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Introduction. A mixed model of hospital services: Catalonia, 1870s-2010s

Abstract

This special issue aims to contribute to current knowledge held on mixed hospital systems from a historical perspective, as there is nowadays much debate on the sustainability and efficiency of public and private healthcare systems in the world in the COVID-19 pandemic. By focusing on the evolution of mixed hospital systems through the case study of the history of such systems in Catalonia in the last century, the authors of this special issue show that mixed hospital systems take a long period of time to be used, and trusted, by the population. It is also considered how public healthcare regulators can create a diversity of mechanisms that facilitate access by the population to healthcare services in times of external shocks such as pandemics. This introductory text begins with a section about the international context which explains the relevance of mixed hospital systems, which is followed by a summary of the main historical points regarding the Catalan model of mixed hospital provision since the 19th century. It also highlights the most significant contributions of the seven articles of this special issue, which consider how the Catalan society confronted social, economic, and political changes and how those actions led to configure a distinctive mixed model of hospital system. Finally, this text also sheds light on areas of research regarding the rich history of hospital healthcare that still need to be addressed.

Keywords: Mixed Hospital Systems; Catalonia; History of Health Care

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1. Hospital systems in the world

Healthcare systems are complex networks with actors that cooperate and often have conflicting interests: suppliers of public and private health insurances, manufacturers and distributors of healthcare equipment and pharmaceutical products, patients with diverse socioeconomic backgrounds, scientific researchers, healthcare staff, and private and public institutions that sponsor healthcare centres (Donzé and Fernández Pérez 2019).

Despite its complexity in terms of organisation, health expenditure represents an increasing share of the total Gross Domestic Product in the world, between 2 and 40 per cent depending on the country. In 2015 health expenditure varied enormously between countries, from 17 US dollars per capita in the Central African Republic in 2015, 2,354 US dollars per capita in Spain to the 9,818 US dollars per capita in Switzerland that same year (WHO 2020c).

More health expenditure does not always denote a better position in the world rankings of life expectancy (WHO 2020a). Between the 1960s and the 1980s there was an increase in public health expenditure worldwide. This subsequently changed and after the 1990s private healthcare expenditure began to take up an increasing share of total healthcare expenditure in the world.¹ World Health Organisation statistics indicate that most of the health expenditure in the world is on hospitals, including infrastructure, equipment, pharmaceutical products, and staff.

¹ According to the World Health Organization, “globally, there is too much reliance on direct payments as a source of domestic revenue for health. The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal basis – prevents millions of people receiving healthcare when they need it” (WHO 2010).

After the 1990s up until today, public plans of reform of health expenditure have called attention to a persistent problem of the sustainability of health systems established after World War II. Governments and institutions have indicated with concern the need for cost contention and more efficiency and productivity within hospital and healthcare systems, due to the increase in life expectancy, the aging population, and the rise in chronic illnesses and cancer that require greater healthcare resources and expenditure that governments or private healthcare companies are not ready to absorb efficiently. The last reforms of health systems in the world in the first years of the twenty first century had budgetary control as one of the key aims as well as increasing the efficiency of existing resources (WHO 2020b).

In this context, there has been extensive academic research into two relevant processes involved in expanding the access to health services and centres in the last century: the increase of public and private health insurance systems, and the consolidation of hospitals as hubs around which access to health services, technology, and products, has been concentrated and coordinated. Policymakers and international organisations have been aware of the relevance of hospitals as resource hubs in their communities and the need to improve cooperation on domestic and international levels since the times of the League of Nations a century ago up until today, as indicated by the International Hospital Federation (formed in 1929) in the occasion of their 90th anniversary this year in 2020 (International Hospital Federation 2020).

Economic and business historians and management scholars have studied the development of health insurance systems in the last century fairly extensively but have relatively neglected the long-term emergence of hospital systems as relevant actors in the improvement of wellbeing. Most academic literature focusing on health systems with a very long-term perspective has approached the context that created the welfare system in the United Kingdom and the Nordic

countries after World War II with a strong influence from public pressure. Scholars has also studied the weaknesses of the private-led healthcare systems and hospitals in the United States and Japan (Donzé and Fernández Pérez 2019; Thomson et. al. 2011; Saltman, Busse and Figueras 2004; Busse, Shreyögg and Gericke 2007; Ellis, Chen and Luscombe 2014; European Observatory on Health Systems and Policies 2020; WHO 2020d). There is relatively less published from a historical perspective about the history of mixed hospital systems, where public and private actors have coordinated their attention to healthcare issues in their communities with varying levels of success over centuries.

Catalonia is an excellent example of historical resilience of a mixed hospital system, which resists the impact of external shocks relatively well due to the significant use of private health insurance (more than 40 per cent of holders of health insurance in Catalonia have both public and a private health insurance) in a territory with universal access to a public healthcare system.

This special issue aims to contribute to current knowledge held on mixed hospital systems from a historical perspective, as there is currently much debate on the sustainability and efficiency of public and private healthcare systems in the world in the COVID-19 pandemic. By focusing on the evolution of mixed hospital systems through the case study of the history of such systems in Catalonia in the last century, the authors of this special issue show that mixed hospital systems take a long period of time to be used, and trusted, by the population. Also, that public healthcare regulators can create a diversity of mechanisms that facilitate access to healthcare services in times of external shocks such as pandemics, by maintaining the legal autonomy of private institutions and associations under the umbrella of the public service, which are efficiently complementing services and products that the public system can be unable to provide especially when there is a sudden increase in demand.

Catalonia, certainly, is not alone in having a long history of mixed hospital systems. There were many regions in Western Europe where the mixed type of hospital system has existed since the Middle Ages and after the Modern times (Donzé and Fernández 2019; Fernández Pérez 2021). During the nineteenth century British voluntary and municipal hospitals had established a very decentralised service model up until the National Health Service (the NHS) came into existence in 1948. After the 1942 Beveridge Report on Social Insurance and Allied Services, a proposal presented to Parliament that established universality in access to health services, free at the point of delivery, paid for by central funding. But even since the NHS came into existence, voluntary hospitals and philanthropic charity have remained very much alive and part of the English healthcare system today (Able-Smith 1964; Boyle 2011; Gahan and Burbidge 2010).² In Germany, there were strong local traditions of science-based healthcare centres, especially in former Prussia, and it was after the impact of the wars with France during the 19th century that the Prussian army established the need to order the sustainable access of science based medicine with the 1883 Bismarck Health Insurance Act, which for many historians is considered as the first social health insurance in the world that helped to finance the development of the German hospital system. This system is world-renowned and firmly established in the country, having its foundations in science, clinical analysis, a dense network of health centres and staff across the territory, and a dense population who have access to high quality and affordable healthcare insurance (Fernández 2021; Busse et. al. 2017). As in the United Kingdom and Germany, France learnt from difficult experiences when providing

² John Mohan and Martin Powell, with research assistance of Martin Gorsky, led a very important project that has studied the history of voluntary hospitals in the United Kingdom between the 1890s and the 1940s, with open access databases and statistics (Mohan and Powell 2020): <http://www.hospitalsdatabase.lshtm.ac.uk/the-voluntary-hospitals-database-project.php> (access 7th December 2020). Martin Gorsky is leading now a research project that studies the resilience in our days of this voluntary hospital system.

healthcare for the military and civil population in the many wars affecting Western Europe from the mid-19th century until the mid-20th century. Moreover, they learnt how important it was for the State to promote coordination between modern scientific institutions, large hospitals, the different health insurance schemes allowing a larger chunk of the population to receive modern healthcare, above all in cities and gradually in rural areas too after the mid-20th century. The United States, aware of the weaknesses of their medical education and the coordination of healthcare services, particularly after their Civil War in the 1860s and the war against Spain in Cuba in 1898, sent several missions of thousands of physicians to Western Europe to learn how to improve their medical education (1910 Flexner Report) and their medical practice (with the integration of research and laboratories and the importance of the faculty having a direct link to a large hospital with the example of the Johns Hopkins Faculty and Hospital of Medicine in the late 1890s). Between the 1910s and the 1930s, Franklin Martin and Malcolm MacEachern, along with hundreds of physicians involved in the American Hospital Association and the American Surgeon Association, elaborated a model of modern hospital organisation that would be frequently imitated worldwide after World War II, with three major components: an standardisation of medical practice, professionalisation of medical staff, and quality control systems of accreditation of standard hospital service. This model was followed and imitated in many regions and countries during the 20th century (Fernández Pérez 2021). There were alternative models of modern hospital organisation created before World War II that endured later, as in Russia. The Communist Revolution, with the leadership of the first People's Commissar of Health N.A. Semashko, created between 1918 and 1930 a different model of hospital organisation and management, being very centralised, that in a very short period of time aimed to achieve something close to universal coverage of basic healthcare services, with

a very modern structure of primary, secondary, and tertiary types of healthcare centres that were very coordinated and centralised, that received strong investments from the public sector during 1918 and 1930. However, these institutions declined in financial strength, efficiency and quality of coordination and quantity of resources during the second half of the 20th century (Arsentyev and Reshetnikov 2017).³

Spain was, in this context, a good example of a peripheral European country in transition from traditional to modern models of hospital organisation and management. It was also a good example of how path dependent regional experiences of healthcare organisation influenced different outcomes in recent times. In the mid-19th century, most regions of Spain were forced to transfer private healthcare property to the State, but in the Basque country and Catalonia local institutions and elites joined forces to maintain the legal property and the control of the huge assets accumulated (mostly by donations) in their private healthcare institutions and centres. In this way, Catalonia became a significant example of European traditions of regional coexistence of public and private interests in regional healthcare systems (Barceló and Comelles 2020).

Catalonia had a medieval tradition that has survived until recent times under different regulatory frameworks, with the coexistence of few relatively large hospitals with a variety of private institutions that provided healthcare insurance coverage, pharmaceutical products, and service. The traditional low health expenditure of the central government made unavoidable to maintain the willingness to remain independent of institutions that existed since medieval times like the Hospital de la Santa Creu, the largest in the city of Barcelona during centuries, with a large

³ See also the interview of Fiona Fleck to Igor Sheiman, in *Bulletin of the World Health Organisation* (Fleck 2013).

patrimony from private donors that could not just be expropriated by the central State in Madrid. The historical existence of self-governing institutions like the Mancomunitat de Catalunya in the first third of the 20th century, and the Generalitat de Catalunya after Franco's death in the last decades of the 20th century, reinforced the self-governing character of many of the private healthcare clinics and hospitals. Self-governance has long been the preference of the Catalan elites and institutions, who have often preferred to put healthcare institutions under private management and view them as private property and resources. This is not as often seen in other regions of Spain or Western Europe where the central government has a much more relevant power than in Catalonia and where health is much more considered a public area of policy that affects society, under the hands of the central government. There are relatively few publications in economic and business journals about the evolution of the mixed Catalan hospital model, and the institutional and political context that made its continued existence possible over the centuries. This is a major gap that this special issue aims to fill.

2. A distinctive Catalan health model

The so-called Catalan health model based on a mixed network of public and private hospital services was set up from the end of the 18th century. The importance of the city of Barcelona was crucial in this process. However, the progressive implantation of factories along the main rivers and in the metropolitan towns surrounding Barcelona expanded the geographical scale of this model to most of Catalonia. Until the 18th century, poor relief and healthcare had followed a pattern similar to that of the other territories of the Crown of Aragon. Since medieval and early modern times, the positive consideration of individual and collective health and the development of charitable formulas in the face of poverty turned into support of civil and religious authorities for university medicine – medical Galenism – and paved the way to two

fundamental institutions: a general hospital known as Hospital de la Santa Creu and the House of Mercy (Arrizabalaga 2014). Concepts of responsibility and management of the *res publica* guided those institutions that were financed in a complex way through public resources and a growing estate based on donations and testamentary bequests. Although the city of Barcelona had the largest general hospital, a great network of small hospitals in towns and villages around Catalonia was also established. Along with this type of charitable hospital devoted to the “poor patient,” representatives of medical Galenism – medical practitioners, surgeons, apothecaries – spread slowly but progressively across the country through a contract – “conductes de comú” – that allowed them to remain and take root in certain labour and socioeconomic conditions. Indeed, those who could afford the payment had a patronage relationship with the aforementioned medical practitioners. Due to the urban and demographic changes experienced in 18th century Barcelona, which were tied to a growing industrial process, these kinds of contracts were increasingly cultivated by urban working population, mainly attached to guilds and brotherhoods. In the genesis of the modern Catalan world, a remarkable process of medicalisation took place through different models of mutual aid associations and friendly societies, which intensified in the first half of the 19th century (Zarzoso 2005).

A new stage began in the 1830s as the Ancien Régime collapsed in Spain and a new liberal state ruled by the bourgeoisie made its way with great difficulty. In this period, the industrialisation of the Catalan urban networks, led by the city of Barcelona, meant dramatic demographic changes. This social transformation happened along with the strengthening of liberal values and features, such as the professionalisation of medical practitioners. They produced the main criticism against the old general hospital and the asylum condition of that healthcare institution. However, the response of the new Spanish liberal state to policy a new

hospital model was rather conflicting and chaotic. On one hand, it was based on the privatisation – “desamortización” or confiscation – by force of land and other properties of the Catholic church and then made available to a developing real-estate market as part of a strategy to obtain money to pay off public debt, as well as to increase national wealth and liberalise the market by creating a class of land-owning farmers and businessmen. This resulted in negative effects in the funding government of both small and big hospitals in Catalonia. On the other hand, the enactment of new legislation, such as the Poor Law of 1842 and the Health Law of 1855, arrogated to the liberal state itself the right to decide who could receive healthcare – henceforth the “impoverished patient” – and how to govern and fund the hospital as a charitable state and liberal institution. Next to these features, the new territorial division of the state through a system of provinces turned its capital and provincial cities into centralised places of healthcare institutions. In most cases and due to the lack of state funding, this resulted in the creation of public provincial hospitals that depended on provincial or municipal and private investment in order to survive. In other cases, such as the Hospital de la Santa Creu or small urban hospitals such as those of Vic or Tarragona, its governors managed to retain control both of its heritage and traditional sources of funding and to avoid a provincial competence on behalf of a purportedly legal trait due to its private condition as a charity. Therefore, this resulted in a distinctive privatisation of some medieval public hospitals, which remained in the hands of the conservative bourgeoisie. Moreover, in a growing industrial context, the local bourgeoisie also invested in new private hospitals that offered medical services as a charity both on a free basis for those patients without resources and in an increasing pay per service basis that was tied to the urban extension of the mutual aid movement. These healthcare institutions transformed the medieval concept and organisation of the hospital as an asylum into a “domestic hospital”. That

is, the introduction of a growing number of medical practitioners along with an intense presence of religious orders, especially sisters that acted as nurses. This resulted in frequent conflicts about how to manage the hospital, and also asserted an image of the hospital as a charitable project (Barceló-Prats and Comelles 2018 and 2020).

Significantly, this progressive transformation of the old regime model of hospital provision crystallised along with the emergence of several private initiatives in the hands of representatives of the local bourgeoisie and of medical entrepreneurs that met a growing demand of medical services in an open medical market. In the second half of the 19th century the city of Barcelona and its hinterland was the place of the settlement of both new institutions for the mentally ill and new private surgery clinics. These healthcare institutions were not only devoted to the affluent, but they also took advantage of the impressive extension of mutual associations, friendly societies, and insurance companies in 1900s Barcelona. This resulted in the consolidation of a process of medicalisation of the Catalan society (Pons-Pons and Vilar-Rodríguez 2017; Zarzoso 2017).

In the first third of the 20th century, demographic changes due to industrialisation intensified and marked a growing urban Catalan society. This coincided with important political movements in the government of Spain that had consequences in the management of healthcare policies and institutions. In Barcelona two new and relatively large hospitals were established. On the one hand, the old Hospital de la Santa Creu was transformed into the new Hospital de la Santa Creu i Sant Pau in a new establishment built in the Eixample district in 1902 and partially in operation since 1916. This hospital was marked as representative of the local bourgeoisie and politically committed with Catalanism. It functioned as a private charity funded through a large medieval heritage and also to private donations and bequests. Medical

practitioners had an important role there as they ran the medical services, organised by speciality. They were either not paid or only received very small salaries for their work, but they built a public prestige in those positions and contributed to the economic health of the hospital by succeeding in channelling investments from their private practice in surgery clinics or home-office medical consultations. They also taught students of medicine there, under the supervision of the religious administrator of the hospital. However, the acceptance of patients was not based on medical decisions but was in the hands of the hospital administration and mainly devoted to the “patient without resources” (Fernández Pérez 2018). In 1906 the Hospital Clínic was also inaugurated in Barcelona. This was a public hospital, the first of those provincial institutions designed by the liberal legislation of the previous century and devoted to the recipients of public charity. It was also marked as a “Spanish institution”. Despite its public funding and government in the hands of representatives of the town council and the provincial authorities, its services also depended on the local bourgeois practices of donations and bequests. Next to these big hospitals, the local authorities of the city of Barcelona promoted a range of medical services and small hospitals such as the Maritime Hospital for infectious diseases and Hospital de la Esperanza (Reventós and Piqué 1990). It has been estimated that in Catalonia there were around 50 hospitals, mainly small and medium sized, in the first third of the 20th century (Barceló-Prats and Comelles 2020).

Interestingly, in those years there were two periods of self-governing institutions in Catalonia that designed and developed the first hospital administrative and organisation reforms on a regional basis. Those plans were promoted and led not only by political representatives of the Catalan bourgeoisie but also by medical representatives eager to participate in the political transformation of that society. In the years of the Mancomunitat de Catalunya (1914-1924),

reforms were planned under the idea of a rationale efficiency stemming from the unification of the local healthcare resources in the more than 50 small hospitals into a new hospital division based on the “comarca,” a new political and territorial concept. Meanwhile, this self-governing institution defrayed a portion of the healthcare costs through the public investment in 28 of those small hospitals, but without any kind of intervention in the direction of those institutions. Despite the suppression of the Mancomunitat de Catalunya by the dictatorship of general Primo de Rivera in 1924, its policies and plans regarding hospitals were executed by the Diputació de Barcelona with the establishment of public hospitals, such as the Clínica Mental in Santa Coloma de Gramenet (1926) and the *comarcal* hospitals of Vilafranca del Penedès (1928), Igualada (1929) and Vic (1931). A second stage of self-governing institutions started in the years of the new Spanish Republican government (1931-1939) that allowed the re-establishment of the old institution of the Generalitat de Catalunya. The recovery of plans was reinforced with powerful and reflective medical reports and this allowed a new legislation in 1934 that planned new *comarcal* hospitals, while still observing its jurisdiction and autonomy in the management of those hospitals. The political situation in the country impeded a whole application and only the Hospital de Sant Bernabé in Berga acquired the condition of a *comarcal* hospital (1936) with the obligation to attend patients of that area in exchange of a public investment. The outbreak of the Spanish Civil War (1936-1939) and its result led to abandoning those hospital plans and reforms, which were the first experience in Spain to organise the whole healthcare system in a hierarchy that included somatic and mental illnesses alongside social work (Sabaté 2017).

In the interwar years, an important novelty appeared in Barcelona that was related to the already consolidated process of private surgery clinics and laboratories. In contrast to those institutions,

some of which were family businesses but all governed by a single owner that acted as a medical entrepreneur, the new Institut Ginecos (1924) and Institut Policlínic (1926), also known as *Clínica Platón* because of the name of the street where it was located, were mercantile societies, organised by specialties, integrating a management and architectural design inspired by the American hospital model (Casares and De Fuentes 2001).

The instauration of the Franco dictatorship (1939-1975) did not bring about general hospital reform, regarding the provincial and municipal hospital. That meant the persistence of the domestic hospital organisation throughout that period. Francoist families divided up healthcare responsibilities. Falangists, a fascist party that supported Franco's *coup d'état*, developed a healthcare system – so called SOE that stands for *Seguro Obligatorio de Enfermedad* (a compulsory sickness insurance) – since 1942. It was ruled through a Social Welfare Institution under the control of the Ministry of Labour and covered general medical consultations, delivery care and some surgical operations for the working classes. Despite a theoretical proposal based on an institutional hierarchy of outpatient centres (ambulatorios) and hospitals (residencias), a profound lack of funding to build a network of resources and even to overcome a negative image of them once inaugurated forced the SOE managers to contract medical services with private clinics and with private and public local hospitals. Moreover, military, monarchic, and Catholic families took control of the General Health Board – the *Dirección General de Sanidad* – under a different government office. They oversaw the charitable provincial and local institutions as well as state hospitals devoted to specific diseases, such as tuberculosis and mental disorders. In the end, there was no coordination, and frequent conflicts between those families and institutions. Beyond this, between 1942 and the implementation of the new Social Security Healthcare in 1967, the hospital became the cornerstone of the state healthcare model,

but the lack of funding and human resources delayed its general acceptance by the Spanish population (Vilar-Rodríguez and Pons 2018a). In Catalonia, middle-classes in cities and the rural countryside embodied a healthcare culture that put full trust in private clinics as a resolute medical institution and that meant a growing affiliation for private mutual insurance companies and associations. So, despite the number of medical problems solved in the private medical consultation at a doctor's surgery or at the patient's home, surgical problems and delivery care reinforced the medicalised behaviour of lay people through the recognition of effectiveness in private clinics (Barceló-Prats and Comelles 2020).

Since the 1950s criticisms of the Francoist healthcare model grew among medical doctors of the College of Physicians of Barcelona. They worked as a think-tank to propose a major healthcare reform with the hospital as its cornerstone. This meant the introduction of international hospital theory and practice and the production of reports and studies both for specific hospital cases and for the whole region of Catalonia. Some of those scholars were trained in the United States and could adapt that knowledge to the main big hospitals of Barcelona in the 1960s and early 1970s (Fernández Pérez 2021). This resulted in the establishment of a hierarchical model of organising the hospital and the creation of new medical services, such as the emergency care, coronary and intensive care units (Barceló-Prats, Comelles and Perdiguero-Gil, 2019). This happened first in several hospitals in Barcelona: the Hospital de la Santa Creu i Sant Pau served as a model for the reforms in Hospital Clínic i Provincial de Barcelona and Hospital del Mar (Bohigas 2020). This new understanding under scientific and technical management of the hospital was also introduced in the hospitals created by the Social Welfare Institutions – which were known under the name of *residencias* – such as those of Vall d'Hebron in Barcelona, Joan XXIII in Tarragona or Verge de la Cinta in

Tortosa. This process coincided with other demographic changes that took place in Catalonia – in small cities this resulted in the end of contracts with private local hospitals and in some cases even its closing – and Barcelona – grassroots associations had a fundamental role forcing changes in healthcare areas related to community medicine – and that required a reform of the healthcare system and not only of the hospital care provision (Pons-Pons and Vilar-Rodríguez 2019).

A new period of democracy started in the Spanish society following the death of Franco. In the late 1970s a growing number of voices from the medical profession, regardless of their ideological differences, claimed an extensive right to health that went beyond hospital reform and included other issues such as primary care, disease prevention, and health education. However, the importance of the hospital and its effectiveness was a determining factor in the Spanish health reform that led to the new General Health Act of 1986 (Perdiguer-Gil and Comelles 2019). Primary care had a decisive role in the new legislation, but under a hierarchical model where all the healthcare system depended on the hospital, in regional terms -local and *comarcal* – and conceding a central role to the city of Barcelona (Vilar-Rodríguez and Pons-Pons 2018b) –. The introduction of a National Health Service was implemented by the Generalitat de Catalunya that was restored in 1977. Social and health responsibilities were transferred to the Catalan government in the following years. In 1980 an initial survey of the hospital situation in Catalonia was designed and in 1981 the new institutions that were to regulate and manage healthcare in Catalonia were created: *Institut Català de la Salut* (Catalan Health Institute) and *Xarxa Hospitalària d'Utilització Pública* (the Public Use Hospital Network). In the 1980s, the Catalan healthcare model acquired a definitive mark of hospital centrism with primary care and other medical services subordinated. The Generalitat de

Catalunya was in the hands of a nationalist and conservative political party between 1980 and 2003 and in those years this healthcare system was developed in a distinctive way. Not only did the hospital continue to play a central role, but it was necessary to rationalise and adequate the provision to the different needs according to demographic, territorial and economic issues. As the public provision of hospitals was insufficient, a decisive measure was to use the old network of public and private local hospitals and turn them into new and hierarchically organised health and social resource through contracts. Remarkably, the historical genealogy elaborated by the government of the Generalitat de Catalunya in the process of building the so-called Catalan health model considered the policies and plans designed in the first third of the 20th century as a precedent of the new model, which was understood as “a mixed healthcare model that integrates a unique network of public utilisation of all the healthcare resources from public and private ownership” (Reventós and Piqué 1990; Sabaté 2015).

3. Contributions to the literature on the history of the Catalan mixed model of hospital system in this special issue

This special issue summarises the historical evolution of the mixed Catalan model of the hospital system. Contributors of these articles provide a range of arguments that allow a clear understanding of the nuances of the Catalan model as part of the Spanish political frame from the end of the 18th century to the first decade of the 21st century. Such distinctive evolution has historical roots. Some of them originated in the distant past of the 13th and 14th centuries when local authorities of Barcelona started to define and shape an extraordinarily strong hospital system. A model based on a public management that went to public and private funding to cope with social and health problems. Not only was this model replicated in other Catalan towns and villages in the following centuries, but it also remained intact until it was threatened from the

end of the 18th century in the context of an incipient capitalism. In the 19th century, industrialisation was a driving force that changed the Catalan society alongside the liberal creed of the new Spanish state. A final determining historical factor comes from the ideas and actions planned or developed throughout the three periods of self-governing institutions that featured contemporary Catalonia. How the Catalan society confronted that social, economic, and political changes and how the responses configured a distinctive Catalan mixed model of hospital system constitutes the aim and contributions of this special issue.

In the first article, economic historians Jerònia Pons and Margarita Vilar try to statistically understand the roots of the hospital system in Catalonia between the years 1870s and 1930s. What were the historical reasons for the greater importance of private hospitals in Catalonia compared with Spain as a whole? Or why municipal hospitals predominated in the public sphere? They find answers both in the long-term and in the features of an industrial society and this allows them to describe an almost complete configuration of that model of hospital care in the 1930s. Interestingly, they add new arguments to the answers developed by most municipal hospitals as a reaction to the liberal legislation regarding beneficence in the last third of the 19th century. Thus, strategies of privatisation allowed members of the elite and professionals to not only keep the governing bodies of hospitals and the proximity of healthcare premises, but also “maintaining ownership of the entity and evading public scrutiny and auditing”. They also observe that the first political attempts to shape a sustainable hospital network were based on those existing and economically fragile local institutions planned by the self-governing Catalan administrations in the 1910-1920s and in the 1930s. Two military dictatorships doomed to failure those plans that tried to rationalise the territorial hospital provision according to political,

economic and professional criteria, “but without altering the prevailing model of the private hospital system”.

The establishment of private surgery clinics in late 19th-century Barcelona and its impressive growth in the first decades of the 20th century is the issue raised by historian Alfons Zarzoso. Here, it is shown that this happened in an open medical market where surgeon-entrepreneurs developed several commercial strategies to meet a growing demand. Private surgery clinics participated in the shaping of a model that transformed the clinical practice in technological terms and fostered a process of medical specialisation and contributed to stimulating the medicalisation of the Catalan society – mainly in the urban popular classes – on behalf of medical effectiveness. The surgical clinical care model was an alternative to the non-profit, charitable public and private hospital, and thus played a fundamental role in the establishment of a private medical care model, based on payments for surgical interventions and hospital stays, and paid for by private insurance companies, mutual aid associations or individuals.

In line with the idea of how new sites of science played a key role in the building of effectiveness and the process of medicalisation, Paloma Fernández-Pérez and Cristina Sans focus on the Grifols laboratories as an excellent case-study that allows to see the early integration of a small modern laboratory in the healthcare district of Barcelona since the 1880s until the mid-1950s. The loss of archival evidence about these kinds of institutions makes the extent of this contribution even greater. By studying the foundations of the scientific and business practices of this family firm, they demonstrate how intangible assets related to early embedded high standards in knowledge creation, knowledge transfer and outward looking attitudes are crucial when attempting to transfer entrepreneurship in the long run, and make a small business become a large company in the competitive field of health activities.

Words are always burdened with ideology and those such as clinics, institutes, polyclinics, or residences – that is, the institutions that acted as hospitals since the late 19th century but avoided the negative connotations of the name through this communication strategy – not only were clear examples of medicalisation but also of the shaping of a popular medical culture that made the hospital a nuclear institution of health. Josep Barceló and Deborah Bekele offer insights into the roots of hospital centrism in 20th century Catalonia. This approach also situates in a historical context why primary care, prevention of disease and health education had a subordinated position. They show that all attempts made by Catalan reformers in this period to transform the healthcare model had in common decentralisation policies as a key factor to make the hospital a cornerstone in the provision of health services.

The contribution by Paloma Fernández is the first research paper that proposes using hospital beds as a long-term indicator to compare the evolution of hospital systems in the world. It confirms that the beginning of the modern increase in the number of hospital beds per capita in Catalonia did not take place during the Franco regime or the Golden Age of growth of capitalism in the world, but before the Civil War and before World War II. Such growth was maintained throughout the 20th century up until the 1980s. After the 1980s, the article demonstrates that in Barcelona, as in the rest of the world, there was a reduction in the number of hospital beds per capita that took place in most countries of the world except for a good number of communist countries, Germany, Japan, and a small number of other countries. Even if still fragmentary, the reconstruction of comparable figures on hospital beds, as shown in the case of Barcelona, suggests that for the earliest period between the 1900s and the 1930s there was initially a rise in the number of hospital beds per capita in the Western world. As this process took place in times of sharp mortality decline, demographic growth, and improvement

of life expectancy, the article suggests that there was a connection between these changes and the increase in hospital beds in the new modern large hospitals that needs to be further explored with more research into hospital archives.

That hospitals are not isolated entities, or the result of patronage of elites and institutions, is clear in the study by Carmen Vila on the origins of the emergency service at the Hospital de Santa Creu i Sant Pau after 1967. In this article the contribution of the community, of associations of neighbours, and the influence of networks of physicians and nurses with a clear willingness to introduce modern management practices from other countries in the hospitals of Barcelona are visible. Carmen Vila highlights, with a variety of historical sources, how the needs and the strength of the neighbourhood of the hospital were a driving force in the origins of the emergency service in this large hospital. She also emphasizes the figure of Carles Soler Durall who was in charge of organising the team that would establish that first emergency service. He was the son of a bacteriologist from the Hospital d'Infecciosos (known today as Hospital del Mar) who had gone into exile to the United States. He had wanted to specialise in microbiology at Yale, but the untimely death of his father made him switch focus onto hospital planning and management techniques. Once he returned to Spain, the President of the Provincial Council of Asturias, José Lopez Muñiz (1916-2005), took him on as manager at the General Hospital of Asturias where he carried out the duties of both manager and medical director by applying American techniques of hospital management.

The influence of local forces in the modernisation of hospitals in some European regions through the example of Catalonia is thus one of the most important general findings of this special issue. As in the other articles, Lluís Bohigas studies this feature from a legal perspective, by studying how self-government in Catalonia and the healthcare policy of the Generalitat de

Catalunya has integrated private not for profit care in the public healthcare service after the 1980s. The main objectives of the Generalitat's hospital policy between 1980 and 2020 have been, according to Bohigas, to keep the participation of city councils in hospital governance and to improve hospital efficiency. In 1980, half of the hospitals providing public healthcare were linked to the City Council of the town where they were based. Some municipalities had invested in the construction of hospitals and their maintenance, as was the case with Barcelona City Council, but most hospitals were private foundations. By 2020, half of the hospitals linked to local foundations were still in operation, while the other half had been transformed into consortia with the Generalitat in majority control and local councils, and in some cases the original foundations, holding minority stakes. Consortia and public companies were the legal formulas chosen by the Generalitat to preserve autonomy in the governance of the hospitals. However, Bohigas indicates that in the last decade, some restrictions have appeared related to the management autonomy of hospitals in Catalonia, due to the integration of consortia and public companies into the European Accounting System (SEC 2010), and to budget reductions for 2010 and beyond with the financial control imposed by the Treasury Department to reduce the public deficit.

Finally, Ferran Sabaté's study about the sources for the study and research of the Catalan health model indicates that despite fragmentation of sources there are abundance of them because of the wealth of institutions and centres that have developed modern medicine and hospital practice in Catalonia since medieval times up until today. Sabaté suggests that the diversity of approaches makes it necessary to consider that the analysis and study of the Catalan health model could be performed from different perspectives: anthropological, economical, legal, historical, institutional, and comparatively with other models. Sabaté presents a definition of

the Catalan health model, divides its main evolution in the 20th century in three different chronological stages, and organises the identification of main archives, libraries, and sources of study for each stage, thus providing an organised research agenda for scholars.

4. Further research

A fruitful history of the Catalan healthcare model has been produced in the last decade. There are a growing number of studies that have outlined a big picture for Catalonia as a whole. Contemporary historians interested in economic, social, political, and cultural aspects have established the main lines of that research. This special issue is a good example of such results. However, there is much work ahead. Given the importance of historical records and the loss of a great number of sources about healthcare provision in Catalonia, an important aim should be the construction of a catalogue of materials, the identification of gaps and the search for and preservation of private historical records. It should also constitute a main objective in this area the recovery of oral accounts that can explain what happened in the last third of 20th century Catalonia. In recent years, the Catalan Medical History Museum has made available through digitization several medical and professional journals that were published by surgeon-entrepreneurs and by medical institutions (such as the College of Physicians of Barcelona). But much remains to be done in this area. It is necessary to remember the usefulness of this type of digital resource to understand medical practices and strategies, visual resources or debates on health service provision policy in Catalonia and Spain in the 20th century.

Despite the number of studies on local hospitals, it seems necessary to foster this kind of research across the country to understand the relationship of local elites and professionals and to outline their attitudes before liberal legislation and their position before the population that

resorted to this type of healthcare provision. Local history is a useful resource to approach the countryside for a better understanding of a world wrongly considered as monolithic. There are several subjects that could be raised in this area such as the relationship between towns and villages, responses to technological change, degrees of medicalisation, strategic uses of provisions resources, funding, architecture, and so on.

Mutuality and its associated aspects of friendly societies and insurance companies is an issue that has received great but sporadic attention in recent decades. However, there seems to be some research pending on this subject. A systematisation of sources and approaches would be desirable, especially throughout the 19th and early 20th centuries, not only in Barcelona and its industrial districts, but also in the industrial cities surrounding the capital. Thus, it could be remarkable to understand the relationship between these mutual aid associations and doctors and to see how private surgery clinics contributed to a growing medicalisation of the urban working classes. In this sense, it would be useful to establish relationships between these sources and the historical medical records of the surgical clinics. In the same vein, clinics and small hospitals established by factory owners throughout the country need intensive research. A good example is the case of the radiator manufacturer Roca, which established a hospital in the 1950s in Viladecans-Gavà, near Barcelona (Alcaide 2013). In addition, this case is also useful for considering grassroots movements in medium-sized towns and cities as driving forces for changes in the provision of hospitals and public medical services in the 1970s. Much remains also to be done in the network of locally developed planning centres, mainly in the industrial metropolitan area of Barcelona (Fajula 2017).

Technology is also a dramatic key factor in this area of research. It is a topic with many analytical perspectives, but there are two sides to it. On the one hand, we see the introduction

of technology in the hospital as a sign of progress and an investment in better health care. On the other hand, the growing technological medicine not only contributed to the dehumanisation of the doctor-patient relationship, but its high cost put the survival of the health care model at risk. There is much research to be done in these areas. Technology also means the circulation of knowledge, adapting it to the local context and training personnel. This indicates the need to study networks of medical equipment suppliers and local technical concerns at different geographical scales, their relationship with the academic environment not only in terms of training but also as part of their communication activities through conferences and exhibitions. Technology is also crucial to understand the new ways of understanding human diseases and this is of utmost importance to study the relationship between clinical rooms and laboratories that were established in the city as family or individual businesses. Along with technology is architecture, and the design of comfortable spaces as well. There is a lot to do in this field of study. The archives of the College of Architects of Catalonia are extraordinarily rich and, likely, will be able to provide arguments as to how science informs design, how healthcare spaces are built and transformed, how these places are negotiated between professionals, contractors and managers, etc.

A general survey of the medical records of the hospitals in Barcelona shows rather poor results (Fajula 2021). This is disappointing as far as the large hospitals are concerned, especially the Hospital Clínic or the Hospital del Mar. In the case of the surgical clinics, as well as for many small laboratories and diagnostic sites, the situation of the archives is even worse. A large number of these small medical centres disappeared, and their records were not kept. Without doubt, the most important and complete archive belongs to the Hospital de Santa Creu i Sant Pau. The research options there are enormous. One of them is related to the development of the

administration and organisation of the hospital since the 1920s, which has been rather neglected until now. In contrast, the introduction of scientific management in the 1960s and 1970s has received considerable attention. The records of this archive also allow consideration for the introduction of engineering and information technology policies to study changes in both medical practice and management administration. Along these lines, cost control efforts and health care rationing are also areas that need further research. This hospital could also be an excellent case study of how local elites, but also many ordinary citizens, showed their charity by donating money or even medical equipment. This practice was publicly acknowledged in the medical press and there are interesting photographic collections that can complete this type of approach.

The relationship between politics and the development of public and government health policies that began in Catalonia in the 1980s is also an area that needs to be explored. During this period, the consolidation of a politically peaceful health model – praised for the excellence of its medical professionals and for the range of quality of medical services – has run parallel to the reporting of scandals and cases of corruption throughout the country that took advantage of the blurred lines of the public and private model (Sánchez Bayle 2013).

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