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"AN OUTLINE OF THE SPANISH HEALTH SYSTEMS"

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I. INTRODUCTION

The modern health services, those which show, the impact of medical research and development, were consolidated in the more advanced notions throughout the nineteenth century and underwent a marked process of acceleration as from the Third decade of this century. Parallel to this development there was a change in the pattern of diseases and mortality which led to a longer and healthier life in the average man.

On the other hand, the level of development (usually measured by the income per capita), and the economic system of any given country, determine the evolution of a health system which can also be influenced by purely ideological elements, reflections of a "pattern for a society worth having".

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II. Stages in the evolution of the Spanish Health System

In 1874, the date of the Restoration, the impression given by Spain to the European onlookers of the time was, in many respects, an example of what a nation seeking to become industrialised should not do. The question is however, if Spain, during the first half of the nineteenth century, really did want to launch out on a dangerous social experiment such as was being carried through in Great Britain and whose positive results for the bulk of the working population, as much in the material field - standard of living - as in that of traditional ethics, were not even clear in that country between the years of 1825 and 1850. (1).

But in short, as G. Tortellà points out: "From a comparative standpoint, the Spanish economy offered a picture of stagnation when contrasted with most of its Western European neighbours. The nineteenth century is the take-off period for Western Europe as a whole. From England to Sweden and including Belgium, France, Germany and Switzerland. Spain did not take off and the difference between her and Western Europe increased considerably throughout the century". (2). The period between 1874 and 1935 provides us with some interesting examples of how a positive outlook and growing aspirations gained an increasing number of followers among the Spanish population. This resulted in a desire for change and was urged on by the colonnial disaster of 1898, which was to provide a certain ideological support for industrialisation. (3). This movement in favour of Spanish material interests and the development of a national capacity for output and productivity becomes more noticeable after the First World War and takes remarkable form in an incipient policy of development, in the present meaning of the term, during Primo de Rivera's dictatorship and the Second Republic. What is certain is that in 1913, or even in 1950, Spain had not created either the interrelations between the different sectors or the social and institutional framework that sustained growth requires. Table 1 shows the evolution of the different sectors of the working population and the sources of the national product.

Thus, in the middle of the fifties, Spain emerges as a clear example of a developing country with great possibilities of incorporating technological innovations and making the most of the wave of prosperity which was then taking hold in those countries that had received aid from the Marshall Plan. The commitment to speed up the rate of economic growth and improve the country's productive mechanism, especially that of industry, formally emerged in the Development Plans of the sixties and first half of the seventies. During this period the renta per capita grew at an average accumulative rate of 6 percent which meant an increase in the level of renta per capita from 570 $ to 2,100 $ in 1974.

The structural changes which the Spanish economy underwent to the benefit of industry and services are striking. (See Table 2). The model of"diffusion of new technology" clearly shows the high growth rates of productivity per head in Spain in the period from 1960 to the early seventies. (4).

As one possible interpretative scheme to analyse the evolution of the Spanish Health System in the period of "modern economic growth" (5), I propose to emphasize the role of the "difussion" (6) and at the same time, to acknowledge the importance of endogenous factors that are mainly seen in the long continuance of a traditional health system, (approximately until 1923) and in the later date, (around 1974), with respect to the majority of Western European nations, in which a modern system was attained.

It is my opinion, therefore, that three stages can be seen:

a) From the end of the nineteenth century of 1923. A period dominated by a traditional health system with few changes and little progress.

b) 1924-1973. A transitional period characterised by important and steady advances in life expectancy at birth and in infant mortality. (7). The Table 3 shows this evolution. During this period a large number of innovations that had been tried in other countries were successfully adopted. They fall into two groups - social and technological. As far as the first group is concerned, the most important innovation was the introduction and later development of a compulsory health insurance for workers and their families. The law was passed

in 1942 and two years later came into operation. The technological innovations, aided by human capital assets which grew in quantity and quality, were mainly incorporated into the field of drugs and into the installation and equipping of hospitals.

c) By 1974, the transition from a traditional health system to a modern one can, in broad outlines, be considered finished. By then, a new breed of problems and health policy objectives had begun to emerge which were similar in many respects to most of the other systems of the European Economic Community. This new and complex period which continues today is resumed under the heading, "Health Reforms". (Section IV)

III. The Traditional Health System and its Transformation.

The epidemics that, frequently imported from outside, decimated the European and Spanish population during the Ancien Règimen (8), continued to be the main focus of attention of the Spanish health authorities (9) throughout the nineteenth century.

These epidemics were not always caused by diseases brought in from outside. Poverty, malnutrition, lack of culture and the people's general contempt for hygiene also contributed to the dramatic effect that the infectious diseases had on the Spanish mortality rates until practically the third decade of the twentieth century. (See Table 5).

The traditional Spanish health system was borne and upheld principally by the provincial and municipal Beneficiencia - public welfare and charity - together with certain municipal doctors, pharmacists and veterinary surgeons, called officials (Titulares).

Health and social welfare were two concepts that were very closely linked in the provision of health services, so much so that at times they were often confused. However, in the second decade of this century the idea of social health insurance and the worker's right to it was recognised and incorporated into the 1931 Constitution.

This intermingling of the aforementioned concepts had both positive and negative effects for the Spanish health service.

It's my opinion that the most important positive consequence was the ability to keep the health care given to the poor from deteriorating, especially in the first half of the nineteenth century, and unlike England and other European countries (11). This is an aspect which few writers have highlighted, perhaps because they didn't rightly appreciate the tremendous importance a certain concept had in our country, that of looking upon the poor as our brothers (12) which resulted in not applying the principle of "less eligibility" except in isolated cases.

Public and private social welfare allowed certain financial and human resources to be channelled into the health services. The severe difficulties of the Spanish Treasury and the extremely low priority given to health in the state budgets have to be borne in mind.

As to the negative consequences, perhaps the most obvious was the very low opinion the ordinary people had of the hospital as a health service institution. It was held in disrepute, (13). This, together with other factors, held back the development of modern hospital care in Spain until the Social Security, (National Institute of Prevision), pushed it forward decisively and spectacularly in the sixties of this century. (14).

The 1855 Health Law established that the medical professions were free to practise and recognised the duty of all Spanish local authorities to provide free medical care to all the poor families resident in each village or town.

These services were established on a hire basis between the local corporation and the doctor appointed by that corporation. The doctor in question received an annual allowance which varied according to the number of poor families he should had to attend. At the same time the doctor undertook to help and advise the local corporation as far as health policies were concerned. (15)

The rural doctor, whether official or not, frequently drew up and agreement ('iguala') with the non-poor local residents. This agreement could be either individual (one family) or collective, and enjoyed a long tradition in Spain. For a long period it governed relations between the doctor and the population he served. It basically consisted in paying the doctor a fixed amount (in money or kind) for giving his attendance, if needed. Sometimes it stipulated a standard fee for a home visit or attendance at a birth.

As a whole, the situation of the rural doctor deteriorated in the nineteenth century compared with the eighteenth. The unpredictableness of the local 'bosses' ('caciques') often put the stipulated payment to the doctors as well as their appointment in danger. All this happened even though there was a deficit of practitioners throughout all the nineteenth century in Spain (16). Quite a different case was that of England where, during the first half of same century, there was a surplus of doctors and evidence of an overcrowded medical profession.

As the nineteenth century progresses, provincial capitals and important cities gradually became the centres of attraction for the private practice of medicine. During the first three decades of this century, it was in the capitals of the provinces, particularly Madrid and Barcelona, where the elite among the medical profession congregated. They consisted of professors of the Faculties for Medicine and doctors from some of the Public Welfare hospitals mainly from the State ones. This elite, to which one could attain after long years of hard work and constant study, including time abroad, was not subject to changes in its privileged position when the symptons of economic crisis for the medical profession became clearly evident, during the last years of Primo de Rivera's dictatorship.

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The social economic crisis of the 30's exaggerated economic difficulties and unemployment among the rank and file city doctors; thus, their economic advantage over doctors in rural areas was reduced. On one hand, the considerable growth in the number of practising doctors (11,680 in 1921 to 20,280 in 1931) increased competence (17). On the other, the demand which private patients represented was reduced because of the development of Public Welfare services (18) as well as the growth of the private insurance movement (with or without lucrative ends) which had seen exceptional growth in its number of clients during the 20's.

Except for Catalonia (especially Barcelona) where the relation between mutual help associations (friendly societies) and the medical class had a greater tradition and a longer standing, it cannot be said that the medical class came out the better for this increase of private insurance.

The long preparatory process and consultations which, lead by the Instituto Nacional de Previsión (INP) were carried out (19) in order to introduce a compulsory health insurance (for workers with earnings below a defined limit) as well as the earlier introduction of a separate maternity insurance (20) make up, in my opinion, the characteristic features of how this social innovation was introduced in Spain.

From the beginning of this century, scientific progress in Public Hygiene was permeating gradually through the Spanish Health Administration (21). After a certain 'lag' it spread through some of the city dwellers and in a much more fragmented and uneven way it penetrated into the rural and semi-rural areas (22). This brought about considerable reductions in the general population's mortality rate as well as the infant mortality rate (See Table 3) It showed a greater control over infectious diseases whose importance as cause of death was reduced (see Table 5). Nevertheless, by the time of the II Republic (1931) the infant mortality figures

were extraordinarily high (especially in some regions) compared to other more developed European countries. This was a proof of the relative backwardness of our levels of health and health care. Furthermore there was an outstanding degree of social (23) and territorial inequality (See Table 6).

The II Republic began its proceedings in this field by remarkably increasing grants for the General Directorate of Health in the state budget (the increase is from 10,3 million pesetas in 1929 to 31,4 millions in 1933). Following the recommendations of the International Conference of Budapest (1930) and of Geneva(1931) (24) an improvement programme for Rural Hygiene through Primary (Municipal) and Secondary Centres was set out.

The acceptance of Primary Centres for Rural Hygiene by local authorities and populace was very varied. The number of Primary Centres which were operating in 1935 was small (about 250). It was an interesting and innovatory experiment in the organization of Preventive Services but it had a very limited effect due to the magnitude of the Social and Health problems the Spanish rural areas suffered at that time.

The traditional Spanish health system gave real signs of exhaustion in the sense that it had almost reached the ceiling of what could be attained from the traditional schemes based on local financing. We can say, with no exaggeration, that in the Spain of 1934, there was almost complete agreement among health classes in the convenience of introducing the social innovation known as compulsory health insurance, financed by the employers, workers and State. The following statements give evidence of this:

a) One of the conclusions of the First National Congress for Health (25) proclaimed that "members of the National Health consider, as a very beneficial work, the setting up of social health insurance for the economic and physical betterment of the largest sector of society, and secondly because it must contribute to the solution of a great number of health problems".

b) An authority on these subjects, the renowned Dr. Martin Salazar expressed himself thus: "The institution of compulsory health

insurance is in our opinion the most far reaching health reform that Spain is demanding at present. The number of poor families who live on one wage and who, as soon as the bread earner becomes ill and cannot work are all left without food as well as catching the disease themselves, is truly amazing". (26).

The civil war interrupted, what seem to be the imminent setting up of a compulsory health insurance by the II Republic.

After the civil war, on September 1 1944, the compulsory health insurance was introduced (27) for employed population with earnings below a defined limit and their families (nearly 20 percent of the total population). The doctors received the payment through the system of capitation. The level of remuneration was rather low and was regarded as an income extra by most doctors in private practice during the difficult post-war years.

Since 1947, there has been very important increases in the number of people who have had the right to health care from Social Security, (See Table 7). This process together with the development of curative services (modern hospitals, polyclinics, and outpatient clinics) for Social Security patients are the two elements which characterized the transition from the Spanish traditional system to the modern one.

Almost from its beginning, the aim of the INP, the management body of the social insurances (28) was to create its own network of health care services since the experiment with the maternity insurance in the 30's had clearly shown the serious deficiencies of the Spanish health services and the weak cooperation, save by exception, of local authorities with the INP and collaborating Funds. (29).

The outstanding decrease in the mortality rate during the period 1939-1950 (from 18,42 per thousand inhabitants to 10,8) can be explained (30) by the hygiene improvements which were introduced into the areas of maternity and pediatrics as well as the first effects of the introduction of new drugs (sulphonamide, penicillin, etc.) In terms of health expenses per capita, the outlays in Spain in the 40's were far below those of the developed countries but they fell like water on dry soil. In my opinion, they obtained the greatest

yield in terms of health per peseta spent, in the history of contemporary Spain.

Progress would continue for the following two decades; this time, I think, brough about mainly by a series of interactions of several kinds:

i) Technological (lung tuberculosis was reduced drastically as a killer, thanks to a new drug. The same occurred with the morbility rate of other diseases like polyomielitis).

ii) Economic (high rates of economic growth, consumption and a high level of employment).

iii) Social (generations with a 'high need of achievement' - McClelland-* and with quite healthy life styles).

iv) Urbanistic (considerable improvements in the chronic hygiene problems of Municipalities and dwellings).

The health delivery system became more specialized. From the mid-sixties on, the demand of hospital sevices began to increase. Starting from very low levels in comparison with the rest of Europe or the United States. The INP responded by enlarging its investment programme for hospitals (See Table 8) and by increasing the number of arrangements ('conciertos') with relevant Public Welfare hospitals and others belonging to the private sector. On the other hand, the General Directorate for Health, throug the Programmes of Public Investment for Plans of Development, managed to somewhat reduce the big gap in the standard of treatment among hospitals that depended on Local Authorities (especially the provincial ones) and those recently set up by Social Security, which were equipped with up to date technology.

In conclusion, it is possible to say that the Spanish Health bodies played a subordinate role, during the period (1950-73), to the need for industrial development. This in turn supplied the necessary funding to carry out (mainly through the INP), with a minimum number of conflicts, without a plan, and almost without realizing it, the transition from a traditional health system to a modern one.

The change brought about in the financing scheme is clearly demostrated by stating that in 1975, health expenses amounted to almost 300,000 million pesetas, which represented 5,1 per cent of the PIB. The percentage distribution of the health expenditure by sources of finance are approximately the following:

Social Security 64

Private Sector 25

State 7

Local Entities 4

The Social Security financed 85 per cent of the public expenditure on health.

In 1975, a total of 47,251 doctors, who represented 81,63 per cent of all doctors in Spain worked within the Social Security system; 23,215 qualified nurses. (31) which represented 48 per cent of the total and 21,183 auxiliary nurses. 2,691 midwives (63 per cent of the total number of midwives in existance) and 10,408 medical assistants (33 per cent) (32). The number of hospital beds belonging to Social Security was 41,582 (33) which meant 27 per cent of the total number of hospital beds available in the country. Furthermore they had arrangements for nearly 17,000 beds in hospitals belonging to other public or private entities (34). The INP had 955 clinics (Ambulatorios y Consultorios).

Hospital personnel and, in general, qualified nurses who worked for the Social Security received their pay in the form of monthly salaries.

IV. Health Reforms

In December of 1974 an Interministerial Commission for Health Reforms was set up.

The priorities of Arias Navarro's government (35) were as follows:

- Modernize the functions and responsibilities of the public sector in the field of health care.

- Restructure the public sector so as to achieve greater efficiency.

- Fully comprehensive health care for the whole population.

- Complete reorganization of the pharmaceutical sector.

- Lay down the principles for a future health law.

The report (36) that the Commission presented to the Government in the short space of six months, only superficially described (37) the deficiencies that were then manifest in the Spanish health sector. The dispersal of the many different administrative organisms, their differing degrees of authority and their lack of coordination were brought out. This diversity and disparity had frequently given rise to double-dealing and gaps in the health care given and, in any case, abetted inefficiency, waste of resources and, at times, even corruption.

The unsatisfactory quality of the care given in the Social Security clinics (Ambulatorios y Consultorios) was stressed in the report. It acknowledged:

- existing division between hospital care and preventive medicine.

- the very short time each patient had to see the doctor, owing to the doctors' limited schedule.

- far too many prescriptions.

- inadequate system of referral to the consultant and the hospital.

The report suggested promoting the figure of the "family doctor" as a full time professional.

The disquieting situation as far as psychiatric care was concerned was also brought out. This sector was rated as the "most behind, depressed and discriminated against of the Spanish health services". (38).As to rural provision, the report acknowledged that the programme, laid down in the III Development Plan for Local Health Services, 1972-1975, had not been carried out. Finally, the right to health and the importance of preventive care was recognised, although it was not expressed clearly.

What I would like to emphasize here is that the awareness of the need for a "technical" health reform had, in general lines, been incorporated into the Spanish health system from the beginning of the seventies. The creation in July 1977 of the Ministry of Health and Social Security, during the period of political transition to democracy, was in response to the demand already existent in the health sector. Another step was taken in November 1978 when the National Health Institute (INSALUD) was constituted. It is an autonomous organism responsible for administration and management of the Social Security health services. (39).

Besides this "technical" crisis and the attempt to remedy the situation with some kind of "technical" health reform, there was a lot of critical literature which began to appear around the middle of the seventies. It came down heavily on the technical aspects, emphasising the social inequalities and the politics of health care. These critics usually employed Marxist or Socialist / Fabian concepts, underlining the obligations and obstacles that the capitalist system uses to reason against health services based on the social needs of the population. They did not trust, and at times openly attacked, the whole idea of liberal medicine to which Socialism is so opposed.

The left wing political parties took up some of these ideas and used them to censure the "social crisis" and "political-cultural crisis" within the Spanish health system. (40).

In 1978, during a conference on Public Health Care, the PSOE made clear its preference for a Spanish National Health Service similar to that of Great Britain. They also pointed out the advantage of controlling health spending. (41).

It is exactly the "economic crisis" or that of funding (the crisis within the Social Security and sharp increase in the budget deficit) which is going to affect the Spanish health system and it is my opinion that it will prove to be a very important factor in the health system's evolution during the eighties.

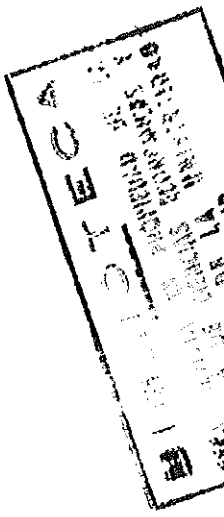
One researcher of the Spanish health system has characterised its evolution up to the Socialists' coming to office in October 1982 in this way:

"Up to November 1982, at least, the public health sector permitted an uninterrupted cycle of fragmentation, an ever-increasing drug bill, the taking on of more hospitals when its own were only operating at 70%, the deterioration of the clinics, the neglect of chronically sick and mentally ill patients, experiments in hospitals with very few ethical guarantees, the private use of its hospitals when they should have been filled with public patients, the taking on of the bulk of the medical profession and 70% of the pharmacists without suitable regulation and control and mismanagement of its economic resources while defending a capitalist system in deficit".(42).

In my opinion insufficent time has elapsed to be able to objectively analyse the social change which has and is taking place in the eighties. Up to now it has proved a confusing period for any impartial observer of the erratic and complex Spanish social policy.

Having made that qualification I shall continue with my exposition.

Since the beginning of the seventies the general policy in



the European region of the WHO (World Health Organisation) "has been to deemphasize the role of the hospital and to promote the development of highly qualfied primary resources.... the degree to which in 1984, the countries have succeeded with this policy varies.... " (43).

In Spain, the policy of setting up Health Centres where Primary Health care Teams with different skills are based began at the beginning of the eighties. (44). In spite of budget limitations and the problems that always arise when trying to do things a new way, the policy has gained momentum since 1984 thanks to the Socialist Government's health policy. The setting up of these Health Centres and their operative capacity varies notably from one Comunidad Autònoma or Province to another.

On the other hand, coordination with hospitals is far from easy, and in some cases the hospital investment crisis of recent years has been worsened because of a transference of investment funds to establish new health centres. We have also seen that as, in Italy, (45). The improvement of primary care, in the short term, has not generally reduced the need for hospitalization. In Spain, the stand still in the INSALUD health budget of 84-86 has produced a deterioration of hospital assistance and dissatisfaction among the INSALUD hospital staff especially the doctors. In April 1987, we witnessed the largest and longest strike of doctors from public hospitals in the medical history of Spain.

The future of Spain's health system is both hopeful and uncertain. Hopeful because of the progress the 1978 Constitution represents and because of the recently approved General Health Law (46). In my opinion, both of them are sufficiently flexible to allow both the paradigms of the health policies based on liberal theories of justice (47), which justify the right of the individual to a minimum adequate health care guaranteed by the state, and other paradigms which consider desirable the equality in health service consumption, based on people's need. One mustn't forget however, that when they are put into practice either of these concepts may be modified by all types of circumstances which finally reflect the limitations of human nature and the underlying relativity in every human performance whether

individual or collective.

Secondly, the decentralization which the formation of a State of Autonomies imposes (48)can, I believe, contribute to the improvement of the National Health System, which establishes the General Health Law of 1986. The most important part of the National Health System is made up to the Autonomies Community Health Services which are already in existence or will be set up by their corresponding Legislative Assemblies in accordance with their Autonomous Statutes. The 1978 Constitution States that the State has exclusive competence in matters of overseas health (Sanidad Exterior), bases and general coordination of health and legislation for pharmaceutical products. The State also has the responsibility for "high inspection", understood as a vigilant overseeing more than a new control (49).

During the last years nearly all state duties and services in matters of Health and Hygiene as well as their corresponding financial, personal and real resources have been handed over to the Autonomous Communities. INSALUD has already been handed over to Catalonia (1981) and Andalusia (1984) and shortly the Basque Country (1987) and Galicia (1988) are to receive their corresponding responsibilities. The population covered by health assistance from Social Security in each Autonomons Community makes up the basic criterion for the distribution of INSALUD budget expenses.

All these processes could give birth to innovations in the delivery and management of health services, adapting them to the peculiar health needs of populations to which they are intended.

But uncertainly and clouds also loom over the foreseeable evolution of the Spanish health system. The first one is the question of funding. It is not at all clear what place 'health' is to have on the scale of priorities of the State Budget, compared to other liabilities (reindustrialization, defence, education, etc). Furthermore, at this time when the tax payer is showing signs of tax resistance and tiredness.

The second has to do with coordination. Here, a great variety of situations in the joint Autonomous Community and Local Bodies functions, are going to be posed. The Area Health Councils (50) could serve as a decent channel to facilitate coordination. But, except certain cases, there is little tradition of local government, in the modern sense, in our country. Only time can resolve this problem and raise well founded doubts as to how they are going to operate in the beginning (51).

In April 1987, the Interterritorial Board for the National System of Health (Consejo Interterritorial del Sistema Nacional de Salud) was established (52) : It is presided by the Minister of Health and Consumption, and made up of a representative from each of the Autonomous Communities and an equal number of members from the State Administration. In my opinion, it would have been more convenient if bodies of technical kind had been included on the named Board. Among other reasons, because of the tasks of examining the Integrated Health Plan (Plan Integrado de Salud) which the Board has to deal with.

Third, during the last years the Spanish health system has been operating as a non-neocorporate model, based on the alliances between the political party in power and the political leaders of the Autonomons Communities. There are reasons to believe that this model could clash with medical power.

To conclude, I would like to share with you the feeling for the need that our present social policy be lead by the everlasting light of the good samaritan.

NOTES

1. The current debate shows greater accuracy in working out the standard of living indicators but both the optimistic position - the standard of living improved for most of the working class between 1800 and 1840 - and the pessimistic one - that it worsened - have their advocates. See : A.J. Taylor (ed). The Standard of Living in Britain in the Industrial Revolution. (Methuen. London. 1975)

2. G. Tortellà: An Interpretation of Economic Stagnation in Nineteenth Century Spain. (Historia Iberica. I. Economia y Sociedad en los siglos XVIII y XIX. 1973. Madrid. Page 122.)

3. A. Gerschenkron has underlined the important role that ideology played in late industrialisation. See: A. Gerschenkron. Economic Backwardness in Historical Perspective. A Book of Essays. (Harvard University Press. 1962).

4. See: C. Sebastiàn. "Difusiòn tecnològica e incorporaciòn del progreso tecnico a la industria española". Revista Española de Economìa. Septiembre. - Diciembre. 1973.

5. S. Kuznets thinks that the modern economic age began in the late eighteenth century and is still going on.

6. For information about the importance of the role of diffusion in the development of social services see: V. Rys. "The Sociology of Social Security". Bulletin of the International Social Security Association. Jan. - Feb. 1964.
J.R. Hay. The origins of the Liberal Welfare Reforms. 1906-1914. (McMillan. London. 1975).
R. Mishra. Society and Social Policy: Theoretical Perspectives on Welfare. (McMillan. London. 1977).
And especially, J. Midgley. "Difussion and the Development of Social Policy. Evidence from the Third World". Journal of Social Policy. April 1984.

7. The Spanish Civil War, 1936-1939, with around 750,000 dead or missing, interrupted the afore mentioned progress, but in 1942 its favourable evolution was again resumed.

8. See: M. and J.L. Peset. Death in Spain. Politics and Society between the plague and cholera. Madrid. 1972.

9. The Organic Health Law of 28 November, 1855, established that the General Directorate of the health services should reside in the then Ministry of Government. The political leaders - Civil Governor and Mayor- were the health authorities under the Ministry of Government.

10. Article 46

11. For further information about the vigorous deterioration that the Poor Law Act of 1934 originated, see: I. Loddon. Medical Care and the General Practitioner: 1750-1850 (Clarendon Press. Oxford. 1986). Chapter 2.

12. See: J. Balmes. A Comparison of Protestantism and Catholicism in their relations with European Civilisation.(A. Brusi. Barcelona. 1844). Chapter 33.

13. In particular the dependents of the Provincial Authorities which constituted the most important part of the public health institutions. During the nineteenth century the level of health care was very mediocre, even poor, but in certain concrete cases it underwent undoubted improvements in the first decades of the present century.

14. The Social Security prefered to use the name of Residence rather than hospital. Only recently has the appropriate terminology been again in use.

15. Article. 64. 1855 Health Law.

16. At the middle of the nineteenth century "for a population of a little more than fifteen million it is calculated that there were approximately six thousand doctors, slightly more surgeons, one and a half thousand blood drawers and a very small number of

qualified midwives". See: L.S. Granjel. Contemporary Spanish Medicine. (University of Salamanca. 1986). p. 71

17. See: Ricardo Royo-Villanova. "La crisis de la Profesiòn mèdica" (Plètora profesional). (Publications of Valladolid University. 1933).

18. La Beneficiencia General. (Public Welfare which is State dependant) had a top quality staff of doctors and a few specialised health establishments from which the Ophtalmic Institute and the Cancer Institute were set up in the first three decades of this century. Moreover, there was a certain laxity in reference to the means test which gave the right to free treatment.

19. Among other activities, it is worth pointing out the Social Insurances Conference of Madrid (1917); the Conference on Insurance for Maternity, Sickness and Disablement (Barcelona 1922); public information (1923), the Government's reply to the questionnaire sent by the International Labour Office (1927), dealing with sickness insurance; papers to prepare the drafts of bills to implement the International Agreements on Sickness Insurance for the industry and commerce workers and for house hold servants as well as for Farm workers. These Agreements were ratified by Spain in April 1932.

20. Act, 22 March 1929. Was implemented In May 1931 [illegible]. Previously (since 1923) there was a maternity allowance (subsidio de Maternidad) for mothers belonging to Retiro Obrero (that is for female workers with earnings below a certain limit).

21. In January 1904, a "Instrucciòn General de Sanidad" was approved. This was an important administrative order which brought the 1855 health law up to date in many ways, the latter still being in force.

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22. Which in 1930 still housed some 70 per cent of the population.

23, See, Severino Aznar. El Seguro de Maternidad y los Mèdicos. (INP Publications. Madrid. 1931) p. 14.

24. The calling of which was requested by The Spanish Government from the Society of Nations.

25. First National Congress for Health (6-12 May 1934). (Madrid 1935) Volume 1, p. 460. Almost 1400 health professionals attended, which I believe constitute a representative display of the most authoritative opinions in Spain.

26. M. Martin Salazar. Valor social y sanitario del Seguro Obligatorio de Enfermedad. (taken from the article published in Siglo Mèdico, February 3, 1934. Madrid. 1934) p. 8.

27. For Gëneral Medicine and pharmaceutical benefits, and from January 1, 1947 on, some consultant medical services and surgical hospitalization were included.

28. In an initial stage of compulsory health insurance, there were various collaborating entities to negotiate the insurance.

29. The first disputes with Medical Collegues also appeared in 1932. The matter had to do with who and how the centres and maternity clinics, (which the INP was about to set out) would be managed.

30. See: a similar argumentation in J. Nadal - La Poblaciòn Española. (Siglos XVI a XX).(Ariel. Barcelona 1984) p. 212.

31. Datum referring to 1974, Ministry for Labour. Social Security Subsecretary. Libro Blanco de la Seguridad Social. Madrid 1977.

32. Since April 1977 a collegiate association was established (Official College of Tëchnical Assistants for Health) from the three old sectors of medical assistants, midwives and nurses.

33. Datum referring to 1976. The average length of stay was ten days.

34. In 1976 some 30 per cent of hospital beds belonged to the private sector.

Other indicators of a comparative nature can be seen in Pilar Coll Cuota's work 'El sistema sanitario español' Comparaciones internacionales de niveles y participaciòn pùblica'. Revista de Seguridad Social. Enero-Marzo 1981.

35. The Government, within the authoritarian regime of General Franco, was made up of Falangists and independent technocrats.

36. See: Ministry of Gobernaciòn. Interministerial Commission for Health Reform. Government Report. July 1975. (BOE, Madrid 1975).

37. The report in question contained 96 pages. It was labelled by some as "hasty, incomplete and superficial".

38. Interministerial Commission for Health Reform. Report. op. cit. Page 44.

39. The Ministry of Health and Consumer Affairs was later set up. (RD 2823/1981 27 November). The issue of the colza oil which had a tremendous impact on public opinion led to the separation of the Ministry of Employment, Health and Social Security from all public health matters.

40. Really, the concern to improve the health systems and make them more responsive to social needs was written into all the Governments' programmes and figured amongst the more important subjects of economic and sociological research in the OECD countries at the beginning of the seventies.

41. From the middle of the seventies there has been a search for ways to contain the cost of health care in the member countries of the EEC, the United States and other industrialised countries. The experience of the European community can be seen in : B. Abel-Smith: Cost Containment in Health Care. (Occasional papers on Social Administration. Number 73. Bedford Square Press. London 1984).

42. Jesus M. de Miguel "La Salud Pùblica del Futuro". (Ariel. Barcelona. 1985).

43. Dr. A. Meyer - Lie. "A Comparative Health Services Study". (February 1986. WHO. Working Paper unedited). Page 6. See also: Leo A. Kaprio. Primary Health Care in Europe. (WHO. Regional Office for Europe. Copenhagen 1979).

44. At the end of the first six months of 1986, there were 221 Primary Health care Teams (PHC teams) based in 211 Health Centres.

45. See G. Venazoni "Verso una polìtica econòmica dei sistemi sanitari: il caso italiano". Rivista di Polìtica Econòmica Ottobre 1983.

46. Law 14/1986. April 25.

47. See A.E. Buchanan- The right to a decent minimum of health care. Philosophy and Public Affairs. Winter 1984. N. Daniels (ed) Reading Rawls (Basil Blackwell. Oxford. 1975).

48. Title VIII of the Constitution. 1978.

49. STC 32/1982. April 28

50. The Health Areas are those basic units of unitary management of the centres and establishments of the Autonomous Community Health Service and of the drafting of the Area Health Plan. The Health Area generally consists of a population of 200,000 250,000 people. The regulation of the Health Areas of the General Health Law of 1986 was inspired by that of the Local health units (unita Sanitaria Locale) of the Italian Law

833/1978, which establishes the 'Servizio Sanitario Nazionale'.

51. In Spain, the collaboration on a personal level, and more recently the coordination via political parties, has served as a substitute coordination mechanism for other more established and genuine ones.

52. Included in article 47 of the General Health Law is the 'permanent body for coordination and information about the different Health Services between themselves and with the Central Administration.

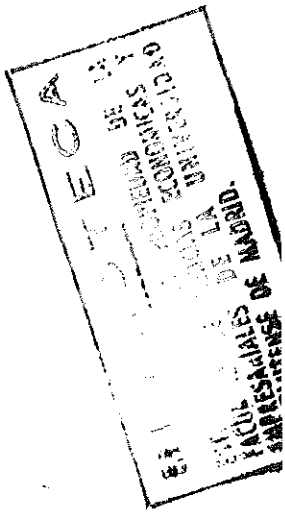

TABLE 1

Employment by sector and structure of production

	Percent labour force			Percent GDP		
	Primary	Industry	Services	Primary	Industry	Services
1901	66,7	15,3	18	46,4	19,6	34,0
1910	64,1	16,5	19,4	44,9	20,4	34,7
1920	58,2	21,4	20,4	41,5	23,8	34,7
1930	47,3	30,9	21,7	34,6	30,9	34,5
1940	51,9	24,1	24	31,9	28,3	39,8
1950	48,9	26,2	24,9	26,5	33,1	40,4
1960	41,7	31,8	26,5	23,7	35,3	41,0
1970	29,1	37,3	33,6	13,5	35,6	50,9
1980	17,2	35,8	42,5	7,4	36,4	56,2

Source. Instituto de Estudios Fiscales. Datos básicos para la Historia Financiera de España 1850/1975. Vol. I (Madrid, 1976). The data for 1980 are from INE (Anuario Estadístico).

Table 2

Growth of production

Average annual growth rates (percent).

	1960-70	1970-76
GDP	7,3	5,4
Agriculture	2,5	2,6
Industry	9,4	6,3
Services	8,2	9,3

Source. World Bank. World Development Report. 1978. Table 2. p. 79

TABLE 3

	Life expectancy at birth (yr)		Infant mortality rate (1) (deaths/1000 live births)	Crude death rate (death s/1000 population)
	Males	Females		
1900	34	36	204,5	28,9
1910	41	43	149,3	23,1
1920	40	42	165,2	23,4
1930	48	51	117,1	16,9
1940	47	53	108,8	16,5
1950	60	64	64,2	10,8
1960	67	72	35,5	8,6
1970	70	75	20,8	8,3
1974	70	76	13,8	8,4

Sources INE. Anuarios Estadísticos (several years)
(1) Newborns who die within the first 24 hours are not included.

Table 4

Health manpower

	1960	1970	1976
Médicos	35.685	45.335	64.597
Odontólogos	2.788	3.361	3.703
Farmaceúticos	11.965	15.963	19.253
Matronas	5.156	4.123	4.356
Practicantes	21.894	22.634	36.051
Enfermeras	13.221	28.175	40.019

Source : INE. Anuario Estadístico de España. Several Years; C. Domínguez-Alcón. "Los cuidados y la profesión enfermera en España". (Pirámide. Madrid. 1986).

Table 5

Mortality rates for Infectious diseases

	Numbers of deaths	Percent of all deaths
1901	140.243	27,1
1926	73.874	17,6
1930	63.577	16,1

Source. INE (Anuarios Estadísticos. Several Years).

Table 6

Infant Mortality Rate by provinces. 1929-1932 average

(deaths/1000 live births)

	IMR
Castilla la Vieja	
Avila	157
Burgos	153
Logroño	135
Palencia	167
Santander	106
Segovia	138
Soria	130
Valladolid	157
Castilla la Nueva	
Madrid	117
Toledo	126
Ciudad Real	144
Cuenca	145
Guadalajara	137
Galicia	
La Coruña	103
Lugo	110
Orense	113
Pontevedra	93
León	
León	130
Salamanca	141
Zamora	139

Table 6 (continuation

	IMR
Extremadura	
Cáceres	170
Badajoz	140
Andalucía	
Sevilla	129
Cádiz	119
Córdoba	112
Jaén	130
Málaga	105
Granada	114
Huelva	108
Almería	109
Murcia	110
Murcia	110
Albacete	132
Valencia	
Valencia	95
Castellón	88
Alicante	97
Aragón	
Zaragoza	119
Huesca	104
Teruel	118
Asturias	
Oviedo	99

Table 6 (continuation)

	IMR
Cataluña	
Barcelona	80
Tarragona	69
Lerida	79
Gerona	70
Provincias Vascongadas y Navarra	
Alava	113
Guipúzcoa	71
Vizcaya	84
Navarra	102
Baleares	62
Canarias	168 *

Source - M. Pascua. La Mortalidad infantil en España. (Trabajos del Departamento de Estadísticas Sanitarias de la Dirección General de Sanidad. Madrid. 1934). Pág. 65)

* 1924-1928

Table 7

Social Security Coverage (Health care contingency)

	Number of persons (thousands.)	Percent of Population
1950	8213	29,36
1955	9572	32,39
1960	13554	43,86
1965	16475	51,62
1970	25429	74,70
1975	27499	77,68
1980	31203	82,72
1982	32527	85,45
1985	36643	94,93

Sources - INE. (España Panorámica Social 1974 (1975). INSALUD (Anuario de Estadística 1983) and Ministerio de Sanidad y Consumo. Memoria Estadística 1984-85.

Tabla 3

Hospital beds owned by Social Security

	Number of beds	Percentage Total beds
1966	14.077	19,19
1972	32.046	18,20
1979	51.579	25,75
1982	57.763	30,48

Source- INE. Censo de Establecimientos Sanitarios (1966) and Estadística de Establecimientos Sanitarios (several years).