>See: Ismael Saz, 'Trabajadores corrientes: obreros de fábrica en la Valencia de la posguerra', in J. A. Gómez Roda and I. Saz, eds, *El Franquismo en Valencia: formas de vida y actitudes sociales en la posguerra* (Valencia: Episteme, 1999), 187-234.

<sup>77</sup>Legally, the agricultural population could not join the SOE until 1958. However, in practice, the SOE did not start to provide effective health coverage to this substantial segment of the Spanish population until the beginning of the 1960s. See: Daniel Lanero, 'Los otros marginados del bienestar. La Previsión Social en la Galicia rural bajo el franquismo (1940-1966)', in P. Capuzzo and Ch. Giorgi, eds, *Centro e periferia como categorie storiografiche. Esperienze di ricerca in Italia, Spagna e Portogallo* (Roma: Carocci, 2009), 189-209.

<sup>78</sup>See, for example, Juan P. de la Cámara, *Fisionomía y vida del Hospital Americano. Estampas de un viaje de estudio* (Madrid: Instituto Nacional de Previsión, 1948).

under the concept of 'modern hospital' until the mid-1960s. Their organisation was more like a private polyclinic than a general hospital, with care provision that only covered surgical and maternity services. Moreover, there was no teaching of any sort in this kind of establishment. The most relevant point, however, was that their services were not offered to the population as a whole, as they only treated beneficiaries of the SOE.<sup>79</sup> In this respect, it should be borne in mind that the SOE did not achieve significant coverage, that is, 50 per cent of the Spanish population, until the early 1960s. Despite the substantial rural exodus initiated in the 1950s, 36.6 per cent of the active population was still working in the primary sector in 1960, 43 per cent of the Spanish population resided in municipalities with less than 10,000 inhabitants and 17 per cent lived in municipalities with less than 2,000 inhabitants.<sup>80</sup> Third, the construction of this new network took place in large cities which, logically, already had other hospitals. This decision often duplicated hospital services unnecessarily and, due to the complexity of managing institutions that were dependent on a great diversity of public administrations in a rational manner,<sup>81</sup> led to a lack of coordination between the different hospital networks in existence. Finally, but no less important, the building of these hospitals absorbed a large part of the investment that the Spanish state was able to devote to health, which was not much anyway, and this was to the detriment of what was already a very meagre budget allocated to rural healthcare. Table 1 shows the medical and healthcare expenditure in Spain compared to seven other countries in the early 1960s.

In short, access to the new hospitals of the SOE continued to be difficult for most of the Spanish population, both because they were located geographically far from rural communities and because they provided care to only groups covered by the public insurance.<sup>82</sup> This political decision, which firstly located the hospitals of the SOE in the country's larger cities with the idea of gradually expanding the network to include provincial capitals, exacerbated the marginalisation of the rural world, both in terms of hospital infrastructure and, more generally, the resources allocated to the healthcare of the population (Table 2).

In order to attain a more in-depth knowledge of the problems of Spanish rural health, in the late 1960s and early 1970s, we have resorted to one of the most widely circulated

<sup>79</sup>For a comprehensive account of the situation of Spanish hospitals during the 1960s, see: José Ortiz, 'Hacia una reordenación de la Sanidad Pública española: el problema hospitalario', *Revista de Administración Pública*, 1966, 50, 151–80.

<sup>80</sup>See: Roser Nicolau, 'Población, salud y actividad', in X. Tafunell and A. Carreras (coords), *Estadísticas Históricas de España*, vol. 1. (Bilbao: Fundación BBVA, 2005), 77–154; Xavier Tafunell, 'Urbanización y vivienda', in X. Tafunell and A. Carreras, eds, *Estadísticas Históricas*, 455–99.

<sup>81</sup>According to the National Catalogue of 1966 and the census of health facilities (*Censo de Establecimientos Sanitarios*) of the Spanish National Statistics Institute for the same year, the plurality of managers in public hospital organisation was shared among the following ministries: the Ministry of the

Presidency of the Government controlled special hospitals; the Ministry of the Interior was in charge of charity hospitals; the Ministry of Labour was responsible for large hospitals known as *residencias sanitarias*, Education managed clinical hospitals, Justice had jurisdiction over prison hospitals and, finally, military hospitals were run by three different ministries (Air Force, Navy and Army). For a more detailed description, see: Ramón Baltar, 'Desventura y riesgo de los hospitales españoles', *Triunfo*, 1971, 476, 10–16.

<sup>82</sup>For more details on the obstacles to introducing the welfare state during the Franco dictatorship, see: Damián A. González-Madrid and Manuel Ortiz-Heras, 'El franquismo y la construcción del Estado del Bienestar en España: la protección social del Estado, 1939–1986', *Pasado y Memoria: Revista de Historia Contemporánea*, 2018, 17, 361–88.

**Table 1.** Medical and health expenditure in Spain and in seven other countries at the start of the 1960s

Country	Year	Medical and health expenditure <sup>a</sup>	Per cent of the GDP	Per cent of national income	Per capita income <sup>b</sup>
USA	1961–62	29,895	5.5	6.8	2,306
Sweden	1962	3,686	4.9	5.6	1,420
The Netherlands	1963	2,344	4.5	5.5	885
Finland	1961	691	4.3	5.4	891
France	1963	16,374	4.2	5.5	1,079
United Kingdom	1961–62	1,088	4.0	4.9	1,172
Czechoslovakia	1961	7,264	3.5	4.0	920
Spain	1960–61	805	0.145	0.143	280

<sup>a</sup>In millions (in each national currency).

<sup>b</sup>In dollars (US\$).

Source: Hèllios Pardell, 'Estudio de la dotación hospitalaria española' (unpublished PhD thesis, Universidad Autónoma de Barcelona, 1973), 247.

**Table 2.** Doctors, hospitals and hospital beds in Spain and in seven other countries (1971–73)

Country	Doctors per 1,000 inhabitants	Inhabitants per hospital	Beds per 1,000 inhabitants
USA	1.68	29,004	8.50
West Germany	2.03	17,348	11.22
United Kingdom	1.36	20,181	9.00
France	1.35	54,157 <sup>a</sup>	9.10
Finland	1.28	13,428	15.09
Czechoslovakia	2.47	55,769	12.10
Sweden	1.38	9,236	16.60
Spain	1.41	25,222	4.78

<sup>a</sup>Only public general hospitals.

Source: Prepared by the authors on the basis of Adolfo Serigó, 'Hospitales', *Tribuna Médica*, 1974, 549, 28–29.

medical journals of these decades: *Tribuna Médica*.<sup>83</sup> Of particular note among the different studies published by this journal on the health situation of rural Spain at this time<sup>84</sup> is the one carried out on the basis of proposals contained in the 3rd Economic and Social Development Plan (1972–75).<sup>85</sup> This affirmed that there were 1,696 primary centres of rural hygiene in Spain in 1969, which in fact were no more than the doctor's house, which had a small consulting room to attend to the sick and administer vaccinations. Furthermore, most of these centres needed urgent reforms. There were also 96

<sup>83</sup>*Tribuna Médica* was published weekly from 1964 to 1996. Its contents make it one of the most important sources for studying Spanish healthcare during these three decades.

<sup>84</sup>See, for example, Justo de la Cueva and Margarita Ayestarán, 'Los médicos españoles y el medio rural', *Tribuna Médica*, 1975, 611, 16–17; Adolfo Serigó, 'Los problemas de la sanidad española', *Tribuna Médica*, 1977, 716, 14–17.

<sup>85</sup>See, No Author, 'La sanidad nacional ante el III Plan de Desarrollo', *Tribuna Médica*, 1971, 386, 1–15. For more information on the Third Development Plan and data on Spanish rural health, see: No Author, *Seguridad Social, Sanidad y Asistencia Social. III Plan de Desarrollo Económico y Social, 1972-1975* (Madrid: Presidencia del Gobierno, 1972).

secondary centres of rural hygiene, although in fact 'only 40 were usable'.<sup>86</sup> Both primary and secondary centres had been a creation of the government of the Second Republic (1931–36),<sup>87</sup> in the years before the Spanish Civil War, following the recommendations of the Hygiene Committee of the League of Nations.<sup>88</sup> The secondary centres, run by a director (doctor) and a health instructor (nurse), had been conceived as the key element for the territorial coordination of healthcare in the rural world.<sup>89</sup> This precarious care structure was completed with a network of emergency maternity and paediatric centres, dependent on the Directorate General for Health and distributed irregularly throughout the country, which had also originated during the first third of the twentieth century, as part of an institutional effort to reduce the then very high rates of infant mortality.<sup>90</sup>

Continuing with the figures provided by the 3rd Development Plan,<sup>91</sup> a total of 321 rural hospitals were recorded. In fact, these were old 'hospital-asylums'—along the lines of the charitable establishments that have already been mentioned—with very precarious conditions, almost all of them classified as 'level C' (the lowest level) from the point of view of the quality of care provisions. Moreover, most of these 'hospital-asylums', which were dependent in terms of property and facilities on public institutions (municipal councils) or private charity, especially that of the Church, were located in large towns and expected to provide for extensive districts. Thus, small and very small rural communities, which were the immense majority, as already mentioned above, did not have any type of hospital infrastructure whatsoever. Table 3 shows that, in the mid-1960s, Spain was the European country with the lowest number of beds per thousand inhabitants. It was possible for the lack of hospitals in many rural areas of the country to be mitigated to some extent by the health and social care traditionally provided by ecclesiastical institutions of a charitable nature.<sup>92</sup> This was also true with regard to the activities of disseminating information on health and hygiene undertaken by the women's section (*Sección Femenina*) of FET—JONS,<sup>93</sup> targeting above all women in rural areas.<sup>94</sup>

<sup>86</sup>Serigó, 'Los problemas de la sanidad española', 15.

<sup>87</sup>For health work under the Second Republic, see: Josep Bernabeu, 'La utopía reformadora de la Segunda República: la labor de Marcelino Pascua al frente de la Dirección General de Sanidad, 1931-1933', *Revista Española de Salud Pública*, 2000, 74, 1–13; Joan Serrallonga, 'Reformadores y reaccionarios en la estructura central de Sanidad en España, 1931-1936', *Investigaciones Históricas*, 2009, 29, 241–64.

<sup>88</sup>See: Iris Borowy, *Coming to Terms with World Health. The League of Nations Health Organisation 1921-1946* (Frankfurt am Main: Peter Lang, 2009).

<sup>89</sup>For more on the origin and evolution of the secondary centres of rural hygiene in Spain, see: Juan Atenza and José Martínez-Pérez (coords), *El centro secundario de higiene rural de Talavera de la Reina y la sanidad española de su tiempo* (Toledo: Junta de Comunidades de Castilla-La Mancha, 2001).

<sup>90</sup>Vicente Pérez-Moreda et al., *La conquista de la salud. Mortalidad y modernización en la España contemporánea* (Madrid: Marcial Pons, 2015), 171–76.

<sup>91</sup>No Author, 'La sanidad nacional ante el III Plan de Desarrollo', 9.

<sup>92</sup>Pilar León-Sanz, 'La Iglesia católica en el sistema hospitalario español (1942-1966): continuidades, cambios, asociacionismo', in J. Martínez-Pérez and Enrique Perdiguer-Gil, eds, *Genealogías de la reforma sanitaria en España* (Madrid: Catarata, 2020), 192–214.

<sup>93</sup>FET-JONS is the acronym for *Falange Española Tradicionalista y de las Juntas de Ofensiva Nacional Sindicalista*. This was the single party of the Franco regime that was created by a Decree of 20 April 1937 and which forced the unification of political organisations—of Falangist and Traditionalist ideological currents—that had supported the coup d'état of July 1936. In September 1943, the dictator Francisco Franco ordered the official press to refer to the single party as a 'Movement' rather than as a party. From then on, the use of the term 'National Movement' became widespread.

<sup>94</sup>See: Sescún Marías Cadenas, 'Por España y por el campo': *La Sección Femenina en el medio rural*

**Table 3.** Hospital beds in the World Health Organisation European region (1964)

Beds per thousand inhabitants	Countries
14.28	Sweden–Ireland
11.11	Austria–France–Iceland–Scotland
10	Czechoslovakia–Switzerland–Federal Republic of Germany–Finland–Italy
9.09	Denmark–Norway
8.38	Belgium–Wales–England
5.83	Portugal
5.56	Greece–Yugoslavia
4.34	Spain <sup>a</sup>

<sup>a</sup>The data for Spain are consistent with those provided by Adolfo Serigó and Pedro Porras, *La planificación hospitalaria en España* (Madrid: Patronato Nacional de Asistencia Psiquiátrica, 1966), 17, of 4.44 beds per 1,000 inhabitants.

Source: World Health Organisation, *Annuaire de statistiques sanitaires mondiales, 1964*, Vol. III (Genève: WHO, 1968).

The use of an official source, the ‘hospital catalogues’ corresponding to the years 1963 and 1970, makes it possible to carry out a complementary diagnosis of the situation of the hospital network in the country’s rural areas during the final decades of the dictatorship, and to detect trends in its evolution, which would be consolidated during the transition to democracy. Table 4 shows the evolution of hospital attendance rate in Spanish hospitals.

Hence, in Galicia, Andalusia and Castile-La Mancha, all of them clearly rural regions in these years, the number of hospitals in municipalities with less than 30,000 inhabitants fell on average by 35 per cent between 1963 and 1970, which entailed the disappearance of many of the aforementioned ‘hospital-asylums’. Specifically, the number of rural hospitals in Galicia fell by 30 per cent, with rural beds decreasing by 19 per cent. In Andalusia the fall was 37 and 30 per cent respectively, while in Castile-La Mancha the reduction in rural hospitals was 40 per cent and that of rural beds 30 per cent (Table 5). Although our analysis has focused on these three regions, we can affirm that this phenomenon was prevalent in all the country’s rural areas throughout the period under analysis.

This snapshot of the hospital situation in some of the country’s most markedly agricultural regions needs to be completed by referring to two types of healthcare establishments of the free or private sector which, throughout the Franco regime, had a significant position in Spanish towns: surgical clinics and maternity clinics, usually equipped with a small number of beds—a dozen at the most—which varied depending on the size of the town in question.

It should be added that there were other problems that exacerbated the unequal and disadvantageous situation of the rural population with respect to medical and healthcare services. There were only one or two ambulances at most in rural provinces, which were



**Table 4.** Hospital attendance rate in Spanish hospitals (1950/1960/1967)

Year	Population	Hospital admissions	Hospital attendance rate <sup>a</sup>
1950	29,976,755	449,751	15
1960	30,903,137	724,088	23
1967	32,140,036	1,064,558	33

<sup>a</sup>HAR is calculated by dividing the total number of registered admissions in the country's hospital system during a year by the number of inhabitants and multiplying the resulting quotient by a thousand.  $HAR = (\text{total number of admissions}/\text{number of inhabitants}) \times 1,000$ .

HAR, hospital attendance rate.

Source: Pardell, 'Estudio de la dotación hospitalaria española' (unpublished PhD thesis, Universidad Autónoma de Barcelona, 1973), 196.

**Table 5.** Evolution of the number and percentage of rural hospitals and beds in three Spanish regions (1963–70)

Region	Year	Number of rural hospitals	Rate of change	Number of rural beds	Rate of change
Galicia	1963	29	100%	364	100%
Galicia	1970	20	-30%	295	-19%
Andalusia	1963	140	100%	2,881	100%
Andalusia	1970	89	-37%	2,010	-30%
Castile-La Mancha	1963	33	100%	415	100%
Castile-La Mancha	1970	20	-40%	300	-30%

Source: Prepared by the authors on the basis of the 'Hospital Catalogues' of 1963 and 1970 ('Catálogo de Hospitales 31 de diciembre de 1963', *Boletín Oficial del Estado* (BOE), 140 (13 June 1966), 7390–427. 'Catálogo de Hospitales actualizado al 31 de diciembre de 1970', *BOE*, 70 (22 March 1973), 5632–61.)

always based in the provincial capital, and hence they were almost never available to attend to health emergencies in small rural communities remotely located at some distance from the capital. Meanwhile, in the late 1960s and early 1970s, there were still very few telephones at hand in the Spanish rural world to send alerts in the case of emergencies. There were also relatively few families of farmers and agricultural workers, about a third of all families, which had their own vehicle to travel quickly to a medical consultation or to the nearest hospital. It was therefore not unusual that the doctor could take hours, or even days, to see patients when needed, or that the sick in rural areas had to wait far too long for the medicines they were prescribed or to be admitted to a clinic or a hospital.

We cannot enter into a detailed analysis of the professional situation of rural doctors during the Franco dictatorship here. Let it suffice to say that the working conditions and the salaries of these doctors were the cause of repeated corporate complaints. Doctors frequently joined the ongoing rural exodus, many of them seeking work in the city in order to leave rural areas as soon as possible. Furthermore, a rural environment was not an attractive destination for recent university graduates. As a result of these circumstances,

it is no surprise to see that 30 per cent of all medical posts in rural areas in Spain did not have a qualified doctor assigned to them in 1971.<sup>95</sup>

In a nutshell, the grave structural shortcomings of healthcare provisions in the rural world, along with the dictatorship's health policy based on the decision to give priority to the urban hospitals dependent on the SOE, pushed the rural population to travel or move to the cities in increasing numbers in search of better quality healthcare,<sup>96</sup> and this was consequently another factor reinforcing the hospital-centric model referred to above.

In view of this situation, the Franco regime promulgated a series of laws and decrees in the 1960s to allow advances, at least at theoretical level, in the coordination and modernisation of the Spanish hospital system. These included the Hospital Law of 1962 and the Basic Law on Social Security of 1963. However, it was not until the second half of the decade when the foundations were laid for future hospital planning at national level. With the publication of Royal Decree 575/1966, it was possible to know for the first time the exact number of hospitals in Spain and their main characteristics (data corresponding to 1963). This same decree also divided Spanish territory into 11 hospital regions, for the purpose of carrying out more precise hospital planning on the basis of the specific needs of each region.

Unfortunately, in the short term, none of this legislation achieved its objectives, which consisted in introducing an integrated model of social protection and reducing the inequalities in accessing hospital services that affected a large part of the Spanish population. In fact, a lack of coordination continued to be the dominant theme in healthcare provision in Spain in the 1960s, as a multitude of overlapping agencies persisted in the management of hospitals and sickness insurance.

Nevertheless, these circumstances did not prevent some Spanish hospitals from starting to make the necessary reforms to meet the indispensable criteria of the 'modern hospital'. The pioneering experience of the '*Casa de Salud Valdecilla*' was already long past when, in the late 1950s and early 1960s, the necessary changes were made at Asturias General Hospital to turn it into the first Spanish hospital to not only provide a curative, preventive and rehabilitative medical and healthcare service, for both inpatients and outpatients, but also to function as a centre for the training and further development of medical personnel, as well as promoting clinical research programmes.<sup>97</sup> By the mid-1960s, the large hospitals linked to the SOE in Madrid, Barcelona, Seville and Valencia were to follow suit in this radical transformation. Meanwhile, the new teaching facet of the hospital entailed the implementation of a new system of medical teaching for

<sup>95</sup>A detailed description of the problems of rural medicine in the early 1970s can be found in: Juan Luna, 'Informe: La medicina rural', *Triunfo*, 1972, 508, 15–20.

<sup>96</sup>The testimonies of rural doctors in inland Spain, recorded by the professional press of the time, clearly indicate this process. For example, it was commented that 'the situation of rural doctors in this province was aggravated by the increase in emigration and the "freezing" of the fees of the SOE, which are not in step with the rising cost of living'. E. Valero, 'La situación del médico rural en nuestra provincia es angustiosa para muchos', *Profesión Médica*, 1966,

840, 1–2. It was also affirmed that 'the massive exodus of the population has reduced, to the point of in-viability, many towns and villages that previously sustained a doctor, or maybe even two'. Millán Morán Hernández, 'El médico rural ante la reorganización asistencial de la Seguridad Social', *Profesión Médica*, 1970, 974, 2.

<sup>97</sup>An extensive monograph on the case of Asturias General Hospital can be seen in: José García-González, *La implantación del hospital moderno en España. El Hospital General de Asturias, una referencia imprescindible* (Oviedo: Ediciones Nobel, 2011).

postgraduates in line with the American model of a 3-year internal medicine residency programme, known in Spain as the '*Médico Interno Residente*' training programme (MIR).<sup>98</sup> Thanks to these changes, before long the Spanish population started to take a new health culture on board, based on a hospital environment that started to be highly technified and with well-trained specialist doctors thanks to the development of the aforementioned MIR system.

Thus, by the end of the 1960s, the hospital was now seen as a desirable and very necessary resource. In Spain, several decades later than in many other European countries a transition was taking place from the concept of hospital as 'charitable guesthouse' to the 'centre of scientific excellence'. This transformation occurred in just a few years and was so radical that the medical director of one of the most important hospitals in Madrid wrote that 'citizens and a very considerable number of health professionals have reached the conclusion that there is no intelligent life outside the hospitals'.<sup>99</sup> Nonetheless, until the beginning of the 1980s, access to this 'intelligent life' was still a complicated process for a substantial part of the Spanish population, above all those in rural areas, who, despite the rural exodus of the previous three decades, still accounted for 31.4 per cent of the country's population and 13.9 per cent of the active population in 1981.<sup>100</sup>

In fact, none of the projects of regionalisation of the rural health services and their co-ordination with higher levels of the hospital system, based on the efficient implementation of a district structure in the rural world, were actually put into practice during the final years of the dictatorship.

Therefore, by the end of the 1970s, the Spanish system could at first glance appear to be a socialised model, given the high level of coverage, the amount of public expenditure and the wide range of provisions. Nonetheless, the 'professional model' was maintained, aimed at workers and their dependants, organised along corporatist lines, fragmented in administrative terms and mainly financed through contributions.<sup>101</sup> These and other reasons explain why the creation of the welfare state health system in Spain is based on a culture focused on curing sickness, which favoured the hegemony of a hospital-centric model. This hegemony deferred the reform of the primary level of care, and the introduction of preventive policies and health education, until the second half of the 1980s. With the arrival of democracy, universal coverage of healthcare was achieved, although not without difficulties. The Spanish healthcare system was gradually brought into line with the systems of other European welfare states and, culturally, this evolution was characterised by a transition in which people were primarily considered as citizens rather than being seen as insured and beneficiaries.<sup>102</sup> Indeed, the General Health Law of 1986 enshrined primary healthcare as one of its basic pillars and improved the quality and

<sup>98</sup>For the origin and the evolution of the specialised health training in Spain known as MIR training, see: Juan D. Tutosaus *et al.*, 'Historia de la formación sanitaria especializada en España y sus claves docentes', *Educación Médica*, 2018, 19, 229–34.

<sup>99</sup>José L. Temes, 'Desarrollo del sistema hospitalario', *Tribuna Médica*, 1989, 1219, 39–42, 41.

<sup>100</sup>Tafunell, 'Urbanización y vivienda', 487–8; Nicolau, 'Población, salud y actividad', 150.

<sup>101</sup>See: Ana M. Guillén-Rodríguez, 'Un siglo de previsión social en España', *Ayer*, 1997, 25, 151–78.

<sup>102</sup>For more on the health reforms in Spain at the beginning of the democratic period, see: Enrique Perdiguer-Gil and Josep M. Comelles, 'The Roots of the health Reform in Spain', in L. Abreu, ed., *Health Care and Government Policy* (Évora: Publicações do Cidehus, 2019), available at: <<https://books.openedition.org/cidehus/8327>> accessed 25 March 2021.

proximity of the first point of contact with the system. Nevertheless, the hospital, despite having been 'rationalised' both internally and externally, has continued to be the cornerstone of the Spanish health system, and this is an element of analysis which, along with others, should be taken into account in current debates on the health sector.

### Conclusions

The affirmation of the hospital as the cornerstone of healthcare for the population, as well as a teaching and scientific research centre, was a protracted historical process that, as explained above, had different time frames in different western countries.

In Spain, the reorganisation and modernisation of its poorly funded hospital system, made up of numerous uncoordinated networks, did not take place until the 1970s, that is, 30 years later than most nearby countries. The data that we provide in comparative terms in this contribution demonstrate the structural shortcomings of the Spanish hospital system (and, more generally, of the health system) during the Franco regime (1936–75). The causes of this time lag were both political and economic. The institutionalisation of the dictatorship not only reinforced the charitable and centralised model of health management inherited from the nineteenth century, but also impeded any project of regionalisation of the hospital system along the lines that had been piloted in the country's most industrialised regions (above all in Catalonia) during the first third of the century. Moreover, without a reform of the tax system, such as that passed in 1977, now during the transition to democracy, the modernisation and standardisation of the hospital system would have been completely unviable.

The international debate on the modernisation of hospital systems also extended to small rural hospitals in the mid-twentieth century, epigones of the traditional hospital-asylum that had continued to be the norm in the western world during the nineteenth century. However, projects to bring the new diagnostic tests and therapeutic techniques to rural communities, which had hitherto received the least attention and been restricted to the worst facilities, were abandoned during the 1970s as it became evident that these small establishments, equipped with only a small number of beds, generated unsustainable expenses with regard to personnel and technical equipment.

However, the reality of healthcare in the Spanish rural world during the Franco dictatorship was very far from such debates. Although the demographic weight of the rural population was very important until the 1970s, the hospital infrastructure to attend to this population was tremendously precarious. It was limited to several hundred old charity hospital-asylums, publicly (municipal) or privately (Church) owned, located in the larger towns and expected to provide for extensive rural districts. The smallest communities had, at the most, a modest dispensary that the municipal doctor may have installed in his home. The few ambulances that existed were highly unlikely to reach these small rural localities, while the doctors practising there (badly paid, without technical resources, isolated from other colleagues and out of touch with hospitals where specialised training was starting to be available) tried to escape as soon as possible.

The gradual extension of the benefits of the SOE to the rural population from the start of the 1960s did not improve the healthcare situation in towns and villages, but rather accentuated their abandonment in terms of health and the practice of travelling to the cities for health reasons became something normal. The modern hospitals of the

insurance were located in the cities, and trips to the city to visit the doctor, receive treatment or be admitted to hospital became normal. Significantly, during the final decades of the dictatorship no project of regionalisation of the health services in Spain was put into practice.

In summary, the same as in many other areas, in the case of the modernisation and standardisation of the hospital system, the Franco regime entailed a break with the reformist experiences of the first third of the twentieth century and, ultimately, a delay of more than 30 years in the convergence of the Spanish hospital model with the surrounding western democracies.

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