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## Historical roots of hospital centrism in Catalonia (1917-1980)

### *Abstract*

The aim of this article is to analyse the roots of the Catalonia health reform, whose first projects on reform have been documented since 1917. This historical process set-up, in Catalonia, a hospital-centric model involving three sets of regenerating and mutually reinforcing institutions: financial resources were being disproportionately distributed to hospitals, high-quality medical professionals were largely concentrated in hospitals and large outpatient departments were incorporated in hospitals, which functioned as a first point of care for many patients. Based on these premises, the intention is to contribute to the understanding of the initiatives that, during much of the 20th century, took place in Catalonia with the aim of bringing access to hospital services to the population. These same organising principles also had decisive influence on hospital planning in the rest of Spain. As such, we develop an historical approach to public policies that have been shaping the current imbalance between hospitals and primary care providers in Catalonia by combining two methodologies. On the one hand, an overview of the existing literature on this topic. On the other, an accumulation of case studies –which does not claim to be exhaustive– the result of this very research and that of other specialists in the object of study. As Catalonia still has a hospital-centric health system seeded throughout the 20th century, these findings can inform the framing of contemporary options for primary care strengthening. Without addressing these deep regenerating causes using a whole-system approach, Catalonia is unlikely to achieve a primary care orientation for health system development.

**Keywords:** Hospital centrism; Health reform; Catalonia; History

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## Introduction

In Spain, analysis of and proposals for health reform were not frequent until the mid-1970s – between the end of the Franco dictatorship and the beginning of Spanish Transition<sup>1</sup> – (Vilar-Rodríguez and Pons 2018a). Most of these studies agreed on the need to launch a national health service, with universal coverage, financed by general budget of the State (Perdiguero and Comelles 2019a). Until then, the Spanish health system had been characterised by chronic lack of investment, a circumstance that began to change after the 1977 tax reform, and due to the lack of coordination between the different publically and privately-owned health services (Vilar-Rodríguez and Pons 2018b). These and other reasons, such as those of a geographical or demographic nature, had set-up very unequal territorial distribution of said services which never aided, rather on the contrary, access for a significant part of the Spanish population to healthcare resources, most particularly among the rural population (Barceló-Prats and Comelles 2018).

Nonetheless, it should be considered that after the 1978 Constitution the Spanish “health reform” was, above all, a “hospital reform” (Perdiguero-Gil and Comelles 2019b). Although attempts were made to change the focus of the health system from a model based on curing the disease to one focused on its prevention and health promotion, the truth is that majority of health expenditure was dedicated to hospital and specialised services<sup>2</sup> (López-Casasnovas 2015, 35-38). For this reason, even though the General Health Law of 1986 established primary health

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<sup>1</sup> The Spanish Transition is the process by which Spain left behind the dictatorial regime of General Francisco Franco and came to be governed by a Constitution that restored democracy. There is certain consensus in placing the beginning of the Transition at the death of General Franco, on 20 November 1975, and its culmination with the entry into force of the Constitution that was ratified by the 6 December 1978 referendum.

<sup>2</sup> This trend has continued to this day. For example, in 2016, more than 60% of consolidated public health spending in Spain, according to functional classification, was dedicated to hospital and specialised services (Lillo-Fernández and Rodríguez-Blas 2018).

care as one of its basic pillars, the hospital-centric culture<sup>3</sup> continued to be predominant in the design of health policies during the last three decades. At this point, it must be pointed out that hospitalocentrism is not only characteristic of the Spanish health system. It also occurs in many other countries such as, for example, China (Xu, Gorsky and Mills 2019), and that is why the 2008 World Health Report already warned “health systems do not spontaneously gravitate towards primary health-care values, in part because of a disproportionate [...] hospital-centrism” (WHO 2008). In order to understand this situation, one must consider, from a historical perspective, the reasons for the hegemony of the hospital (Comelles, Alegre-Agís and Barceló-Prats 2017) and the subalternity of primary care, as well as the prevention of disease and health education (Perdiguero-Gil 2015).

On the other hand, it should also be mentioned that the planning of the Spanish health system was conditioned by the deployment of territorial organisation of the State. The consecration, by the Spanish constitutional legal order, of the Autonomous Communities as territorial and administrative entities endowed with a certain legislative autonomy, as well as certain executive powers, implied a slow process of sanitary decentralisation that was carried out in various stages (López-Casnovas and Rico 2003) and was not completed until 2002 (Cantarero 2003).

All this makes the Spanish health system an interesting case study, since it is linked to its universalist vocation by its decentralised nature. Some authors suggest “the building of the Spanish NHS has not apparently been impeded but rather fuelled by the parallel process of federalisation” (Rico and Costa-Font 2005, 231). According to this perspective,

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<sup>3</sup> Hospital centrism should be understood as a concept that situates the diagnostic and therapeutic capacity of the hospital at the top apex of the health system and its policies. Hospital hegemony with respect to the rest of the healthcare establishments is also given by its value as a fundamental space in the training of healthcare professionals. During the 20th century, then, these processes contributed to definitively change the collective imagination of the hospital on part of the citizens (Comelles, Alegre-Agís, Barceló-Prats 2017, 57-61).

«decentralisation» would have brought health services access closer to all citizens by wagering on a more egalitarian socio-political structure that, in addition to promoting innovation and policy change, was compatible with «some regional diversity» and prevented the risk of territorial inequalities<sup>4</sup> (Rico, González and Frayle 1999). Certainly, decentralization is not specific to the Spanish hospital system either (Bernal-Delgado et al. 2018), since it also occurred in other states, whether federal such as Germany (Busse and Blümel 2014) and Switzerland (De Pietro et al. 2015) as well as in other countries centralised *a priori*, like France (Chevreul et al. 2015). In this sense, it should be noted that there are many countries in which local governments have played an active role in shaping health systems. However, although the formation of a coordinated hospital system is a general phenomenon that can be observed in the United States, since the beginning of the 20th century, and in Western Europe since the end of World War II, in Spain this development did not have place systematically until the end of the seventies (Barceló-Prats, Comelles and Perdiguer-Gil 2019, 162).

Focusing on the region under study in this article, Catalonia was the first Autonomous Community to receive powers on health-related matters<sup>5</sup>. The effective transfer of these powers allowed the *Generalitat* of Catalonia (as is the official name of the current local government)

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<sup>4</sup> With nuances, the large part of the evaluations on the effect of the healthcare power transfers to the Autonomous Communities indicate that health inequalities have not increased (López-Casasnovas, Costa-Font and Planas 2005; Rico and Costa-Font 2005; Costa-Font and Rico 2006; Costa-Font and Turati 2018). From a comparative perspective, similar arguments are defended (Costa-Font and Greer 2013; Alves Peralta and Perelman 2013). Nevertheless, the level of citizen satisfaction with health services has not only not improved the transfer process, but also created greater disparities (Antón et al. 2014). The difference in evaluations of quality of regional health services is also notable (FADSP 2015).

<sup>5</sup> In relation with these competencies, everything included in the Statue of Autonomy of Catalonia was regulated by Royal Decree 1949/1980, of July 31, on transfers of State services to the *Generalitat* of Catalonia on health and social assistance service matters.

the preparation and deployment of the first Catalan «health map» (Generalitat de Catalunya 1980a; Generalitat de Catalunya 1980b; Clos, Seculí and Segura 1980).

The development of this «map» (Generalitat de Catalunya 1983) which, in addition to taking stock of and evaluating the existing health resources in Catalonia, presented a proposal for health zoning, making it possible to carry out directives that regulated the accreditation of the health centres and facilitated the start of two main lines of healthcare services; on one hand, the Primary Care Reform and, on the other, the creation of The Network of Hospitals of the Catalan Health System and the Hospital Reorganisation Programme. These set of initiatives and reforms, including the Primary Care Reform, presented the hospital institution as the cornerstone for a health care network coordinated by the hospitals itself, but which exceeded its limits. Without any doubt, this formulation reinforced the foundations of a hospital-centric culture that, since the 1970s, the population had been integrating from contact within a hospital approach that was becoming highly technical and with well-trained medical specialists thanks to the development of the Spanish Specialty Training system (Tutosaus, Morán y Pérez-Iglesias 2018). Of course, the role of new technology in the organization of the health system deeply impacted hospital planning in many countries and, in addition, it implied major changes in their respective health markets, the effects of which boosted the development of health industries” (Donzé and Fernández-Pérez 2019). Although it would be very interesting to analyse how this new reality modified the financial equilibrium within the Catalan health system and determine if this produced a competition or collaboration between public and private sectors (Pons and Vilar-Rodríguez 2019), our research question, due to the limitations of space, has focused on responding to, from a purely historical perspective, to why the roots that shaped the current

Catalan health system can be found long before the debates held during the Spanish Transition (Barceló-Prats, Comelles and Perdiguero-Gil 2019, 161-162).

In this sense, the main singularity of the Catalan case doesn't consist of being the first to receive and exercise powers that, until then, had fallen under the State, but in verifying that the aforementioned health map "had not started from scratch as would happen in other Spanish regions, already since 1917 studies already have been carried out on the health reality in Catalonia and the factors of change that have almost reached to present day."<sup>6</sup>

This text seeks to contribute to the understanding of the debates that, during much of the 20th century, took place in Catalonia whose aim was to design and implement a comprehensive health plan. The design of the Catalan health system had a decisive influence on hospital planning in the rest of Spain and served as the basis for accrediting the quality of Spanish hospitals through the standards established by the international hospital doctrine. To do this, this paper will, firstly, describe the hospital planning initiatives developed by the different regional governments in Catalonia between 1914 and 1939. These proposals were already aimed at coordinating the Catalan hospital system to address the existing deficiencies in healthcare and to respond to the growing demand of medical care that could no longer be absorbed by the structures of liberal charity. Finally, after analysing the complex hospital panorama in Catalonia during the first Franco regime, special attention will be paid to the less-known elements of the hospital planning projects that emerged in the 1960s and 1970s, the results that influenced the major reforms during the following two decades and whose practical

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<sup>6</sup> Aragó, Ignasi. 1980. "Descentralización, base de la sanidad catalana." *La Vanguardia*, October 30, 29.

application determined the hospital-centric design of the 1980 Catalan health map (Reventós, García and Piqué 1990; Nadal 2016; Asenjo 2017; Bohigas 2020).

### **1. The beginnings of health planning in Catalonia (1917-1939)**

Spain, from the 1849 Welfare Law and the 1955 Health Law (Carasa 1985; Maza 1991), opted for a health policy that concentrated hospital care in provincial capitals, distant from rural populations (Comelles et al. 2020). This situation not including highly industrialised regions such as Catalonia (Barceló-Prats and Comelles 2020) and the Basque Country (Pérez-Castroviejo, 2002). Due to the lack of a fiscal reform, the Spanish hospital system never disposed of the necessary investments to employ enough medical personnel or technologies (Carasa 1991). This implied that the State had to resort to religious-and-private-owned institutions, mainly, to be able to guarantee the care of, at least, the most vulnerable groups (Pons and Vilar-Rodríguez 2017).

This precarious welfare situation, centralised in the provincial capitals, could not be extrapolated to all Spanish territories. Focusing on Catalonia, its early proto industrialisation (Marfany 2013) also implied that the process of medicalisation of Catalan society was quite pronounced by the 18th and 19th centuries (Zarzoso 2006). The rapid insertion of Catalan society into capitalism and the establishment of industries throughout its territory – textiles along its rivers, cork along the northern coastline, and sales of spirits in the southern coast, among others – , played a key role in the demographic growth through all of Catalonia and, obviously, also in the increase in population in Barcelona, its main city. Taken together, these conditions fostered collective awareness of the need to have profuse health services throughout Catalonia. These same circumstances also explain the proliferation, since the last third of the

19th century, of a powerful private medical market, characterised by the creation of small diagnostic centres and surgical clinics (Zarzoso 2017), as well as the recent emergence of mutuals and other private health insurance (Duch 2019).

By the twentieth century, the first proposals to respond to the concern about hospital management problems in Catalonia have been well-documented (Calafell et al. 1967, 184), the pioneer of which was the communication titled: “Hospitalisation in Barcelona”, which Dr. Higinio Sicart presented in the 1st Congress of Doctors of the Catalan Language in 1913 (Sicart 1913). This study gives a damage report assessing the then existing health resources in Barcelona in 1912 and makes a proposal of how many hospital beds would be needed to respond to the medical care needs of that moment (Pardell 1973, 105; Sabaté 1993, 118).

It was not until 1917 when the then regional Catalan government, known as the *Mancomunitat* (1914-1925), commissioned Dr. Jacint Reventós to draw up a proposal for the hospital regionalisation<sup>7</sup> of Catalan hospitals (Balcells 2015, 83). Although it never was implemented, this proposal is considered as the precedent of all hospital regionalisation plans in Spain (Sabaté 2015a, 77). It was also a turning point for Catalan doctors to become interested in the organisation of hospitals as a measure to increase their health efficiency.

However, due to the great demographic growth that Catalonia underwent, a result of being a territory with an elevated rate of immigration from many other regions in Spain, resulted in an exponential growth in the healthcare needs of the population, as a whole. According to a study on hospitalisation in Barcelona in 1933 (Mer 1933), the Catalan capital suffered a deficiency

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<sup>7</sup> The concept of «hospital regionalisation» refers to “a complex mechanism of technical and administrative decentralisation that includes the establishment of levels of care that go from community’s primary care health centre to the general hospital and speciality hospitals” (Bravo 1974, 231). In short, it is about the organisation and coordinated operation of health services in both rural and urban areas.

of more than 4.000 hospital beds (Mer 1933, 4). This was the precocious health situation that, with the advent of the Second Spanish Republic (1931-1939), the recently reinstated regional government of Catalonia, under the name of *Generalitat*, was forced to manage. As such, one of the first petitions made by the *Generalitat* to the still Spanish Provisional Government of the Second Republic was to have legal authorisation to be able to carry out “the necessary studies leading to the establishment of structuring plan for health services in its various aspects”<sup>8</sup>. Once this authorisation was granted, the *Generalitat* commissioned different medical institutions to draft the corresponding reports (Pardell 1973, 106; Sabaté 2015b, 6).

The report that most influenced the subsequent drafting of the health laws by *Generalitat* was that written by Dr. Enric Fernández Pellicer (1932, 387-408), the title of which was Hospital Organisation in Catalonia: practical solutions. In its drafting, it was stated that “all hospitals have to be considered as institutes of public utility and, consequently, be subject to the power of due vigilance by the public and to regulations inspired by the modern norms, both scientific and economic, of social assistance” (Fernández-Pellicer 1932, 387). It concluded by stating “a hospital can no longer be more be an island. Hospitals need to complement one another” (Fernández-Pellicer 1932, 408). Therefore, then, following the recommendations of the Conference on Rural Hygiene of Europe<sup>9</sup>, held in Geneva in 1931 at the proposal of the League of Nations, this proposal classified healthcare centres into three types: “primary” (rural hospitals), “secondary” (county hospitals), and “tertiary” (district hospitals), meaning the

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<sup>8</sup> *Gaceta de Madrid*. 1931. 142 (May 22): 866-877.

<sup>9</sup> Publication number C. 473.M.202.1931.111 from League of Nations (SDN). <https://iris.paho.org/bitstream/handle/10665.2/10471/v11n3p246.pdf?sequence=1&isAllowed=y>

existence, at the top of this medical hierarchy, referral hospitals for the entire region of Catalonia (regional hospitals).

Many of the proposals contained in Fernández Pellicer's report influenced the drafting of the Basic Law for the Organisation of Health and Social Assistance Services in Catalonia that the *Generalitat* passed in 1934 (Peláez 1982). This was possible thanks to the fact that the *Generalitat*, unlike the *Mancomunitat* – its predecessor – did have power to legislate, control, inspect, direct and organise health and social assistant services. The practical application of the aforementioned law configured a health map that divided Catalonia into twenty health zones, using the main Catalan cities as points of reference. Once the law was fully implemented, these twenty territories would have had, at least, a district hospital, a laboratory, and a charity-assistance establishment.

For the first time, in Spain, a legislative design broke with the structure of liberal welfare, in force since the second half of the 19th century, and no concentrated all hospital equipment in the capitals of each province in order that the majority of the population could have rapid access to hospital care. However, the outbreak of the Spanish Civil War (1939-1939) modified the deployment and implementation of this novel health model. Due to space limitations, we cannot tackle here what happened in Catalonia, in terms of health, during the war, the consequences of which implied the adoption of radical organisational measures, both at the civil and military level (Hervás 2014).

## **2. The hospital system in Catalonia during the first Franco regime (1939-1955)**

After the Spanish Civil war, the beginning of Franco regime put a halt to all the reforms that, in terms of health, had been developing during the Second Republic by the *Generalitat* of

Catalonia. In 1939, for reasons previously described, the health system in Catalonia was much more complex than in other regions of the Spanish geography, and given the ample network of municipal and religious-own hospitals, as well numerous private clinics, it served patients coming from a profound network of labour mutuals or those who had private health insurance.

However, after a short time, the emergence of a new element would change the Spanish hospital landscape forever. At the end of 1942, aware that the control on social action was indispensable in order to ensure the adherence of the popular and working classes, the Falangists created the Compulsory Health Insurance (CHI). After overcoming various obstacles for the implementation of this social insurance, initially as if it were a State mutual (Bismark model), the CHI began its operation lacking its own hospitals and having to arrange the care of their affiliates and beneficiaries with other hospitals (Vilar-Rodríguez and Pons 2018c). Only the partisan interest of the Falangists in offering CHI users alternative care to that of the provincial charity, very close to that which could be provided in private clinics or hospitals services paid for by mutual, led to the decision that the CHI had its own network of hospitals, without any incentive to coordinate with the existing ones (Quintana and Espinosa 1944). The main problem with this decision was how to finance a network of new hospitals that demanded a mobilisation of financial resources that neither the autocratic Franco regime nor the late Franco regime could serve without profound fiscal reform. Thus, in 1952, of the thirty-four planned residencies in the 1949 National Plan of Sanitary Facilities, only six were completed.

The design of this new CHI hospital system was Jacobean and depended on a command chain at the top of which was the National Insurance Institute (NII). At the bottom were doctors, both those who practised in rural and urban areas. At the intermediate level were the specialised outpatient departments, and finally, at the top was the new hospital, euphemistically called a

*residencia sanitaria*. This model of pyramidal organisation should be understood as the first attempt by the Spanish State for a network structure, like that of CHI, going beyond the atomised and uncoordinated provincial structure of charities and the private sector. However, the global complexity of this insurance and its dependence on a multitude of administrations made it very difficult to rationalise its management, which ended up producing financial inequalities and discrimination among the population (Pons 2010). This explains, for example, why in 1960 the population covered by the CHI barely reached 50% of the total Spanish population (Solé-Sabarís 1965).

In Catalonia, the first CHI hospital was the *Residencia Sanitaria Francisco Franco* in Barcelona – the current *Hospital de la Vall d’Hebron* – whose inauguration took place in 1955. Thus, between 1944 and 1955 Catalonia did not have NII hospitals for CHI policyholders, even though Barcelona was one Spain’s most populated provinces and with the highest affiliation to this State insurance. At the end of 1955, “the number of those insured by the CHI in Barcelona [was] almost 10% of the national total, and that, together with the capital and the province, reached up to 17%, the former with its 350.000 insured and both with 680.000”.<sup>10</sup> However, the number of beneficiaries, normally the dependents of the insured, was practically double and this implied that more than half of the Barcelona population received some type of medico-pharmaceutical benefit from the CHI.

The reality is that the CHI, in Catalonia, was incapable of meeting the demand for care that increased exponentially every year. For this reason, the CHI had to arrange the services of other Catalan hospitals or clinics, both privately-and-church-owned (León 2019). Although the

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<sup>10</sup> Ezcurra, Luis. 1956. “Una eficaz labor sanitaria ha reducido notablemente la mortalidad.” *La Vanguardia*, January 26, 8.

signing of these agreements signified a considerable economic injection for these healthcare centres, what is certain is that it did not allow the ability to achieve the necessary investments in diagnostic and therapeutic technology, as well as in internal reorganisation and hiring of qualified personnel, to be homologated with the international standards criteria that at that time had on the quality of hospital services. This circumstance condemned these small hospitals and clinics to become obsolete from a technical point a view. Therefore, during this first Franco regime the situation of the Catalan hospital system had become “pathological” (Aragó 1967, 11).

### **3. The first attempts at organization of hospital system (1955-1975)**

In Catalonia, the first proposals to reverse this pathological situation had already been documented during the mid-50s. It was in 1955 when the Official College of Physicians of Barcelona created a collegiate section on hospitals to initiate necessary studies to plan and modernise the Catalan hospital network. One of its first initiatives was the creation of the journal *Estudios sobre Hospitales y Beneficencia* (León and Sarrasquesta 2017), whose publication for more than two decades was key to disseminating international theory on new hospitals, as well as studies and contributions by the most relevant experts who intervened in the Spanish health reform. Some doctors related with the aforementioned section, like Carles Soler-Durall (1928-current), were the protagonists of the pioneering initiatives that promoted the Spanish Specialty Training system and implemented a new internal organisation of the hospitals, with a hierarchal structure, starting with the creation of clinical services. The testing ground for both projects took place in the General Hospital of Asturias (García-González 2011) and, a few years later, in one of the most important Catalan hospitals, the *Hospital de la Santa Cruz y San Pablo* in Barcelona (Soler-Durall 1968). This milestone should be considered the

starting point of a new way of understanding hospitals in Catalonia, the consequences of which ended up placing a clear hegemony on the diagnostic and therapeutic efficacy of the hospital within the health system (Nadal 2016).

However, at the beginning of the 1960s, in Spain, the hospital continued being a healthcare resource that was hardly beginning to be accessible to broad sectors of the public. While in most European countries the rates of hospital attendance,<sup>11</sup> during this decade, ranged between 80 and 120 admissions per thousand inhabitants, in Spain the figure was only 23 in 1960; and 37 in 1969 (Pardell 1974, 28).

Another piece of information that helps to contextualise the dire situation of the Spanish hospital system is the rate of beds, per 1,000 inhabitants. According to data from the World Health Organization (WHO), in 1964, Spain was the European country with the fewest beds per 1,000 inhabitants (Table 1).

**TABLE 1.** Hospital beds in the main European countries

Number of Beds (per 1000 habitants)	Country
13 - 15	Sweden- Ireland
12 - 13	East German – North Ireland- Luxemburg
11 - 12	Austria - France –Iceland – Scotland
10 -11	Czechoslovakia – Switzerland – West Germany - Finland - Italy
9-10	Denmark - Norway
8 - 9	Belgium – Wales – England
7 - 8	Bulgaria - Hungary - Poland - Holland - Romania
6 - 7	Faroe Islands - Malta
5 - 6	Albania - Greece - Portugal - Yugoslavia
4 - 5	Spain

Source: WHO 1968.

<sup>11</sup> Hospital attendance (HF) is calculated by dividing the total number of registered admissions in the country's hospital system during a year divided by the number of inhabitants and the resulting quotient multiplied by a thousand.  $FH = (\text{total number of admissions} / \text{number of inhabitants}) \times 1,000$

The Spanish hospital crisis was more than evident, and the Franco regime was forced, not without difficulties, to enact a series of laws that would allow progress in the coordination and efficiency of hospitals. In the attempt to reduce health service access inequalities amongst the Spanish population, the Hospital Law of 1962, the Social Security Law of 1963 and the Royal Decree 575/1966, of the 3<sup>rd</sup> of March. This last decree made a National Catalogue of hospitals and divided the Spanish territory into 11 hospital regions in order to try providing specialised care for rural and urban population (image 1). However, all this legislation did not achieve its objective of implementing a unitary and integrated model of social protection, since a multitude of overlapping agencies in hospital management and health insurance continued to exist.

The genealogy of the hospital regionalisation, understood as “a complex mechanism of technical and administrative decentralisation comprising of the establishment of levels of hospital care” (Bravo 1974, 231), should be sought in the implementation of the aforementioned hospital section of the Official College of Physicians of Barcelona. Thanks to the dissemination efforts in Spain, the regions began to be considered as an ideal «planning» unit to create, based on them, a coordinated, efficient, and operational hospital network (Barceló-Prats, Comelles and Perdiguero-Gil 2019).

**IMAGE 1.** The eleven Spanish hospital regions according to the Royal Decree 575/1966

Source: AHDB 1972, 138

This new way of planning began with a basic axiom and two technical imperatives. The basic axiom consisted of the “equality of Public Service for all users” (Aragó 1974, 81-85), which was based on the principles of «legal», «economic», and «physical» accessibility for hospital patients. As such, the principal objective of the «hospital regionalisation» was to try to reduce inequality in health service access. The two technical imperatives consisted of assuming the diverse frequency of diseases and optimising diagnostic and treatment services. “Both items completed each other and postulated the necessity to create numerous services for those more

frequent ailments, reserving the specialised and costly services, whose volume of care is less, for the more complex hospital centres” (Pardell 1973, 47).

However, with the exception of the regions of Catalonia (Aragó et al. 1970) and Asturias (Artigas and Asenjo 1971) in which specific hospital regionalisation plans were developed, the true incidence of the regionalisation in the whole of Spain, before 1978, was scarce. In relation with the General Hospital Regionalisation Plan for Catalonia (Aragó et al. 1970), the data it provides allows us to reproduce a very clear photo of the composition of the Catalan hospital system in 1965 (tables 2, 3 and 4).

**TABLE 2.** Data related to the population of Catalonia in 1965 and its number of hospital beds

Catalan Population	Number of Beds (total)	Number of beds per 1000 habitants
4.524.034	25.912	5,72

Source: Aragó et al. 1970, 70.

**TABLE 3.** Number of hospitals and beds in Catalonia in 1965, classified according to whether they were public or private

	Number of Hospitals	Number of Beds	% of Beds
<b>Public Sector</b>	60	10.205	36,1
<b>Private Sector</b>	231	18.039	63,9

Source: Aragó et al. 1970, 68.

**TABLE 4.** Distribution of hospitals and beds according to their membership

	Organising Body	Hospitals	Beds
<b>Public Sector</b>	Ministry of Interior	3	1.141
	Ministry of Labour	6	2.894
	Ministry of Education	1	904
	Provincial Councils	13	3.341
	Municipalities	37	1.925
<b>Private Sector</b>	Red Cross	3	190
	Church	5	210
	Religious Orders	17	4.695
	Private	205	12.902
	Foreign	1	42

Source: Aragó et al. 1970, 69.

By way of comment on all these data, it is important to underline the high proportion of beds dependent on private organizations. These were generally small in size, with an average capacity of 63 beds. In contrast, hospitals belonging to public entities used to be much larger. In 1965, most of the beds in the public sector in Catalonia belonged to hospitals dependent on the Provincial Councils (32.7%) or the CHI of the Ministry of Labor (28.3%). In relation to the bed/population index, in 1965, the average for Catalonia (5.72 beds per thousand inhabitants) was 1.28 points higher than the Spanish one (4.44 beds per thousand inhabitants). However, it was far from the close to and even higher figures of 10 beds per thousand inhabitants that were recorded in European countries with a population similar to that of Spain (Pardell 1974, 25). Finally, if we look at the rates of hospital attendance, in 1967, Catalonia registered a rate of 39.6 admissions per thousand inhabitants, also well below the European average of 100 admissions per thousand inhabitants (Pardell 1974, 28). All this added to the unequal distribution of hospitals within the Catalan territory – the majority concentrated in Barcelona and its metropolitan area – , aggravated the situation of the already weak Catalan and, by extension, Spanish hospital system.

For all these reasons, the health reform proposals of the first half of 1970s once again put on the table the «hospital problem» and the need to resolve the unequal access of health services, especially in rural areas (Comisión Interministerial 1975). Hence, during the Transition the priority of the State was hospital reform rather than health reform, whose most visible consequence was the subalternity of primary care in the design of planning Spanish health system.

## Conclusions

As of 1975, most of the health system reform proposals were published in Catalonia and in all of them hospital regionalisation was a basic issue (Acarín et al. 1976a; Acarín et al. 1976b; Acarín et al. 1977; Solé-Sabarís 1978). For its part, the reinstated *Generalitat* of Catalonia, during its provisional stage (1977-1980), ordered a series of sectoral studies on health and social assistance that served to design the 1980 health map (Generalitat de Catalunya 1980a; Generalitat de Catalunya 1980b). This map, with a clear decentralisation vocation, was inspired by the laws developed, in 1934 by the *Generalitat* during the Second Republic and, thus, reinforced the idea of recuperating the structure of the regions, and not the provinces, as a frame of reference. The objective, yet again, was the necessity to solve the problem of hospital service accessibility, the demand of which –in the 1970s– was much more compelling than half a century before. We can no longer address here how the process of health decentralisation continued or its consequences after the implementation of health transfers to the Autonomous Communities. The entire decade of the eighties, with special attention to those immediately after the approval of the General Health Law of 1986, require detailed attention.

As has been pointed out, the development of different autonomous health systems has not increased health inequalities, but neither has it managed to reduce them, and the differences in their quality are notorious (Costa-Font and Turati 2018). Decentralisation, by bringing access to health services closer to all citizens and placing their management centres in areas closest to them, sought to respond to population health needs, correct inequalities, both interregional and intraregional, and promote innovation.

To conclude, after the decentralisation of the Spanish health system, a hospital-centric model has been maintained, with nuances, despite the rhetoric about services focused on health and not on disease. Although it is certain that the deployment of primary care has improved the proximity and quality of the first point of contact with the health system, the meaning of the hospital in health cultures shared by health professionals and the population remains central. Due to its genealogy, decentralisation has maintained the hegemony of the hospital and has converted into an element of analysis that, along with others, must be considered in current discussions about the health system.

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