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The Health System in Spain 1942-1986: Measurement and patterns under dictatorship and democracy•

Margarita Vilar-Rodríguez (University of A Coruña)
Jerònia Pons-Pons (University of Seville)

Health insurance came late to Spain compared with more advanced countries and was introduced under the Franco dictatorship in 1942. Both aspects distanced Spain from the European pattern and conditioned the characteristics of the Spanish health care model. From the outset, there was collaboration between public and private sectors, which was necessary during the dictatorship due to the severe financial and logistical shortcomings of the state system. During the transition to democracy from 1975 to 1985 the Spanish health care model was yet to be defined and was the subject of debate in the unstable political climate of the time. The first General Health Law was not passed in Spain until 1986, under the first stable government of the democracy and after the democratic Constitution and a tax reform had been approved. The tax reform introduced by the minister Fernández Ordoñez in 1977 was necessary to finance the welfare state that it was intended to implement. While Spain tried to belatedly follow the path of Western Europe with respect to welfare policies, by the late 1980s European countries were beginning to apply cuts and have doubts about the viability of their welfare states. Spain, which had only recently joined the European Union, faced two challenges that were not necessarily compatible: to implement the adjustments required by Europe and to introduce the long-awaited health care system in a young, unstable democracy. In the 1990s, private health care coverage started to recover ground, supported for ideological reasons and justified by alleged budgetary constraints, and it was at the centre of debates in the 1993 general elections. Despite the PSOE government's continuation of the public management model, cuts were introduced in pharmaceutical expenditure, while in the regions (*comunidades autónomas*) governed by conservative parties (CIU in Catalonia and PP in Galicia and Valencia) the regional governments started to introduce private management health care models, in particular in public hospitals.

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Overall, we can say that the path Spain followed with regard to health care coverage did not coincide with general European cycles after the Second World War. While Europe was constructing health insurance models with public funding, Spain was establishing a private management system based on workers' and employers' contributions. In 1986, when publicly-funded health insurance was approved in Spain, cuts in public expenditure were being introduced in Europe, and which would reach the Spanish health care system ten years later.

Studies on the development of a public sickness insurance scheme and a National Health System in Spain during the twentieth century, undertaken by researchers in disciplines such as history, economic history, the history of medicine, law and economics, have not been comprehensive, either thematically and chronologically. Until recently there had not been any long-term historical analysis, and in the few cases that something was published, the editors managed to cover an extensive chronological period by compiling work by specialists in different areas and with a short-term perspective, with different methodologies and explanations that did not correspond to the same factor analysis.[1]In the late twentieth century, studies of a technical and political nature were published with the intention of analysing the health care system while the model was at the centre of political debate.[2]However, the Spanish historiography has dealt with certain chronological periods in much greater depth, for example the Second Republic(1931-1936) due to the advances in social medicine and the increase in the budget earmarked for health care during the period with left-wing governments.[3]

This paper analyses how the health care system in Spain belatedly took shape and with specific features under dictatorship and democracy. This analysis is accompanied by a reconstruction of the main variables that determined the functioning of public and private health care coverage in Spain from 1942 to 1986. An international

[1]In this respect, the works compiled by Álvarez Junco (ed.) (1990) are worthy of mention. For an attempt to carry out a long-term analysis on the basis of three lines of argument, the legislation, management and funding of the Spanish health care system in the long term from 1880 to the present, see Pons and Vilar (2014).

[2] Barea Tejeiro et al. (1992), Cabares Hita (dir.) (2006), Álvarez Dardet and Peiró (eds.) (2000) and Artazcoz et al. (eds.) (2010)are all worthy of mention.

[3]In the ample historiography, we highlight the works that analyse the development of sickness insurance before the Civil War, especially Porras on the debate in the Ateneo in Madrid (Porras, 1999), Bernabeu (2000) on Marcelino Pascual's work as head of the Directorate General for Health Care (*Dirección General de Sanidad*) during the Second Republicand Rodríguez Ocaña (1990) on collective medical care in Spain before 1936. For a detailed description of the literature on the development of sickness insurance, see Vilar and Pons (2013: 271-272) and Pons and Vilar (2014).

perspective helps us to understand how the Franco dictatorship conditioned the creation and characteristics of the health care system in Spain in the medium and long term. With this aim, the paper is divided into three main sections. Section 1 analyses the period from the introduction of the first state health insurance in 1942 to the passage of the Basic Law on Social Security in 1963. The second section analyses health care coverage in the last stage of the Franco regime after the passage of this law, which was intended to replace the existing social insurance system with a universal social security model. The third section analyses the debate on the health care system in Spain during the transition to democracy and the passage of the first General Health Law of 1986.

1. The first stage of compulsory sickness insurance (1942-1963)

Spain was one of the last countries in Western Europe to pass compulsory sickness insurance. It did so, in 1942, under different conditions to the majority of its European neighbours: under a dictatorship that submitted the population to harsh working and living conditions, in the context of an autarkic economy with serious problems of shortages and rationing and without state funding. Within a framework of repression, sickness insurance was sold by the dictatorship as a key piece of the propaganda machine, far removed from the principles upheld by the European welfare states established after the Second World War. In fact, sickness insurance was the only insurance that remained to be legislated after the Civil War (1936-1939). The main reasons for this were the financial difficulties in a country with an outdated tax system and with little revenue, a lack of basic infrastructures for its management and the resistance of professional doctors(a powerful lobby at this time).The dictatorship managed to overcome these obstacles in the post-Civil War period with three basic policies. First, it overcame the resistance of the professionals by creating well-paid posts for publicly employed doctors that were compatible with their private activities. The total staff for compulsory sickness insurance, including doctors, anaesthetists, nurses and other auxiliary personnel, was almost 44,000 workers in 1962(Martín López, 1963). Second, it implemented the insurance without the necessary tax reform on the basis of two strategies. For its initial implementation, it used the surpluses of other insurances (old age, maternity, accidents and family allowances) as start-up capital for sickness insurance (50 million pesetas) in a system where the insurance accounting was independent, which enabled opaque operations. On top of this, state contributions virtually disappeared, except in particular times of serious financial difficulties for the

insurance, such as in 1956, when the regime was obliged to cover the deficit of the insurance with funds of unknown origin (Pons and Vilar, 2014: 142-143).Under these conditions, the financing of the insurance was based on the contributions of employers and workers, more burdensome for the latter because their wages were very low and because employers often failed to meet their obligation.[4] Third, given the lack of state health care infrastructures and the state's very limited management capacity, collaboration agreements were signed with mutuals and other forms of private insurance in order to implement the health care coverage. In the late 1950s the state tried to initiate a National Health Care Facilities Plan(*Plan Nacional de Instalaciones Sanitarias*), but from its inception it had serious financial problems and did not overcome the shortcomings in this area (Vilar and Pons, 2016). For this reason, the signing of agreements with the private hospital system - the Church, the Red Cross, mutuals and insurance companies - was indispensable.

As a consequence of these limitations, in the first years of operation of the insurance it covered a very limited proportion of the population (1959: less than 40% of the population was a beneficiary of compulsory sickness insurance, Pons and Vilar, 2012: 257), there were imbalances in the coverage for rural and urban populations (agricultural workers were excluded from the insurance until the late 1950s), and the provisions offered were very limited (basic general medicine). Furthermore, more than 70% of these benefits were provided by the private bodies that had signed a collaboration agreement. Despite the limited operating conditions, the sickness insurance was on the verge of bankruptcy in the early1960s(1962: the deficit exceeded 373 million pesetas) (Table 1).

Table 1. Economic results of compulsory health insurance, old age pensions and family allowances

	(in current pesetas)				(in constant 1958 pesetas)			
	Sickness insurance	Old age pensions		Family allowances	Sickness insurance	Old age pensions		Family allowances
	Deficit*	Surplus	Deficit	Surplus	Deficit*	Surplus	Deficit	Surplus
1950	53,717,848		157,886,076	124,743,593	81,974,436		240,937,091	190,361,045
1951	31,914,967		217,803,163	160,245,790	44,505,602		303,727,741	223,463,659
1952	78,741,524		246,306,834	226,062,355	112,023,793		350,415,186	321,613,821
1953	71,907,904		136,307,626	312,467,595	100,683,148		190,853,579	437,507,134
1954	50,047,032	6,990,862		508,559,450	69,221,344	9,669,242		703,401,729

[4] See Fernández Asperilla and Lomas Lara (2000); and also Babiano and Fernández Asperilla (2009).

1955	105,546,603	17,546,306		559,918,238	140,335,864	23,329,751		744,473,126
1956	94,184,548		486,076,905	377,935,365	118,292,575		610,495,987	474,673,907
1957	56,719,321		814,886,086	798,656,323	64,307,620		923,907,127	905,506,035
1958	181,354,548		989,348,852	977,208,905	181,354,548		989,348,852	977,208,905
1959	160,070,705		1,011,565,253	964,217,750	151,410,050		956,834,329	912,048,572
1960	256,971,402		1,205,056,967	1,052,216,451	241,855,437		1,134,171,263	990,321,366
1961	384,122,735		777,483,925	1,632,012,466	355,044,584		718,628,270	1,508,468,866
1962	373,094,506	495,940,354		2,218,791,143	326,217,108			1,940,011,492

* Only that managed by the INP (National Welfare Institute).
Source: *Estudio sociológico sobre el seguro de enfermedad en España* (1964). The deflator of Maluquer (2009) has been used to calculate the constant pesetas.

The shortage of medical staff and hospital bed sat the time the 1942 law was passed obliged Franco's governments to reach collaboration agreements with collaborating bodies known as *entidades colaboradoras* (employers' industrial accident mutuals, insurance companies, medical *igualatorios* and company funds that already offered employees sickness insurance). These had clinics with staff and beds as the result of a long historical process. The employers' mutuals and insurance companies that had been operating in the branch of industrial accidents since 1900 had created hospitals to attend to sick or injured workersof insured employers. Meanwhile, a considerable number of doctors and surgeons had founded medical *igualatorios* (doctors' associations)or surgery centres with clinics and staff. These infrastructures were put at the service of public sickness insurance in exchange for part of the premiums collected to cover administration costs.In 1947 this percentage was set at 20% of workers' premiums for those collaborating bodies operating on a national scale, 16% for interprovincial, 12% for provincial and 9.62% for company funds (*cajas de empresa*). These percentages proved to be very high, especially in view of the increasing deficit, and they were gradually reduced in the following years. Up to 1953, the private bodies managed more than 50% of affiliated companies and covered more than 70% of the insured and the beneficiaries (Table 2). The collaborating bodies provided 75% of the benefits (Table 3).[5]

[5]The fact that the collaborating bodies collected more fees was due to various factors: a) the collaborating bodies adopted a risk selection policy which enabled them to reject certain companies (the National Sickness Insurance Fund was obliged to accept all applicants) and choose to insure workers with higher wages; b) employers preferred their own associations (employers' mutuals) where they had more influence on the board of directors and on doctors.

Table2.Internal structure of the management of compulsory sickness insurance (1945-1962)

	Member companies			Insured			Beneficiaries*		
Year	Direct Insurance (%)	CBs (%)	Total	Direct Insurance (%)	CBs (%)	Total	Direct Insurance (%)	CBs (%)	Total
1945	45	55	279,809	23	77	2,516,135	26	74	3,397,085
1946	46	54	319,829	23	77	2,749,088	26	74	4,948,971
1947	48	52	364,277	23	77	3,034,106	26	74	5,285,853
1948	48	52	373,953	23	77	3,166,296	26	74	5,380,155
1949	46	54	383,468	22	78	3,131,501	26	74	5,248,352
1950	46	54	367,674	22	78	3,064,641	28	72	5,115,996
1951	47	53	369,015	23	77	3,145,194	28	72	5,385,080
1952	49	51	379,037	24	76	3,297,287	28	72	5,469,244
1953	52	48	399,365	26	74	3,482,947	28	72	4,945,032
1954	60	40	408,516	33	67	3,705,553	36	64	5,480,900
1955	63	37	422,499	36	64	3,885,020	39	61	5,688,470
1956	63	37	432,877	37	63	4,095,319	40	60	5,943,787
1957	63	37	450,453	36	64	4,212,200	39	61	6,193,669
1958	64	36	473,738	37	63	4,354,622	39	61	6,608,933
1959	65	35	498,648	38	62	4,398,820	41	59	6,980,454
1960	64	36	484,145	38	62	4,363,004	41	59	7,180,261
1961**	62	38	403,689	38	62	4,275,850	41	59	6,895,821
1962	62	38	407,616	40	60	4,488,868	43	57	7,189,276

Note: Percentages calculated according to the data for 31 December of each year.
*Excluding insured. CBs = Collaborating bodies **From 1961 onwards the series only includes workers in industry and services, while permanent agricultural workers started to be recorded by the agricultural mutual MNPA.
Source: *Anuarios Estadísticos de España* (1950) (1955) (1960) and (1963), *Boletín Información del Instituto Nacional de Previsión*(1944-1945); *Revista española de Seguridad Social* (1947-1951), INP (1961), *Memoria 1961*;*Estudio Estadístico del Seguro de Enfermedad (1954-1957)* drawn up by Alberto Rull Sabaté (1959), INGESA archive manuscript.

Table3.Compulsory sickness insurance provisions 1946-1957(in current pesetas)

Year	Direct Insurance	%	Collaborating Bodies	%	Total
1946	50,714,106	25.52	147,973,078	74.47	198,687,184
1947	88,506,497	25.67	256,241,657	74.32	344,748,154
1948	138,705,290	25.90	396,668,748	74.09	535,374,038
1949	178,760,208	25.48	522,724,123	74.51	701,484,331
1950	213,384,023	22.32	742,565,832	77.67	955,949,855
1951	313,971,258	22.72	1,067,852,135	77.27	1,381,823,393
1952	365,794,798	24.02	1,156,655,808	75.97	1,522,450,606
1954	603,029,146	30.06	1,403,015,962	69.94	2,006,045,108
1955	745,234,342	33.10	1,506,090,528	66.90	2,251,324,870
1956	856,948,007	34.44	1,631,124,787	65.56	2,488,072,794
1957	1,118,001,095	32.74	2,296,337,758	67.26	3,414,338,853

Source: *Revista Iberoamericana de Seguridad Social* (1954), 3, p. 441 and *Estudio Estadístico del Seguro de Enfermedad (1954-1957)* drawn up by Alberto Rull Sabaté (1959), INGESA archive manuscript.

An analysis of the benefits provided under compulsory sickness insurance show that during this first stage, as the coverage of this insurance increased, the cost of medical provisions rose, along with pharmaceutical expenses that went from 35% of the total cost in 1946 to almost 50% in 1952. Cash benefits remained more or less constant, as did hospital expenses (Table 4). The difference between the income from contributions and the increasing costs gave rise to an annual deficit in the system. By 1953, the negative balance was 71,907,904 pesetas.

Table 4. Direct insurance provisions

(in current pesetas)

Year	Economic	%	Medical	%	Pharmaceutical		Hospital	%	Total
1946	5,091,376	10.03	26,245,030	51.75	17,891,892	35.27	1,485,808	2.92	50,714,106
1947	13,725,851	15.50	36,316,354	41.03	34,008,487	38.42	4,455,805	5.03	88,506,497
1948	23,991,683	17.29	57,860,239	41.71	48,821,888	35.19	8,031,480	5.79	138,705,290
1949	32,965,217	18.44	71,530,815	40.01	65,763,600	36.78	8,500,576	4.75	178,760,208
1950	32,495,051	15.22	82,978,860	38.88	87,649,215	41.07	10,260,897	4.80	213,384,023
1951	38,749,818	12.34	102,431,494	32.62	159,962,804	50.94	12,827,142	4.08	313,971,258
1952	46,542,000	12.72	126,838,800	34.67	178,248,000	48.72	14,165,998	3.87	365,794,798

Source: *Revista Iberoamericana de Seguridad Social* (1954), 3, p. 441.

In view of this situation, the Ministry of Labour put an end to the original agreements between the National Welfare Institute (*Instituto Nacional de Previsión* or INP), the National Sickness Insurance Fund (*Caja Nacional del Seguro de Enfermedad*) and the collaborating bodies. The first agreements were terminated in 1954. In the new agreements, the National Welfare Institute stepped up the requirements for renewing the agreements, and in particular the required deposit was increased to the equivalent of 10% of the annual amount of premiums collected. As from 1958,the deposit was linked to the amount of premiums collected regardless of the type of collaborating body and whether it operated on a national or regional scale.[6] On 18 February 1955, the rules were established for those entities that decided to terminate their activities as collaborating bodies of compulsory sickness insurance.[7] The National Welfare Institute took charge of creating a settlement commission and paying off all debts, many of them for pharmaceutical services.[8] After several agreements had been terminated in 1954, the number of managing bodies fell from 121 in 1954 to 92 in 1957. Preference was given

[6] BOE (*Boletín Oficial del Estado* or Official State Gazette), 29/8/1954, no. 241, p. 5942 and BOE, 20/8/1958, no. 199, p. 1475.
[7] BOE, 07/03/1955.
[8]For the case of Mapfre, see Hernando de Larramendi (2001: 235).

to disassociating mutuals and insurance companies and prolonging the relationship with the funds, or saving institutions, of large public and private companies.

Table 5.Staff of the compulsory sickness insurance

Year	Doctors				Anaesthetists and theatre nurses	Doctors' assistants, nurses and other auxiliary staff	Total Staff
	GPs	Specialists	Assistants and residents	total doctors			
1953	12,208	5,459		17,667	1,300	8,395	27,362
1954	12,574	5,744		18,318	1,338	12,559	32,215
1955	12,578	5,762		18,340	1,156	12,941	32,437
1956	12,663	5,772		18,435	1,089	12,342	31,866
1957	12,931	5,772		18,703	1,089	14,255	34,047
1958	14,729	7,297	1,255	23,281	1,172	14,739	39,192
1959	13,542	7,432	1,360	22,334	1,343	14,944	38,621
1960	13,579	7,512	1,420	22,511	1,382	14,238	38,131
1961	13,457	7,630	2,233	23,320	1,471	14,861	39,652
1962	13,998	8,275	2,376	24,649	4,465	14,877	43,991

Source: Ministry of Labour, (Enrique Martín López, director) (1963), *Estudio sociológico sobre el seguro de enfermedad en España*, Madrid, Ministerio de trabajo, Gabinete de Sociología, Secretaría General Técnica, Volume I, INGESA archive manuscript.

As well as the increase in health care personnel and pharmaceutical expenditure, a substantial part of the deficit generated in the first decade of the implementation of compulsory sickness insurance was due to the goals of those responsible for the development of a health care facilities plan aimed at building hospitals and outpatient clinics throughout Spain. The first plans were drawn up in 1943,with the creation of a committee that at the end of 1944 announced an initial project intended to provide 34,000 beds. These initial predictions were gradually reduced over the following months and years in order to adapt to the prevailing autarky and lack of public funding. In 1945 the National Welfare Institute transferred a watered down National Health Care Facilities Plan to the Ministry of Labour, which now set a target of 16,000 beds.[9]The ratified project envisaged the construction of 86 large hospitals (known as *residencias sanitarias*) with between 100 and 500 beds, 149 large outpatient clinics and 110 smaller ones, and 73 maternity institutions, for a total cost of 1,000 million pesetas.[10] Finally, an Order of 26 February 1947 set the number of large hospitals at 68,with 62 large outpatient clinics and 144smaller ones (with lower costs). The maternity homes of the initial projects disappeared completely. Work on the first outpatient clinics and hospitals was not started until 1948.

[9]The plan was approved by a Ministerial Order of 9 January 1945. INP (1944): *Seguro de enfermedad. Estudio para un plan general de instalaciones de asistencia médica*, Madrid, INP.
[10] BOE 27/01/1945, no. 27, p. 793 and BOE 21/03/1947, no. 80, p. 1821.

The financial difficulties to make the substantial investment these infrastructures required soon became evident. As well as using the reserves of other social insurances, the authorities once again resorted to taking a percentage of the premiums paid by employers and workers. After an Order of 9 January 1947, managers of compulsory sickness insurance had to allocate 1.5748% per cent of premiums collected to the construction of hospitals, a percentage that had risen to 3% by December 1948. This figure, along with the growth of benefits, including labour costs and pharmaceutical expenditure, which also came from premiums without any state funding, had the effect of aggravating the deficit and delaying the construction of hospitals and outpatient clinics. By 1953, almost 10 years later and at the end of the first agreements, only 9 large hospitals and 18 outpatient clinics had been completed.[11]

From 1954 onwards, after the basis of the agreements with the collaborating bodies had been made more demanding, the members of the National Sickness Insurance Fund progressively increased. This was due to the pressure put on workers registered with other insurances managed by the National Welfare Institute, the National Fund's radio propaganda and the coercion of company supervisors who appeared in the workplace to pressure employees into signing options favourable to the National Fund. The collaborating bodies reported these coercive practices. In some government offices workers could not receive the family allowance until they registered with the National Fund. In order to increase direct insurance, the National Welfare Institute used its extensive network of contacts, and meanwhile the so-called *jurados* (comprising the company owner, an executive and nominal worker representation) of the vertical "union" *Organización Sindical* penalised the commercial network of private insurers by prohibiting their agents from receiving a commission for the contracting of compulsory sickness insurance.[12]The fact is that those responsible for compulsory sickness insurance tried to lay the blame of the budgetary crisis of the insurance with the collaborating bodies, pointing to their profit seeking and the high percentage they charged as administration costs.

[11]Instituto Nacional de Previsión, no. 62. In spite of the slowness in the execution of the Health Care Facilities Plan, each completion and inauguration was used by the regime as a motive for propaganda via the regime'sofficial documentaries (NODO). For their role, see Medina-Doménech and Menéndez-Navarro (2005), pp. 393-408.

[12]These practices were reported to the local insurance union in Almería by members of the union who contacted the head of the National Insurance Syndicate (*Sindicato Nacional del Seguro*) and the Directorate General for Insurance (*Dirección General de Previsión*) reporting these events in their city. Archivo General de la Administración (AGA), Sindicatos, Caja 13/R-349.

However, it seems clear that the extension of coverage to include surgical treatment, specialities and hospital treatment, and expenditure on an expanding medical staff and pharmaceutical costs, which continued to comprise 50 per cent of the cost of benefits, all without any state funding for the system, made it unviable. Furthermore, there was the increase in expenditure on building hospitals and outpatient clinics. The growth of this deficit, which was just over 105 million pesetas in 1955 and reached 373 million in 1962, can be seen in Table 1.

2. The Basic Law on Social Security(1963): a universal social security model?

On top of the problem of the management of sickness insurance, there was a problem with old age pensions, also with a negative balance, which compelled a reform of the social insurance system. The Basic Law on Social Security of 1963was intended to replace the existing social insurance system with a universal social security model, in an environment where the economy and Spanish society were both undergoing significant change after the Stabilisation Plan and the start of the development stage. However, the successes achieved by this reform were severely limited by two basic problems: the meagre public funding, hampered by the continuance of an obsolete tax system, and the predominance of political interests over the population's general interests, under a dictatorship whose upper echelons became a hornet's nest where the regime's different political families fought for power. The need to establish agreements between the different factions led to a social security system full of contradictions, where unity was advocated but in fact there were a multitude of special regimes (agricultural, civil servants, the military, etc.)with very different provisions and coverage (agricultural and industrial labourers). Moreover, the system, which continued to be funded by employers' and workers' contributions and without any financial commitment by the state, had serious financial problems and provided very limited benefits compared with other European countries. Suffice it to say that in 1972 health care provision received 59,500 million pesetas through social contributions, while costs exceeded 76,000 million pesetas in the same year. The mechanism used to balance the accounts was the same as in previous decades: the system of compensation between the different insurance items. By the mid-1970s, health care provision within the General Regime had reached approximately 62% of the Spanish population, but coverage remained very inadequate. The low ratio of hospital beds available per capita compared with other countries is proof of this (Table 6).

Table 6. Ratio of hospital beds to population(1968)

Country	Per thousand inhabitants
Sweden-Ireland	14.28
East Germany- Northern Ireland- Luxembourg	12.50
Austria-France-Iceland- West Germany -Finland-Italy	11.10
Russia	9.30
Denmark-Norway	9.09
Belgium-Wales-England	8.33
Hungary-Poland-Netherlands-Romania	7.69
Bulgaria	7.14
Faroe Islands-Malta	6.66
Albania-Portugal	5.83
Greece-Yugoslavia	5.55
Spain	4.34
European average	*9*
Optimum average according to the WHO	*10*

Source: *World Health Organisation Statistics*, Geneva 1968, published in Baltar (1971: 23).

What were the novelties of the 1963 law? Overall, the basic law maintained the preceding system without major changes, although there were some small modifications. First, health care provision was unified, regardless of the cause of the contingency (workplace accident, occupational disease, maternity or common illness). Second, freedom of choice of doctor was established within the health care provision. Third, health care services were divided into two large categories: a) by their nature: general and specialised medicine, with an increase in the number of specialties offered; and b) by the type of provision: outpatient, at home, emergency and hospitalisation. This last provision was only fully recognised in the case of admission to hospital to undergo surgery. The system excluded the right to psychiatric or geriatric care, among other things. Basically, the law only provided a temporary solution for a system hindered by the state's financial shortcomings, and which afforded a very deficient system of health care provisions compared with other European countries. By the end of the dictatorship, health care provisions continued to be one of the main elements creating an imbalance in the Social Security accounts. It is curious to observe how the main health care expenses were concentrated in pharmacy and personnel.

However, one of the effects of the new situation was the progressive winding-up of the profit-seeking collaborating bodies that had been so important in the first stage, despite the protests of some of them, especially in the case of the historical mutualism in Catalonia. Those running the National Welfare Institute argued that the regime of collaboration had not solved the problem of health care in Spain, but had only improved the provision to the high-wage sector, and to the more highly developed provinces as

opposed to other more depressed areas that only had the infrastructures created by the National Welfare Institute itself (Pons and Vilar, 2014: 227). The Franco regime defended the basic law of 1963 as distributive and obeying the principle of national solidarity. With respect to the personnel of the private collaborating bodies, some of them were indemnified and a few were incorporated into the National Welfare Institute.

At first glance, the basic law was going to deal with one of the major problems of public health and the social insurances in general: funding. Despite the continuance of the principle of workers' and employers' contributions, it was acknowledged that “no social security is possible without state contributions”. In line with this philosophy, it was decided to establish “the permanent allocation of subsidies to this end in the general state budget, with a view to achieving the redistribution of the national income”. However, the data show us how state contributions to the Social Security remained very low until the end of the dictatorship. In 1970,90.26% of Social Security income came from workers' and employers' contributions. By the end of the dictatorship in 1975, these still accounted for 88.62% of income (Table 7), albeit in a process of growth of the population covered, which led to an inadequate service and a shortage of beds per inhabitant (Table 8).The number of insured grew to almost 10 million and beneficiaries to 12 million (excluding the insured). The ratio of hospital beds to population was 4.34 per 1,000 inhabitants in Spain in 1968, compared with 14.28 in Sweden and Ireland and12.50 in East Germany, Northern Ireland and Luxembourg, and below the 5.83 of Albania and Portugal and the 5.55 beds per 1,000 inhabitants in Greece and Yugoslavia (Baltar, 1971: 23). Social Security provisions as a percentage of national income were among the lowest in Europe (Table 10).

Table7. Social Security System. Evolution of income and expenditure(in millions of current pesetas)

Income	1970	%	1972	%	1975	%
Employers’ fees	*137,558*		*209,567*		*451,960,80*	
Workers’ fees	*27,769*		*47,092*		*95,511,10*	
Total fees	165,327	90.26	256,659	89.48	547,471,90	88.62
Subsidies	11,126	6.07	16,335	5.69	25,713,50	4.16
Patrimonial Resources	4,640	2.53	5,187	1.81	5,986,00	0.97
Other	2,068	1.13	8,648	3.02	15,002,80	2.43
Application of reserves					23,598,30	3.82
Total income	183,161	100	286,829	100	617,773	
Expenditure	1970	%	1972	%	1975	%
Health care provisions	*47,196*		*81,530*		*178,410*	

Cash benefits	*105,203*		*175,401*		*355,651*	
Total benefits	152,399	83.21	256,931	89.58	534,061	86.45
Allocation to reserves	21,650	11.82	16,612	5.79	41,946	6.79
Administration costs	*7,194*		*11,429*		*22,898*	
Patrimonial costs	*146*		*832*		*617*	
Miscellaneous expenses	*1,773*		*1,025*		*1,826*	
Total administration costs	9,112	4.97	13,286	4.63	25,341	4.10
Construction health care centres					16,424	2.66
Total expenditure	183,161	100	286,829	100	617,773	100

Note: The item "Other" included yields from capital assets and other income not included in the previous sections.
Source: Ministerio de trabajo, Subsecretaria de la Seguridad Social (1977); *Libro blanco de la Seguridad social*, Madrid, pp. 98 and 109.

Table 8. Basic data of health care coverage before and after the entry into force of the 1963 law

	Number of affiliated companies			Affiliation of insured to compulsory sickness insurance			Beneficiaries (excluding insured)		
	Direct Insurance	CBs	Total	Direct Insurance	CBs	Total	Direct Insurance	CBs	Total
1963	256,967	161,684	418,651	1,912,563	2,786,830	4,699,393	3,205,093	4,248,421	7,453,514
1964	271,167	164,856	436,023	2,079,203	2,844,781	4,923,984	3,465,124	4,263,392	7,728,516
1965	343,442	122,150	465,592	3,240,149	1,938,827	5,178,976	5,407,441	2,755,738	8,163,179
1966*	501,691	1,946		5,179,324	315,975	5,495,299	8,214,386	515,993	8,730,379
1967	545,402	1,862		5,356,785	295,269	5,652,054	8,560,669	461,755	9,022,424
1968	581,805	1,889		5,452,990	286,295	5,739,285	8,778,313	449,035	9,227,348
1969	614,323	888		6,067,374	195,011	6,262,385	9,374,093	301,292	9,675,385
1970	635,472	971		6,722,559	222,134	6,944,693	10,957,771	362,078	11,319,849
1971	656,808	977		7,249,508	236,469	7,485,977	12,179,173	397,267	12,576,440
1972	688,696			7,873,729	248,933	8,122,662	12,653,082	400,035	13,053,117
1973	718,098			8,566,150	243,223	8,809,373	13,954,258	396,210	14,350,468
1974	640,813			9,008,093	226,304	9,234,397	14,310,927	345,845	14,656,772
1975	634,703			9,755,717	235,837	9,991,554	11,761,570	280,330	12,041,900

Source: *Memorias estadísticas de la Social Security*, 1967, 1972, 1976 and 1979.

CBs = Collaborating bodies

The data contained in this table only includes those insured for health care coverage – not workplace accidents or occupational diseases - within the General Regime. (*) As from 1966, the data refers to workers in active employment for the contingency of health care provision. Protected family members(beneficiaries) were also included, and the companies registered for the same contingency.

Table 9.Staff of different professions in the Social Security

Year	General medicine (%)	Specialists (%)	Total doctors	Doctors' assistants(%)	Nurses (%)	Midwives (%)	Clinic assistants (%)	Total auxiliary health care personnel
1965	55	45	25,595	38	44	8	10	19,533
1966	55	45	26,034	35	45	9	11	21,265
1967	55	45	26,927	35	47	7	12	21,990
1968	53	47	27,930	31	49	6	14	25,734
1969	51	49	28,929	29	49	6	14	27,747
1970	50	50	30,197	26	51	2	19	31,127
1971	46	54	32,104	21	52	1	24	37,594
1972	44	56	34,554	25	46	4	24	40,399
1973	42	58	35,700	21	39	4	36	50,867

1974	38	62	41,812	18	40	4	36	57,430
1975	37	63	43,796	17	44	4	34	62,384

Source: Ministerio de Trabajo, Subsecretaria de la Seguridad Social (1977: 544-547).

Overall, the percentage of public spending dedicated to health care by the state went from 0.87% of total expenditure in 1945 to 0.79% in 1950 and 1.32% in 1970 (Comín and Díaz, 2005: 946). By the end of the dictatorship, health care continued to create an imbalance in the Social Security accounts. In 1972, for example, the sickness insurance deficit and the temporary inability to work were compensated with the surplus from other benefits such as temporary disability, family protection and unemployment, bolstered by state subsidies, patrimonial resources and other less significant resources (INP, 1973: 136). Contribution fees continued to be the main form of financing.

Table 10. Comparative indicators of Social Security provisions in Europe

Countries	Years	%Cash benefits/Household disposable income	% Benefits in kind / Household consumption	% Total benefits/National Income
Belgium	1965	15.0	4.3	17.5
	1970	16.6	4.8	19.4
Germany	1965	17.0	4.9	18.3
	1970	18.2	6.2	19.9
France	1965	15.7	5.5	18.8
	1970	16.0	6.8	19.5
Italy	1965	12.0	4.5	17.3
	1970	14.8	5.5	18.8
Netherlands	1965	18.8	5.5	18.9
	1970	22.2	6.7	23.2
Spain	1965	5.5	2.1	6.5
	1970	6.4	3.1	8.2
	1973	6.7	4.4	10.7

Note: The household disposable income also includes that of private non-profit institutions.

Source: EEC, *L´evolution Financière de la Securité Sociales dans les Etats membres de la Communauté*, Brussels, November 1971; INE: "Contabilidad nacional de España" and "España Panorama Social 1974", OECD, National Accounts. Data compiled by the Ministerio de trabajo, Subsecretaria de la Seguridad Social (1977: 105).

In late 1976, there were a total of 11,522,345 workers affiliated to the Social Security, which accounted for 32.02% of the Spanish population (35,981,002). Most of them belonged to the General Regime, although other special regimes persisted (Agricultural, Domestic Workers, Student Insurance, Workers at Sea and Railway Workers).[13]The beneficiaries of Social Security made up 80% of the population. The General Regime covered 22 million people(including beneficiaries) and the special regimes covered another 7 million. Nevertheless, a weak structure persisted due to the

[13] Memoria Estadística de la Seguridad Social, 1976.

funding problem, the multiplicity of regimes and management, and the low quantity and quality of the health care provisions. However, universal health care coverage was a target to achieve in Spain during the transition to democracy. Moreover, the end of the dictatorship demanded a profound reform of the system that had inherited a fraudulent management of infrastructures and health care resources by a reviled National Welfare Institute, the central body controlling social insurances during the almost forty years of the Franco regime.

3. Health care coverage under democracy: legacies and reforms, 1976-1985

From the point of view of health insurance, the 1970s in Spain was a decade of two long-awaited events: the arrival of democracy, and with this a real welfare state, and the creation of a Ministry of Health.[14]These were two necessary, though insufficient, requisites for establishing a health care model along European lines. However, the context was not at all straightforward. The press of the time offered a chaotic image of Spanish health care, aggravated by the negative effects of the 1970s crisis(Pons and Vilar, 2014: 295).

The first governments of the transition created the eagerly-awaited Ministry of Health(1977) and proposed two main objectives: the reform of the Social Security and the preparation of a law on health care. Meanwhile, the country still had the approval of a constitution, and the democratisation of several institutions and bodies, pending. A fundamental element in this process was Fernandez Ordoñez's tax reform (1977), which modernised tax administration made it compatible with a modern welfare state. From this point on, the percentage of state contributions raised through taxation used to fund public health care expenditure increased, while the percentage from workers' contributions fell(Table 11). Later, in 1978, the entire Social Security system was reorganised, and the old National Welfare Institute, a key element in the Franco regime's social policy and tainted by all kinds of corruption scandals, disappeared. Simultaneously, three major Social Security management agencies were created, subject to principles of financial solidarity and a common fund: the National Social Security Institute, managing cash benefits; the National Health Institute, for the administration and management of health care services; and the National Institute of Social Services,

[14] Francia (1997: 107). Until then the Directorate General for Health Care had been under the auspices of the Ministry of the Interior, while the Social Security had remained under the Ministry of Labour. This duality hindered changes and management strategies in the field of health care.

responsible for the provision of supplementary services(the elderly, the disabled, etc.). While these changes were being implemented, there were a number of scandals as a result of irregularities in the Social Security accounts and in the management of hospitals, legacies of the dictatorship. Innumerable draft bills were drawn up for a law on health care, but all these proposals fell by the wayside while being debated in parliament for two reasons: the political weaknesses of the first governments of the transition and the political division between two health care models. The centre parties in power but without an overall majority, supported by the political right, opted for the private management of public health care, justified by the failure of the Spanish Social Security, inundated by scandals and the squandering of resources (Pons and Vilar, 2014: 307). On the other hand, the left-wing parties, led by the PSOE and from the opposition, defended a National Health Service type of health care system founded on three basic principles: universal coverage for all citizens, mainly funded through taxes and with public management (Sevilla, 2006: 14). The balance tilted in favour of this second model when the PSOE won the general elections in 1982 with an overall majority; although the law on health care had to wait until the end of the legislature in 1986, as an attempt was made to achieve the greatest possible consensus (the resistance of the conservative party Alianza Popular and the more conservative medical associations was extremely tenacious). In the end, the General Health Law of 1986 did not satisfy anybody, since its content was more a set of principles and long-term objectives than a roadmap for immediate action. Its greatest success was to modernise Spanish health care, achieving universal coverage of the population and progressive financing through taxes(Table 12).

Table 11. Financing of public health care expenditure

(in percentages)

	1980	1981	1982	1983	1984	1985	1986	1987	1988
% Workers' contributions	75.2	70.5	68.0	66.2	60.9	62.3	61.3	57.9	58.0
% State contributions	24.8	29.5	32.0	33.8	39.1	37.7	38.7	42.1	42.0

	1989	1990	1991	1992	1993	1994	1995	1996	1997
% Workers' contributions	27.2	27.2	27.2	27.2	28.0	27.1	20.4	14.9	8.3
% State contributions	72.8	72.8	72.8	72.8	72.0	72.9	79.6	85.1	91.7

Source: Aracil et al (1996).

Table 12. Social protection in health care. Europe1960-1990

(% population covered)

	1960	1965	1970	1975	1980	1985	1990
Germany	85.0	85.8	88.0	90.3	91.0	92.2	92.2
Austria	78.0	92.0	91.0	96.0	99.0	99.0	99.0
Belgium	58.0	68.5	85.0	99.0	99.0	99.0	98.0
Denmark	95.0	95.0	100	100	100	100	100
Spain	*54.0*	*55.0*	*61.0*	*81.0*	*83.0*	*90.0*	*99.0*
France	76.3	85.0	95.7	96.0	99.3	99.0	99.5
Greece	30.0	44.0	55.0	75.0	88.0	100	100
Netherlands	71.0	71.0	86.0	75.0	74.6	73.2	69.0
United Kingdom	100	100	100	100	100	100	100
Ireland	85.0	85.0	85.0	85.0	100	100	100
Iceland	100	100	100	100	100	100	100
Italy	87.0	91.0	93.0	95.0	100	100	100
Luxembourg	90.0	100	100	100	100	100	100
Norway	100	100	100	100	100	100	100
Portugal	18.0	32	40.0	60.0	100	100	100
Sweden	100	100	100	100	100	100	100
Switzerland	74	82.0	89.0	94.0	96.5	98.0	99.5

Source: OECD Health Data 2012. http://stats.oecd.org/Index.aspx?DataSetCode=SHA

However, Spain developed its welfare state in general and its health law in particular against the tide of other European countries, where they were debating the viability of welfare states and cuts were being proposed for the main items of social spending. Consequently, the Spanish deficit in health expenditure as a percentage of GDP and in per capita terms remained constant, as the shadow of the cuts loomed before Spain was able to achieve similar patterns to Europe (Table 13). Yet this was in spite of the fact that between 1976 and 1986 public health care expenditure in Spain almost quadrupled; while the debt of the health system kept rising, hampered by a budget that was chronically insufficient from the outset.

Table 13. Total health expenditure in Europe

	Total health expenditure as % GDP							Public health expenditure per capita PPP $US						
	1960	1965	1970	1975	1980	1985	1990	1960	1965	1970	1975	1980	1985	1990
Germany			6.0	8.4	8.4	8.8	8.3			195.6	454.2	768.6	1,096.0	1,370.2
Austria	4.3	4.6	5.2	6.9	7.4	6.4	8.4	53.4	74.9	123.7	303.5	540.0	713.9	1,195.3
Belgium			3.9	5.6	6.3	7.0	7.2							
Denmark				8.7	8.9	8.5	8.3				462.3	783.4	1,070.4	1,275.4
Spain	*1.5*	*2.5*	*3.5*	*4.6*	*5.3*	*5.4*	*6.5*	*9.3*	*21.6*	*62.0*	*164.4*	*290.1*	*401.1*	*685.9*
Finland	3.8	4.8	5.5	6.2	6.3	7.1	7.7	34.2	70.4	133.7	266.0	446.6	721.5	1,102.6
France	3.8	4.8	5.4	6.4	7.0	8.0	8.4	43.0	83.3	146.4	288.6	534.2	810.0	1,105.6
Greece			5.5		5.9		6.7			68.2		272.2		454.2
Iceland	3.0	3.5	4.7	5.7	6.3	7.2	7.8	38.1	59.4	115.8	325.1	664.0	1,025.8	1,441.2

Ireland	3.7	4.0	5.0	7.3	8.2	7.4	6.0	32.5	46.6	94.7	215.8	418.2	497.0	565.0
Luxembourg			3.1	4.3	5.2	5.2	5.4							
Netherlands				7.0	7.4	7.3	8.0				298.6	508.4	680.7	948.0
Norway	2.9	3.4	4.4	5.9	7.0	6.6	7.6	38.4	63.0	131.1	309.7	566.9	805.8	1,132.1
Portugal			2.4	5.0	5.1	5.6	5.7			28.1	93.2	178.1	215.9	411.6
Sweden			6.8	7.5	8.9	8.5	8.2			267.6	478.0	872.8	1,146.3	1,432.2
Switzerland	4.9	4.6	5.5	7.0	7.4	7.8	8.2						739.4	1,063.2
United Kingdom	3.9	4.1	4.5	5.4	5.6	5.8	5.9	72.0	94.4	138.2	265.7	416.5	590.9	802.1

Source: OECD Health Data 2012. http://stats.oecd.org/Index.aspx?DataSetCode=SHA

With regard to hospital care, in 1993 Spain had one of the lowest ratios of hospital beds per thousand inhabitants in Europe(4.3 in Spain, compared with 9.4 in France and 10.1 in Germany, Temes and Gil, 1996:117) (Table 14). Overall, the General Health Law of 1986 was another step forward, necessary but insufficient, in the progress of the Spanish health care model.

Table 14. Catalogue of hospitals in Spain on 31 December 1994

	Hospitals	Beds
National Health System	198	86,005
Ministry of Justice	2	506
Autonomous Communities	31	7,706
Provincial, City or Town Council	44	8,683
Municipality	21	5,828
Accident mutual	24	1,784
Private charity (Red Cross)	19	1,878
Private charity(Church)	57	12,030
Other private charity	59	7,169
Private non-charity	308	29,975
Ministry of Defence	20	6,900
Total	783	168,464

Source: Ministerio de Sanidad y Consumo (1995): *Catálogo Nacional de Hospitales*. http://www.msc.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/home.htm

The inconclusive nature of the health care reform became apparent in 1991 with the publication of the so-called “April Report” on the state of health care in Spain, drawn up by experts in the field who were supposedly independent of political parties. The study strongly criticised the public health care system and recommended the private management of public health care operating on business criteria. The report dropped like a bomb on the political scene, where the PSOE was in government, a party that defended a publicly managed National Health System, and where the financial situation of the Social Security in general and health care in particular was critical. In 1996 the

conservative party PP won the elections and once again proposed private management models for public health care. At the same time, cuts in public health care resulted in a deterioration of both provisions and coverage. After ten years of application, the two main successes of the general health law of 1986 were the increase in public funding and universal coverage. However, cuts in public expenditure, neoliberal policies and the new models of private management of public hospitals provided an early challenge to the recently formed Spanish public health care system.

Conclusions

This study has enabled us to analyse how a health system belatedly took shape, and with special characteristics, in Spain under dictatorship and democracy. The analysis has been accompanied by a wealth of statistical support and an international perspective that enables us to better understand Spain's relative position in this area. Overall, the study makes it clear that the main problem of the Spanish health care system during the dictatorship lay in the system of financing. The Franco regime maintained an obsolete tax system, mainly based on indirect taxes, raising low revenue and with a high level of fraud and corruption. In this respect, during almost forty years of dictatorship there was little political will to promote a tax reform that was indispensable in order to implement a welfare state along the lines of other Western European countries. From the outset, the lack of public resources impeded the introduction of a public sickness insurance that required substantial investment in health care infrastructures, human and material resources and also needed a complex management structure in a country with a large, dispersed and low-income rural population. These circumstances conditioned the financing, management and provisions of sickness insurance from the very beginning.

With regard to funding, the insurance relied on contributions from employers and above all workers in a context of low wages and harsh working conditions. These contributions were eventually supplemented by small state subsidies or completed by the transfer of money from other insurances running a surplus. With respect to the management, the state needed collaboration agreements with private bodies in order to implement the insurance; without these agreements it would have been impossible. Finally, in practice the lack of money obliged an insurance scheme limited to part of the population (not universal), and with very modest health care provisions (initially just general medicine, without specialities or the right to hospitalisation). Consequently, sickness insurance became a key element of the regime's propaganda, but without

financial support from the state it accumulated deficit until it was on the verge of bankruptcy in the 1960s.

The Basic Law on Social Security in 1963 was an attempt to find solutions, but without a prior tax reform the system's basic problem did not disappear. It was not until the end of the 1970s that two fundamental, although insufficient, changes occurred. These changes, intended to establish a welfare state similar to other Western European countries, were the democratisation of the country and the guarantee of fundamental rights (1978 Constitution) and a tax reform compatible with a welfare state (Fernandez Ordoñez, 1977). The need to define which health care model the country was to have continued to be an open question, and not a simple matter, due to the lack of political agreement and the fact that the governments in the first years of the democracy lacked stability, as well as the economic crisis that the country was going through. The first General Health Law was passed in 1986, at the same time as Spain joined the European common market and when countries in Western Europe were starting to question the viability of the welfare state. The national health system established in 1986, with universal coverage and progressively funded through taxes, started up in very difficult circumstances. This was the great drama of Spanish health care, going against the tide of other European countries. In this area, as in many others, almost forty years of dictatorship took a heavy toll.

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