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ARTICLES/ARTÍCULOS

The emergence of financial capital in the health insurance business in Europe: The case of Spain in the last fifty years

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Abstract

Sickness insurance companies were developed in Spain by doctors and healthcare professionals, remaining outside the interests of general insurance companies. Their management was hardly professional, with limited actuarial techniques and they only accounted for a small percentage of total insurance business premiums. From the 1970s onwards, various factors changed this situation, driving processes of concentration, with numerous takeovers and mergers, first reducing the number of local and regional companies to the benefit of companies of national scope. Subsequently, the growth in demand for this type of coverage sparked the interest of national general insurance companies and multinationals, leading to a restructuring of the sector which has progressively acquired greater weight within the insurance business and become increasingly internationalised. This last stage immersed the health sector in Spain in the great processes of globalisation of the sector, characterised by a financialisation of capital promoted by the bank investment funds. These processes are little known and are the focus of analysis of this paper, with the aim of enabling comparison at international level.

Keywords: health; business; insurance; Spain; XX-XXI centuries

JEL codes: I13; G22; N84; O16

Resumen

Las compañías de seguros de enfermedad fueron desarrolladas en España por médicos y profesionales sanitarios, quedando fuera de los intereses de las compañías de seguros generales. Al principio, su gestión era poco profesional, con técnicas actuariales limitadas y solo representaban un pequeño porcentaje del total de las primas del negocio de seguros. A partir de los años 1970, diversos factores cambiaron esta situación e impulsaron procesos de concentración, con numerosas absorciones y fusiones, reduciendo primero el número de empresas locales y regionales en beneficio de empresas de ámbito nacional. Posteriormente, el crecimiento de la demanda de este tipo de coberturas despertó el interés de compañías de seguros generales nacionales y multinacionales, provocando una reestructuración del sector que progresivamente ha ido adquiriendo mayor peso dentro del negocio asegurador y cada vez más internacionalizado. Esta última etapa sumergió al sector

sanitario en España en los grandes procesos de globalización del sector, caracterizados por una financiarización del capital impulsado por los fondos de inversión bancarios. Estos procesos son poco conocidos para el caso español y representan el principal foco de análisis de este artículo. Su estudio nos permite también introducir el estudio de este país en el debate internacional.

Palabras Clave: seguro; empresa; España; siglos XX-XXI

1. Introduction

A healthcare system is essential for human well-being and for achieving sustainable and more equitable socio-economic development. The recent pandemic has highlighted these elements and fuelled the debate on the role of the private sector in healthcare provision. In fact, health systems have been undergoing a continuous process of transformation that has accompanied changes in the conditions of economic production and the social, political and ideological reproduction of capitalist economies. Comparison between countries is very complex due to the variety of institutions, the collaboration or competition between public and private institutions, the diversity of financing and management models that exist, the role of the state in the process, the degree of coverage of the population, among other factors (Packard 2016; Gorsky *et al.* 2020).

Historically, depending on the time and place, the development of healthcare provision was based on a variety of public and private institutions. The first studies available in the international field mainly focused on Northern European countries and the United States, a country where, in the absence of state intervention, private health insurance[1] developed earlier (Granshaw and Porter 1989; Risse 1999; Thomasson 2000, 2002; Grell *et al.* 2002; Harris 2004; Murray 2007; Dreyfus 2009; Chapin 2015). In Europe, in general, the private insurance sector initially showed little interest in the branch of health insurance, which was limited to the initiative of doctors who promoted the first specialised companies, and which obtained a very small percentage of the market share of the business (Borscheid and Haueter 2012; Donzé and Fernández 2019). Thus, in the decades preceding the Second World War, a number of public and private charitable institutions funded by alms and taxes coexisted with insurance mutuals created by civil associations or firms, private health insurance companies and limited public health coverage through the first compulsory social insurance schemes (Thane 1982; Ritter 1991; Baldwin 1992; Companje *et al.* 2009; Herranz 2010; Vonk 2012). This situation may be described as a mixed economy of welfare for the field of healthcare (Harris and Bridgen 2007).[2]

In the mid-20th century, these diverse paths of healthcare provision evolved into more integrated and regulated systems. The process was conditioned by various factors such as a country's wealth, its traditions and institutions, its political evolution and the conquest of social and political rights, the weight and financing capacity of the private and public sectors, and the dissemination of medical and technological advances and medical professionalisation (Ashford 1989; Ritter 1991; Dutton 2002; Fraser 2003; Harris 2004; Gorsky and Sheard 2006). By the end of the 20th century, access to healthcare provision in most European Union countries was through different compulsory and universal medical insurance schemes within a broader system of social protection (Cherry 1997; Hilger 1998; Gorsky *et al.* 2002; Domin 2008; Chevandier 2009; Hüntelmann 2020). However, private

[1] The concept of private health insurance (PHI) has been used throughout the paper, as this is the most common term used in the research literature.

[2] A term used from a more global perspective of welfare (coverage of a set of social risks, including sickness) by Harris and Bridgen (2007).

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health insurance has gradually gained ground in recent decades, above all since the emergence of an ideological questioning of welfare states and the application of austerity policies in relation to social spending (Mossialos *et al*. 2002). In this respect, the outbreak of the crisis of 2008 had a decisive impact. As regards the United States, the gradual expansion of health coverage under the Social Security, through the well-known Medicare and Medicaid programmes, targeting the elderly population and low-income groups, respectively, has not overcome the inequalities in healthcare access and has engendered a great political, business and social debate (Starr 2011). Meanwhile, in countries with planned economy models, the market has been progressively introduced into the health economy since the late 20th century. This is the case of China, for example, a country where the encouragement of private enterprise after the death of Mao led to a growing commercialisation of healthcare provision and the erosion of the previous social protection systems, especially for rural populations (Duckett 2011). In general, the ascendancy of the World Bank over development policies in low-income countries, burdened by excessive debt, enabled the imposition of the «Washington Consensus», which spread the idea that single-state welfare models were dysfunctional, while simultaneously recommending healthcare provision through a variety of formulas with significant participation of the private sector and widely financed by paying users (de Ferranti 1985). These countries ended the 20th century with a substantial foreign debt which conditioned everything, including the goal of universal health coverage, which was not even close to being achieved.[3] In recent decades, private health insurance has experienced increased activity in Europe, especially in its supplementary role to public health coverage. The reduction in public expenditure, the privatisation of public health services and tax incentives for private insurance, along with changes in the population's consumption patterns and a diversification of the offer, have fostered this process.

In 2020, within this framework, an interesting debate between leading figures in economic history and the history of medicine was published.[4] This collection of essays evidenced the need to combine knowledge from these fields in order to conduct a long-term analysis of such relevant questions as the extent to which the logic of capitalism had influenced the functioning of markets, the making of profits and commercialisation throughout the history of medical care. In particular, Hoffman points out that understanding the capitalist system in its different stages is crucial to analysing the path that the health industry has followed in each country (Hoffman 2020). From this perspective, questions can be asked about how the capitalist institutions of medical care, including medical clinics, hospital companies and even insurance companies, have accumulated political influence and market power at different times, and what impact this different predominance has had on health coverage and on the welfare of the population. At the same time, it should be asked whether other legal formulas of healthcare provision such as friendly societies, cooperatives, trade union funds or lay and Church charitable entities may be considered as competitive capitalist threats for publicly organised medicine or as alternatives to the pursuit of profit in healthcare (Chapin 2020a, 2020b).

In fact, the preponderance of private actors in the provision of medical care and the behaviour of the prices of this provision reveal its market power and the strength of the state's role in this area. It seems clear that, in the countries with solid public health

[3] See, for example, Cordilha (2023) for the case of France. This has also happened in Sweden, a country whose welfare model has served as a reference in studies carried out in the European framework. «The privatisation of provision and the emerging privatisation of funding, manifested in the rapid rise of private health insurance, are the most obvious signs that the universal, Swedish health system is gradually weakened», see Lapidus (2019 and 2022).

[4] See *Bulletin of the History of Medicine* 94 (3) published in 2020 with Christy Ford Chapin, Beatrix Hoffman, Nancy Tomes and Patrick Wallis participating in this debate.

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systems, financed through social contributions or taxes, and with universal coverage, the private actors have had to seek market niches either to collaborate with public institutions or to cover market failures of the public coverage. It is also very interesting, in this respect, to study to what extent government-run health systems imitate or take advantage of the mechanisms of capitalist markets by, for example, using private organisations to administer public services or introducing competitive conditions in public healthcare schemes. On the contrary, when public health systems are marginal or are debilitated in terms of coverage and provisions, the market power of the private actors is enhanced, and their field of action broadens. At this point, it should be asked to what extent modern healthcare markets are «embedded» in state power or are a mixture of public and private power (Polanyi [1944] 1997).

In any case, there is no doubt that the advance and predominance of the profit-seeking actions of insurance companies, hospitals and the pharmaceutical industry have contributed to a profound transformation in the functioning of the economy in general. At the same time, these changes have had consequences for the population's health coverage and provisions and also in terms of inequalities in healthcare (Hoffman 2020). In this respect, Tomes points out the need to extend research beyond the 1970s, when the flow of public and private money into medicine changed to include more powerful external actors such as large healthcare corporations or venture capital funds (Tomes 2020). From the last decades of the 20th century, above all, in the more service-oriented post-industrial economies, and in a context of debilitation of public health systems, healthcare became exponentially profitable, thereby attracting new types of investors «without special knowledge in the sector or interest in medicine itself» (Tomes 2020). This process has been described as «the destabilisation of medical care produced by a new type of monetisation» (Ginzberg 1986). In fact, this new stage entails moving from the commercialisation of healthcare to its financialisation; that is, medical care becomes just one more financial asset, and its price and quality are quoted on the stock exchange (Waitzkin 2020).

In general, the processes of financialisation refer to stages of the capitalist system in which the relationships between the financial sector and the real sector change. According to Sawyer (2013, p. 10), these changes have been proceeding frequently throughout the history of capitalism; they are not new. Nevertheless, it seems clear that, since the 1980s, national and international financial transactions have grown by leaps and bounds within a framework of surging neoliberalism and globalisation, which has led to unprecedented consequences, including within the sphere of healthcare coverage (Davis and Kim 2015). This new process may be considered different to that of the expansion of private health companies and activities observed in previous periods. Thus, unlike health companies, financial institutions (banks, investment funds and large insurance companies) do not focus their activity on health; instead they penetrate the health sector as one more opportunity for obtaining returns from these activities (Cordilha 2023). In particular, Hunter and Murray (2019) argue that the progressive commercialisation of healthcare has led to a deregulation of activities to facilitate access, investment and the profitable provision of services for financial capital. According to these authors, this deepening of financialisation since the late 20th century represents a fundamental shift in the organising principles of healthcare systems, with negative implications for health and equality. Lavinas (2018) goes even further and argues that financialised capitalism has radically subverted the role and the logic of social policy, bringing about a radical change in the field of social welfare. From this point of view, the use of the term «financialisation» seems appropriate for this study. In particular, financialisation is understood here as a process of substitution of the founding shareholders of the healthcare companies—basically medical personnel—by bank capital and

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investment funds. This process has entailed a change in the companies' strategic objectives and interests with consequences for patients and medical professionals.

That said, the question arises as to whether the healthcare «market» may be considered as a market *per se* within the capitalist system. If so, we should bear in mind the nature of the product. That is, among all the categories of goods and services, medicine and healthcare are among the most appreciated by the population, as they are crucial not only to people's survival but also to their welfare and quality of life (Chapin 2020a). The recent global pandemic has only reinforced this basic idea. There is still much to be learnt about what causal relationships distinguish the economic history of healthcare. In dealing with this challenge, it is essential to establish the thread of historical continuity between the incipient capitalist forms, modern capitalism and the trend towards a new stage of financialisation in recent decades, and how these changes have impacted on the provision of such an inelastic and fundamental good as the care of our health.

Health insurance companies, originally founded by doctors themselves, operated in a marginal market for years in Europe, until they became an object of desire for banks and general insurance companies in recent decades, thanks to their attractive growth. The genesis, growth and organisational changes of private health insurance companies in Spain from a historical perspective was analysed in Pons-Pons and Vilar-Rodríguez (2019). Following on from there, this paper intends to analyse how financial capital has penetrated the private healthcare business in Spain, what the access strategies have been and how this has transformed the sector. In this way, this paper aims to contribute to this international academic debate so relevant to the present moment, focusing on the case of Spain. The main aim of the paper is to study the transformation of the health insurance branch and companies in Spain in the last fifty years in the European context. First, the concentration of health insurance companies at national level from the 1980s is analysed. Second, there is an attempt to understand the phenomenon of the financialisation of the sector, during the first decades of the 21st century, through the introduction of financial capital, above all bank capital. This process removed the founding shareholders, mainly doctors, from the boards of directors, and gave rise to a diversification of business to include dental clinics, hospitals, cosmetic surgery clinics and homes for the elderly.

In order to analyse these objectives, the paper has been divided into two chronological sections. The first covers the evolution of the market and the strategies of health insurance companies from a situation where the fragmentation caused by the existence of a multitude of provincial and regional companies evolved towards a concentration of companies at national level, driven by the provision of services to the mutual insurance funds of civil servants and public employees and the demands of Spain's accession to the European Union in 1986. The second section studies the increase of this concentration thanks to growing demand and the interest of general insurance companies, the banking sector and foreign multinationals in acquiring health insurance companies in a context of deterioration of public health services. The end of this section includes an analysis of how the financialisation of the main healthcare companies in Spain is taking place, with the capital of the founding doctors being replaced by national and international bank capital.

2. The development of private insurance companies in Spain in the last third of the 20th century

From a historical point of view, it should be clarified that in Spain different types of private insurance related to the risk of sickness existed, which were statistically classified in different branches. In the official statistics available in Spain after the law of 1908 which regulated private insurance, the data on companies and premiums related to the health branch were aggregated, and even included death or funeral insurance. In 1925,

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the premiums of these different types of insurance accounted for 4.97 per cent of all private insurance, a percentage that was falling given that by 1935 they only accounted for 2.87 per cent. These statistics included sickness insurance, the most important in this context, which was based on a monetary compensation in the event of sickness (benefits) and healthcare insurance, which provided medical and hospital care and which very few insurance companies covered at this time.[5]

Private insurance companies in the health branch had very little weight in the insurance sector in Spain before the Spanish Civil War (1936-1939) (Pons-Pons 2008, 2013). Although they multiplied in number, they were associations, mutuals or cooperatives promoted by doctors who provided their services in single-family dwellings that were fitted out for consultations. In general, they were small, with very little capitalisation, a small number of employees, and concentrated in Madrid and Barcelona or in some of the more populated provincial capitals. Of particular note, among other obstacles to their growth, were the minimal demands (including deposits and reserves) of legislation governing the sector (the laws of 1908 and 1954) and the dual control (Directorates General of Insurance and Health), factors that certainly did not favour modernisation. The Franco dictatorship managed to overcome the obstacles hindering the introduction of a state health insurance in 1942, which required the collaboration of the private health sector in its management through special agreements, a key manoeuvre to address the lack of adequate funding and public infrastructures (Vilar-Rodríguez and Pons-Pons 2019). The first agreements concluded with the private sector (1944-1954) enabled the progressive implementation of coverage of an increasing number of beneficiaries. Basically, the state offered business to the private healthcare sector, and this responded by facilitating its reorganisation. In 1954, many of the agreements with mutuals and private health insurance companies were not renewed in the light of new and more stringent demands. Consequently, private health insurance companies tried to increase their existing market niche (upper and middle classes) in a context of limited coverage by state insurance (with little access to specialised and hospital care, except for urgent surgical cases) and the rising costs of surgical and pharmaceutical provisions. Moreover, the slowness of the construction of a network of public hospitals for the state insurance allowed the private sector to maintain a high market share, especially in maternity care.

The Basic Law of 1963 put an end to the private management of state health insurance —by prohibiting operating in the Social Security sphere in order to obtain or seek commercial gain. Consequently, private healthcare companies could no longer continue to function as collaborating bodies of the Social Security, as they sought to make profit. Henceforth, health insurance companies focused their strategy on the growth of the private market (Vilar-Rodríguez and Pons-Pons 2020). Between 1960 and 1975, territorial growth processes were initiated through the organisation of associations, doctors' cooperatives and collaborative mechanisms that enabled the treatment of those insured by small local and provincial companies via networks of broader geographic scope. This process led to the creation of health insurance companies at national and regional level by means of some vertical integration processes that saved small private health insurers, which did not have the possibility of signing agreements with the Social Security, from closure. In fact, insurers played a major role in the formation of health business systems in many countries (particularly in continental Europe, including Spain) because they helped regulate competition through the adoption of fixed fees and prices (allowing hospitals, doctors, producers of drugs and equipment, etc., to benefit from minimal prices). This was important to ensure the long-term growth of the system.

[5] Information obtained from the *Boletín Oficial de Seguros* (1926) and the *Boletín de Oficial de Seguros y Ahorro* (1934-1941).

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The start of democracy brought about key changes in this sphere. The Ministry of Health was created in 1977; the National Welfare Institute (INP), with serious holes in its accounts and episodes of corruption, was replaced by a new management body, a national health institute called INSALUD (*Instituto Nacional de Salud*); a major tax reform was passed in 1977 and the Constitution of 1978 established healthcare as a basic right. These last two changes opened the door to universal public healthcare coverage and a new funding model progressively based on taxes. Democracy, moreover, put two new challenges on the table: the passage of a general health law and the initiation of a process of transferring responsibility for healthcare to Spain's regions, known as autonomous communities. There was an impasse from 1975 to 1984/86 while awaiting the passage of a law to modernise public and private insurance and it was necessary to define a public healthcare model within the new democratic framework (Pons-Pons and Vilar-Rodríguez 2019). In this situation, health insurance companies progressed, aided considerably by providing coverage for the mutual funds of civil servants and other public employees, to whom the state gave the right to choose between public or private healthcare.[6]

From the 1970s, the healthcare branch became the main type of private health insurance. The branch of death insurance had already separated in this decade, but the sickness branch was still linked (including monetary assistance and healthcare). It was in the 1980s when the sickness and healthcare branches separated, with the latter growing massively and sickness insurance (benefits) being reduced to small percentages. The evolution of the healthcare branch was very successful, and by 1997 it now controlled 90 per cent of the premiums of all branches of health insurance (Ordaz 2003, pp. 71-72).

The main problem of the private health sector in Spain during this period was related to the large number of companies that operated in the field. The explanatory factors continued to point to the low requirements for capital, deposits and reserves in this area and a great proliferation of health insurance companies of limited geographical scope. This geographical fragmentation was one of the main obstacles to be overcome during this stage, especially for the health insurance entities that wanted to participate in the special agreements with the mutual funds of public servants. Between the 1970s and the 1980s, as part of their business strategy, these companies created or acquired their own clinics or concluded agreements with healthcare establishments that facilitated the preferential care of policyholders. Whereas in 1970 the twenty leading health insurance companies accounted for 44.9 per cent of market share (in a joint classification), by 1980 the twenty leading companies obtained 63 per cent. This agglutination was not exclusively the result of mergers or portfolio purchases but also included the liquidation of companies.[7] Essentially, in the first years of democracy, both public insurance and private insurance were awaiting reforms that were delayed due to country's serious economic, social and political problems. The 1980s were crucial in the legislative field for both the public and private health sectors.

On the one hand, the passage of a General Health Law (*Ley General de Sanidad*; LGS) in Spain in 1986 was a milestone in the creation of a healthcare model befitting a modern democratic state, along the lines of other Western European countries.[8] From the start of the transition to democracy, the creation of such a model was a long, drawn-out process due to a lack of agreement between different political parties. Proposals ranged from

[6] For further details, see Pons and Vilar (2014). For more on the compulsory medical provision schemes for civil servants and other public employees in other countries, see Verhoef (2006).

[7] Comparison of the data of the *Revista del Sindicato Nacional del Seguro*, special statistical issue, and data for 1980 from *Estadística de seguros privados* (Madrid, 1981), p. 56, p. 88.

[8] General Health Law 14/1986, of 25 April, BOE (Official State Gazette), Consolidated legislation, No. 102, of 29 April 1986, pp. 8-49.

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the establishment of a national health service offering universal coverage, basically funded through taxes and under public management, defended from left-wing ideologies, to a health model based on the signing of agreements with private healthcare, advocated by the opposite extreme of the parliamentary spectrum (Vilar-Rodríguez and Pons-Pons 2018). The deadlock of the debate and its prolongation over time conditioned to some extent the passage of a general and watered-down law intended to integrate the interests of all parties and achieve the greatest possible consensus.

With regard to the role of the private sector, the LGS incorporated two key aspects for its interests. First, the strictly public management model contemplated *a priori* in the LGS was soon called into question as the private sector was guaranteed a portfolio of «privileged» clients: civil servants and some other public employees (permanent jobs and above average salaries). Thus, the law retained the possibility of an annual choice of insurance for the mutual funds of public servants (MUFACE, MUGEJU and ISFAS), which constituted an exception within the national healthcare model (chap. VI, art. 85). The public employees belonging to these mutuals did not have double health coverage. They had part of their salary deducted for Social Security, including health coverage, the same as other workers, but they were the only ones who, without paying anything extra, had the privilege of being able to choose between private and public health coverage. Most opted for a private healthcare company from among those that had agreements with the mutuals. Other workers did not have this option. If they wanted to have double coverage they had to take out a private policy with a health insurance company and pay the premium.

In 1989, of the six million people covered by private health companies, around two million were public servants who had opted for the private sector instead of the Social Security, while the rest had double coverage (public and private) (Pons-Pons and Vilar-Rodríguez 2014). Second, the LGS established a publicly owned and managed National Health System to provide services via publicly owned health centres and hospitals. However, the law also incorporated the possibility of «establishing agreements for the provision of healthcare services with means external» to the public health administrations via the signing of special agreements. In practice, this meant the possibility of agreements with the private health sector by means of referring patients from public to private healthcare for both consultations with specialists and hospital care (LGS, chap. II, arts. 90, 94.1 and 94.2). This has been common practice in Spain since this time, and a growing number of patients have been referred from the public system to receive treatment in authorised private centres at the expense of the public administration. In fact, these two aspects were already being applied within the health framework in Spain and the LGS only consolidated them. It should be borne in mind that the mutual funds of public servants had been functioning since the 1970s, and public expenditure on agreements with private health services had not ceased growing since the start of Spain's democracy (Pons-Pons and Vilar-Rodríguez 2014, p. 6).

On the other hand, the legislative reform of the private insurance sector, initiated in 1984, reinforced with Spain's incorporation into the EEC and completed with a Law of 1995, created a different regulatory, economic and social framework for the development of this activity, which particularly affected private health insurance. The law on private insurance of 1984 (and its implementing regulation of 1985) modified the regulatory framework of the insurance business, which for thirty years had been governed by the insurance law of 1954. The red tape surrounding the new law was very slow and the process was initiated with draft bills during the Franco dictatorship (Tirado Suárez 1984). The new law sought to comply with European directives on freedom of establishment and protection of insured persons so that the Spanish insurance regulation would be in line with Common Market legislation. Moreover, it managed to adapt the regulations to the economic and social reality of the business, especially by reducing the excessive number of insurance

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companies and strengthening the solvency and solidity of those that continued. Among other objectives, the law was intended to reduce the cost of insurance, strengthen technical guarantees, make investment more flexible and control insurers' obligations to policyholders and the state. The new law facilitated the reduction in the number of companies, the entry of foreign companies and an improvement in the competitiveness of Spanish insurers. In the case of the health insurance branch in particular, it encouraged concentration and the entry of foreign capital (Tortella *et al.* 2014, pp. 275-281).

The insurance facet of the private health industry experienced a process of concentration, now vertical and horizontal, changes of strategy in the growth of companies in the health branch, and also aroused the interest of general companies and multinationals operating in the Spanish market, which purchased portfolios and companies. The growth of health insurance not only attracted the interest of the multinationals, but also stimulated the participation of national general insurance companies, which incorporated companies providing healthcare and funeral insurance into their business groups and/or gave priority to health or funeral insurance in their operations as a means of expansion.

It should also be mentioned that in the last decades of the 20th century there were changes in the policy of health management driven by some autonomous communities in two respects. On the one hand, they fostered the creation of new healthcare provider companies. On the other hand, insurers were encouraged to participate in the business of provision of services not only through agreements with the public health service but also through the management and operation of hospitals and public health centres, as and when new opportunities arose.

Within this framework of regulatory changes, the transformations of the health insurance branch from 1985 to 2002 were quite profound in various areas. For example, health lines increased their weight in the insurance sector on the basis of policies from the mutual funds of public servants, a general increase in private policies and, later, the involvement of corporate groups. Moreover, this expansion of business was accompanied by the acquisition and merger of the small regional companies that had fragmented the sector for decades. This phenomenon of vertical concentration was determined by the obligation to triple the solvency margin, as provided for in the Law on the Organisation and Supervision of Private Insurance of 1995 (Uri 1989).

From 1984 to 1993, after the effects of the reform of the sector arising from the law of 1984, the number of entities operating in the branch of health insurance fell from 243 to 128.[9] In 1993, all of the companies were of national capital and most of them were stock companies. The market share in 1993 reflected an increase in the concentration of business. The first ten companies in the ranking collected 75 per cent of premiums (Table 1). The leading company was Asisa with 23.76 per cent of premiums, followed by Sanitas with 14.8 per cent and Adeslas with 14 per cent of the market share. These were followed by Asistencia Sanitaria Colegial with 6.6 per cent and Previasa, S.A. with 5 per cent.

The process of concentration of health insurance companies is not an isolated case of Spain or within the business itself. The concentration in the insurance sector in general, from a historical perspective, has been analysed in the case of Great Britain by Robin Pearson, in Germany by Peter Borscheid, in Spain by Jerònia Pons, and André Straus has investigated this phenomenon in France in a monograph of the journal *Entreprises et Histoire* (Borscheid 2013; Pearson 2013; Pons-Pons 2013; Straus 2013). Numerous concentration processes in different countries have been also studied in Borscheid and Haueter (2012). All these studies evidence the concentration process as an international phenomenon and general to the entire insurance sector. One can see how historical processes of

[9] Law 33/1984, of 2 August, Regulating Private Insurance (*ley sobre ordenación del seguro privado*), BOE no. 186, of 4 August 1984, pp. 22736-22747.

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Table 1. Ranking of insurers operating in the health branch in 1970 and 1993 (voluntary insurance, in millions of pesetas)

	1970			1993		
	Insurers	Premiums	% Total branch	Company	Premiums	% Total branch
1	Igualatorio Médico Quirúrgico, S.A.	251.08	7.76	ASISA	53,834.81	23.8
2	Sanitas S. A.	209.58	6.48	SANITAS	33,475.43	14.8
3	Asistencia Sanitaria Colegial	177.02	5.47	ADESLAS	31,622.82	14.0
4	Unión Previsora S.A. Cia. de seguros	173.28	5.36	Asistencia Sanitaria Colegial, S.A.	14,853.00	6.6
5	Equitativa de Madrid, La	108.44	3.35	PREVIASA	11,338.78	5.0
6	Honradez, La[1]	55.62	1.72	Igualatorio Med. Quirúrgico	11,184.74	4.9
7	Previsión Médico Social, S.A.	51.80	1.60	ARESA	6,919.38	3.1
8	Interprovincial Esp. Seg. Intesa	51.16	1.58	FIATC	4,822.97	2.1
9	Crédito Español, S.A.	50.22	1.55	CAJA SALUD	3,932.14	1.7
10	Poles	40.78	1.26	AEGON	3,244.29	1.4
	Total top10 entities	1,168.98	36.13	Total top 10 entities	175,228.36	75.6

[1]La Honradez was a mutual; others in 1970 were national companies.

Source: For 1970, see Pons-Pons and Vilar-Rodríguez (2019) with data elaborated from *Revista del Sindicato Nacional del Seguro*, Special Statistical Issue (Madrid, 1971), pp. 75-81; for 1993, see UNESPA, Servicio Actuarial, *Estadística del Seguro Privado 1984-1993* (Madrid, 1994), p. 251.

capital investment abroad have developed and the existence of phases of concentration prior to the present one. Nevertheless, what is especially striking is that the branch of health insurance, due to its particular characteristics and due to the development of the public health system in each country, remained isolated from this process until the late 1990s and the first decades of the 21st century, when some factors that condition the crisis of the welfare state have changed and the demand for private health insurance has increased, stimulating investment in this branch.

In the case of Spain, two phases can be detected in the merger process of health insurance companies. In the first, small provincial insurers were absorbed, whereas in the second, foreign capital and the banking sector now participated (Pons-Pons and Vilar-Rodríguez 2019). The first waves of concentration processes were initiated in the second half of the 1980s, when the larger companies (Adeslas, Aresa and Aegon) took over others that only operated on a local or provincial scale. It should be borne in mind that the era of strictly regulated and isolated national insurance markets came to an end in the 1980s, with the liberalisation of markets, especially in the European Economic Community, see Borscheid and Haueter (2012). Spain's incorporation into the EEC meant an opening up and liberalisation and encouraged the entry of foreign capital.

This phenomenon accelerated in the insurance sector between 1990 and 1996, when 143 entities were involved in mergers or takeovers. Three important conclusions can be drawn regarding this trend:[10] (a) most of these operations were undertaken by stock companies (92 per cent of total insurers); (b) 51 companies acted as the absorbing company of another 88 firms; (c) the waves followed this pattern: the largest number of agreements were concluded in 1991 and then there was another wave in 1994 and 1995. In this second phase, the entry of foreign capital, linked to incorporation into Europe, and the recent acquisition of health insurance companies by general insurance companies, were crucial factors. General insurers became very interested in the expansion of the health branch, which they had largely ignored throughout 20th century. With these two phases, the large health insurers consolidated their position.

In short, the market for healthcare coverage has undergone a profound transformation in Spain since 1986, characterised by business concentration and increasing demand (Table 2). Under these circumstances, the interest in providing private health insurance in Spain grew significantly among general insurance companies, bancassurance companies and the multinationals of the sector until the beginning of the 21st century. Meanwhile, the mutilation of the public healthcare system, with budgetary adjustments and the approval of formulas for the private management of public hospitals, increased the business opportunities for a growth sector in all European Union countries, and Spain is no exception.

3. The financialisation of the Spanish health sector since the end of the 20th century

The crisis of the public health model over the last few decades, ravaged by budgetary adjustments and cuts, fuelled the trend towards the privatisation of healthcare services managed by central and regional governments within the framework of neoliberal ideology. This change in trend opened the way to the participation of health insurance companies in the management of hospitals and medical services or publicly owned foundations. The development of this process coincided with the expansion of the private hospital network. Since 1990, almost all health insurance companies have increased their medical centres, dental clinics, hospital groups and healthcare staff with the aim of giving preferential treatment to their policyholders and beneficiaries. This is the case of Adeslas,

[10] In line with Serra *et al.* (2001).

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Table 2. Evolution of the health branch in Spain 1986-1993

Year	No. of insurers	Number of policies	Insured	Premiums in millions	Claims (millions of pesetas)
1986	199	1,747,500	4,210,847	71,544.88	58,313.30
1990	132	1,827,274	5,419,516	12,281.11	97,754.20
1993	128	2,174,532	5,644,041	226,571.19	–

Source: UNESPA Servicio Actuarial, *Estadística del seguro Privado* 1984-1993 (Madrid, 1994), p. 251.

Asisa, DKV and Sanitas, companies which already had hospitals and clinics and took advantage of these resources to offer their services to insurers or to sign agreements with the public health service, intended to reduce waiting lists for certain provisions.

Within this context, the number of people with health insurance policies with a private company in Spain grew from 5.2 to 8.5 million between 2000 and 2020 (Table 3). This process of growth was continuous, although it experienced a slight deceleration with the onset of the economic crisis in 2008. These people benefit from a model of double insurance in a country with universal public healthcare coverage. There are also a further 1.8 million people who opt for «administrative mutualism» (those mutual companies covering civil servants and some other public employees). This rise in the number of policies has led to health insurance premiums having greater weight as a percentage of total premiums earned (2000: 6 per cent and 2020: 13 per cent) and also a greater percentage of the total number of non-life premiums (2000: 14.6 per cent and 2020: 20 per cent) (Table 4). However, the expansion of the health insurance business is not only a result of the increase in the number of premiums, but it is also due to the income from complementary and substitutional agreements signed with the public health sector. This public–private collaboration is even more significant in the hospital sector. Hence, within the private non-charitable hospital market in Spain in 2019, total income rose to 6,670 million euros, a figure that represents a compound annual growth rate of 3.96 per cent compared with 2015. By segments of demand, the agreements with health insurance companies account for 63 per cent of the market, followed by public agreements (25 per cent), purely private patients (10 per cent) and other items such as catering and parking, which account for 2 per cent of the bill.[11]

How has the business sector reacted to these changes in business opportunities? Two clear trends in the sector can be highlighted. First, important progress in the concentration process already initiated at the end of the 20th century. In this respect, three companies, Asisa, Adeslas and Sanitas, went from controlling slightly more than 50 per cent of total premiums in the health branch in 2000 to over 60 per cent in 2020 (Table 5). Second, there has been an increasing penetration of national and international financial capital in the sector. In this regard, Spanish health insurance companies have become a target of international health companies, Spanish banks and international investment funds.[12] All of these have been attracted by private healthcare in Spain, which was consolidated as a sector with great prospects of profits sustained by two fundamental pillars: healthcare as an inelastic service and the business opportunities arising from the budgetary stranglehold of public healthcare and the expansion of channels of collaboration with private healthcare.

[11] *Análisis de Situación de la Sanidad Privada. Informe IDIS* for the year 2020, p. 38.

[12] This brought to an end the historical national capital ownership of these types of companies, traditionally linked to medical professionals Pons (2013) and Pons and Vilar (2019). For more details on the historical relationship between banking and insurance, see Montijano (2010).

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Table 3. Evolution of the number of insured persons in health insurance companies (thousands of persons)

	Reimbursement of costs		Healthcare		«Administrative mutualism»		Total insured insurance companies	
Year	No.	%	No.	%	No.	%	No.	%
2006	688	8	5,274	67	1,958	25	7,919	100
2007	728	8	5,661	68	1,985	24	8,374	100
2008	767	9	6,130	69	1,989	22	8,886	100
2009	769	9	6,287	69	1,991	22	9,047	100
2010	770	9	6,031	69	1,981	23	8,782	100
2011	747	8	6,121	69	1,970	22	8,837	100
2012	699	8	6,033	69	1,969	23	8,701	100
2013	690	8	6,178	70	1,960	22	8,828	100
2014	674	7	6,396	71	1,946	22	9,016	100
2015	689	7	6,635	72	1,914	21	9,238	100
2016	735	8	6,951	73	1,883	20	9,569	100
2017	721	7	7,335	74	1,850	19	9,906	100
2018	740	7	7,698	75	1,830	18	10,268	100
2019	748	7	8,029	76	1,809	17	10,586	100
2020	764	7	8,504	77	1,788	16	11,056	100

Source: *Análisis de Situación de la Sanidad Privada. Informe IDIS* for the years 2021, 2020, 2019, 2018, 2017, 2016, 2015 and 2012. Graph on the evolution of the insured in thousands.

These processes took place in two of the three leading companies in the 21st century. Adeslas and Sanitas would end up being controlled, the former by bank capital (CaixaBank) and the latter by BUPA (British United Provident Association), an international insurer of British origins that had already acquired the Spanish company in the late 1980s. Likewise, another European health insurer, the German DKV, showed interest in the Spanish market in 1997. In this year it reached an agreement for the acquisition of the Spanish company Previasa, belonging to the Cordón family and with 350,000 policyholders, which was purchased for 16,000 million pesetas. DKV paid off its debt of 5,000 million pesetas and began its capitalisation and financial restructuring with a capital increase of 6,900 million pesetas. In the same year, the resultant Previasa DKV moved into fifth position in the ranking with 5 per cent of the market share. It then managed to consolidate its position in the Spanish market as the fourth largest company in the health insurance branch in the first twenty years of the 21st century. It should be noted that DKV was incorporated into the ERGO group in 1990s, with a volume of 420 million pesetas and 2.7 million insured, being one of the largest health insurance companies in Europe.[13] MunichRe is currently the main shareholder of ERGO.

The most interesting case is the company Adeslas, originally created as an association of small health companies of provincial and regional scope (around thirty throughout Spain) which, after a long initial process of legal adaptation, became a stock company

[13] Borscheid (2013) and ABC newspaper, 13 December 1997, 50 and ABC newspaper, 12 February 1998, 37.

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Table 4. Percentage of total premiums, non-life premiums and healthcare premiums (in thousands of euros)

Year	Total gross premiums earned	Total non-life insurance premiums	Non-life premiums as % of total premiums earned	Total gross healthcare premiums	Healthcare premiums as % of total premiums earned	Healthcare premiums as % of total non-life premiums
2000	40,989,369.47	16,604,098.61	40.51	2,421,671.58	5.91	14.58
2001	42,066,104.46	18,504,010.87	43.99	2,649,127.08	6.30	14.32
2002	48,166,902.96	21,213,164.80	44.04	2,888,598.38	6.00	13.62
2003	41,678,817.82	23,310,501.45	55.93	3,210,672.77	7.70	13.77
2004	45,243,620.75	25,359,980.30	56.05	3,505,098.58	7.75	13.82
2005	48,759,826.70	27,224,911.72	55.83	3,829,821.09	7.85	14.07
2006	53,578,844.93	29,410,226.26	54.89	4,196,143.16	7.83	14.27
2007	55,022,956.71	31,040,971.78	56.41	4,577,722.37	8.32	14.75
2008	62,462,211.43	34,401,247.00	55.08	4,935,653.00	7.90	14.35
2009	64,576,832.14	34,552,342.57	53.51	5,217,478.66	8.08	15.10
2010	61,105,126.72	32,707,289.74	53.53	4,786,277.02	7.83	14.63
2011	64,041,001.33	33,906,034.43	52.94	5,784,590.87	9.03	17.06
2012	61,152,668.15	34,082,754.14	55.73	6,031,803.42	9.86	17.70
2013	60,551,888.37	34,186,397.68	56.46	6,220,393.14	10.27	18.20
2014	59,528,386.90	33,828,310.72	56.83	6,508,306.17	10.93	19.24
2015	60,702,367.64	34,486,929.77	56.81	6,645,570.90	10.95	19.27
2016	68,827,914.22	37,189,117.90	54.03	6,906,226.18	10.03	18.57
2017	69,133,894.95	38,675,193.46	55.94	7,229,083.46	10.46	18.69

2018	69,922,609.89	40,178,199.30	57.46	7,590,719.06	10.86	18.89
2019	69,723,275.63	41,302,736.20	59.24	7,953,447.82	11.41	19.26
2020	65,872,277.83	42,198,742.29	64.06	8,538,170.09	12.96	20.23

Source: Database of the Dirección General de Seguros y Fondos de Pensiones. *Memoria estadística anual de entidades seguradoras* (Annual Statistical Report of Insurance Entities). «Desglose del negocio-pólizas-primas». Years 2020, 2019 and 2011. For the years from 2009 to 2021. Base de datos de la Dirección General de Seguros y Fondos de Pensiones. *Memoria estadística anual de entidades seguradoras*. «Desglose de la rama de Asistencia Sanitaria. Gráfico de la Evolución de Primas y Siniestralidad 2000-2008». Year 2008. For the years from 2000 and 2008. The data referring to Gross Premiums for the years 2000-2008 have been obtained from the Desglose del ramo Asistencia Sanitaria, in the section «Evolución de Primas y Siniestralidad 2000-2008», and not from the Desglose de negocio-pólizas-primas as for other years. This is due to the fact that there are discrepancies in the data source between the values given for the same information (Gross Premiums for 2000 to 2008) in the two breakdowns consulted. For this reason, we have chosen to use the data of the *Desglose de la rama de Asistencia Sanitaria* in its section «Evolución de Primas y Siniestralidad 2000-2008», given that its values still continue in the historical series that are currently prepared and presented.

Table 5. Evolution of the weight of the 15 most important entities in the healthcare branch (2000-2005) (in millions of euros)

	2000			2005			2010			2015			2020		
Company	TGPE	R	%	TGPE	R	%	TGPE	R	%	TGPE	R	%	TGPE	R	%
Asisa, Asistencia Sanitaria Interprovincial de Seguros	502.3	1	20.7	631.4	3	16.5	868.7	2	18.2	1,041.0	3	15.7	1,250.4	3	14.6
Compañía de Seguros Adeslas, S.A.	464.9	2	19.2	886.8	1	23.2	730.1	3	15.3	2,051.6	1	30.9	2,834.8	1	33.2
Sanitas, S.A. de Seguros	398.4	3	16.5	726.1	2	19.0	1,066.5	1	22.3	1,185.9	2	17.9	1,450.9	2	17.0
Asistencia Sanitaria Colegial	116.8	4	4.8	148.3	6	3.9	170.9	6	3.6	185.9	7	2.8	202.0	8	2.4
Mapfre Caja Salud de Seguros y Reaseguros, S.A.	103.7	5	4.3	194.8	5	5.1	250.0	5	5.2	295.7	5	4.5	409.6	5	4.8
DKV Seguros y Reaseguros, S.A.E.	101.3	6	4.2	243.6	4	6.4	359.5	4	7.5	489.6	4	7.4	626.6	4	7.3
Igualatorio Médico Quirurgico, S.A. de Seguros y Reaseguros	86.2	7	3.6	83.5	10	2.2	152.6	7	3.2	193.0	6	2.9	204.1	7	2.4
Aresa Seguros Generales, S.A	80.7	8	3.3	118.8	8	3.1									
Caja de Seguros Reunidos, Compañía de Seguros y Reaseguros, S.A. (Caser)	73.1	9	3.0	122.8	7	3.2	130.1	8	2.7	112.4	9	1.7	141.6	10	1.7
Fiatc Mutua de Seguros y Reaseguros a Prima Fija	56.9	10	2.4	109.6	9	2.9	109.1	9	2.3	142.6	8	2.2	168.6	9	2.0
Aegon España S.A de Seguros y Reaseguros	50.6	11	2.1	65.5	11	1.7				63.5	13	1.0	79.9	14	0.9
Seras, Mutualidad de Seguros a Prima Fija	22.0	12	0.9												
Seguros de Vida y Pensiones Antares, S.A.				32.6	12	0.9	39.8	12	0.8	40.4	15	0.6			
Igualatorio Médico-Quirurgico Colegial, S. A. de S	20.6	13	0.9	27.7	14	0.7	32.3	14	0.7						
Seguros Groupama, Seguros y Reaseguros, S.A.U.	16.5	14	0.7	30.9	13	0.8	49.9	11	1.0						
Aseguradora Islas Canarias de Seguros, S.A.	17.1	15	0.7												
Banco Vitalicio de España, Compañía Anónima de Seguros y Reaseguros.				25.7	15	0.7									
Mutua General de Cataluña, Mutua de Seguros y Reaseguros							60.4	10	1.3	63.7	12	1.0	69.2	15	0.8

La Estrella S.A. de Seguros y Reaseguros					33.9	13	0.7					
Mutualidad de Previsión Social de Futbolistas Españoles					30.4	15	0.6	43.2	14	0.7		
Agrupacio Amici d´Assegurances i Reassegurances,S.A								87.5	10	1.3	124.8	11	1.5
Mutualidad General de Previsión del Hogar								86.3	11	1.3	94.9	12	1.1
Axa Seguros Generales, S.A. de Seguros y Reaseguros											224.4	6	2.6
BBVA Seguros, S.A. de Seguros y Reaseguros											93.4	13	1.1
Total	2,111.2	87.2	3,448.0	90.0	4,084.2		85.3	6,082.4		91.5	7,975.0		93.4

Notes: R, position in the ranking; TGPE, total gross premiums earned; % of total in the health branch.

Source: Prepared by the authors on the basis of the database of the Dirección General de Seguros y Fondos de Pensiones. *Memoria Estadística anual entidades aseguradoras. Cuota de Mercado Ramo Enfermedad*. Year 2008; and database of the Dirección General de Seguros y Fondos de Pensiones. *Memoria Estadística anual entidades aseguradoras*. *Desglose de Asistencia Sanitaria* Year 2008. From 2005, prepared by the authors on the basis of the database of the Dirección General de Seguros y Fondos de Pensiones. Memoria Estadística anual entidades aseguradoras. Cuota de Mercado Ramo Enfermedad. Years 2020, 2015 and 2010; and database of the Dirección General de Seguros y Fondos de Pensiones. *Memoria Estadística anual entidades aseguradoras. Desglose de Asistencia Sanitaria* of 2020, 2015 and 2010.

Table 6. Process of takeover of health insurance companies by SegurCaixa Adeslas, S.A. (1989-2014)

Acquiring company	Date Order	Acquired company	Date Order	Acquired company
	27/12/2010	ADESLAS	20/07/1989	Madrid Salud, S.A. and Previsión Médico Social de Huelva, S.A. de Seguros
			17/04/1991	Ten companies
			16/09/1991	Alianza Médica Granadina, S.A.; Asistencia Médico Quirúrgica de Zaragoza, S.A.; Centro de Seguros San Jorge, S.A.; Igualatorio de Especialidades Médicas, S.A.; Seguros Asmevirca, S.A. and Unión Previsora Sanitaria, S.A. (UNIPRESA), Compañía de Seguros
			09/05/1994	Compañía de Seguros Igualatorio Médico Colegial, S.A. and Sascom, S.A. de Seguros
			15/12/1995	Asociación Médica conquense, S.A. and Compañía de Seguros y Asistencia Médica, S.A.
			18/12/1998	Compañía de Seguros Hermandad del magisterio leonés, S.A.
			27/12/2000	Igualatorio Colegial de Asistencia Médico Quirúrgica,S.A. de Seguros Imedic, Igualatorio Médico Quirúrgico Castellón de Seguros, S.A. and Unión Médica Gaditana, Sociedad Anónima de Seguros
			31/01/2003	Asistencia Médica Colegial Extremeña, S.A and Inversiones Badajoz
			11/01/2007	Inisas, Compañía de Seguros y Reaseguros, S.A.
			28/12/2009	Seguro Colegial Médico-Quirúrgico
	14/12/2012		14/10/1987	Seven, S.A.
SEGURCAIXA ADESLAS, S.A. DE SEGUROS Y REASEGUROS		ARESA Seguros Generales, S.A.	24/07/1991	La Unión Unversal, S.A. de Seguros; Mediresa Seguros, S.A.», «Médica Burgalesa, S.A.», Compañía de Seguros de Asistencia Sanitaria y Seguro Médico, S.A.

		05/10/1992	Renacer Unión, Sociedad Anónima de Seguros, Previsón Sanitaria Madrileña Compañía de Seguros, S. A. and Igualatorio Médico Quirúrgico San Ignacio, S.A., Sociedad de Seguros de Asistencia Sanitaria
		08/04/1994	Médica Barcelona, Sociedad de Seguros Instituto Médico Quirúrgico en todas las Especialidades, S.A.
		12/02/1996	San Rafael y San Juan de Dios, S.A. de Seguros
		02/12/1996	Organización Sanitaria CEYDE, SANY, Compañía de Seguros, S.A., Compañías de Seguros Nueva Vida, S.A. and Crédito Español, Compañía de Seguros, S.A.
		05/02/1998	Clínica San Bernardo, S.A. de Seguros
		30/12/1998	Protectora Mundial, S.A. de Seguros
		05/11/1999	Previsión Médico-Social, S.A., Compañía de Seguros
		19/10/2005	Capisa, S.A. and El Pensamiento, Compañía de Seguros, S.A.
		30/12/2005	Barcelona Aseguradora, S.A. de Seguros
		21/11/2007	Igualatorio de Asistencia Médica Colegial de Burgos, S.A. de Seguros
17/11/2014	Can Seguros de Salud, S.A Sociedad Unipersonal y Cajasol S. Generales		

Source: Dirección general de seguros, operaciones societarias http://www.dgsfp.mineco.es/es/Entidades/Operaciones%20societarias/Paginas/default.aspx and BOE (Official State Gazette).

in 1983. As from this time, it started a process of mergers that enabled it to grow and it also began to attract the attention of insurance entities and later the banking sector.[14] The growth process began when Adeslas acquired Madrid Salud, S.A. and Previsión Médico Social de Huelva, S.A. (1989). Later, starting in 1991, it initiated the merger of almost twenty insurers that operated at local level throughout Spain (Table 6). In 1991, the French group Médéric acquired 45 per cent of its capital, while the remaining 55 per cent was in the hands of Aguas de Barcelona. By 2006, thanks to this process, Adeslas had become the leader in the health branch with 23.69 per cent of premiums. This distribution of shares changed in October 2009 when one of the largest banks based in Spain, La Caixa, acquired Adeslas through its own general insurance company, SegurCaixa. This operation was authorised by the General Directorate of Insurance (*Dirección General de Seguros*) in 2010 (Table 6). This was effectively the start of the financialisation of the company, which was now under the control of the financial capital of the bank and is the leader in the health sector in Spain (see Table 5).

For its part, Aresa (Interprovincial Española de Seguros, S.A. before 1984) absorbed dozens of small provincial and regional insurers between 1991 and 1999 until it was taken over by Mutua Madrileña in 2005. Mutua Madrileña is an entity whose insurance business was originally built on motor insurance in the Madrid area. This purchase formed part of its process of diversification towards other profitable products and the expansion of its geographical presence to the rest of Spain.[15] In 2011, Mutua Madrileña and CaixaBank reached an agreement by means of which Mutua Madrileña acquired 50 per cent of SegurCaixa Adeslas, with CaixaBank retaining the ownership of 49.9 per cent. This strategic alliance between the banking sector and an insurance entity was strengthened in 2013 when SegurCaixa Adeslas bought the insurance business of Banco de Valencia and Banca Cívica, entities that had been taken over the year before by CaixaBank. In 2014, there was a merger between Adeslas and Aresa—the health insurer of Mutua Madrileña up until then—which represented another major step forward in the business of health insurance[16]. Previously, in 2013, CaixaBank had acquired Can Seguros de Salud and CajaSol Seguros Generales. These two entities were completely under its control and then, one year later, in 2014, they were taken over by the bank's insurance company, SegurCaixa Adeslas, for 47 million euros.[17] It should be borne in mind that Mutua Madrileña continued to have majority ownership of this insurer and the other major shareholder was CaixaBank. By 2014, SegurCaixa Adeslas enjoyed a market share of 27.4 per cent with 3.2 million customers; by 2020 the percentage had risen to 29.49 per cent, according to the data provided by the Spanish association of insurers and reinsurers: Unión Española de Entidades Aseguradoras y Reaseguradoras (Unespa).

[14] Adeslas was created as an association of small provincial health companies in order to participate in the provision of healthcare to different mutuals of civil servants and public employees. However, in 1982, it was reported by the insurer Muthuos, Previsión Médico Quirúrgica, which accused Adeslas of not being able to perform private insurance operations and claimed that it was the entities grouped in the association that bore the risks. As a result, there was a legal change converting the association into a joint stock company. ABC newspaper, 23 October 1982, p. 37.

[15] During this period, it had participated in the capital of banks and companies, including the Santander Group, Inmobiliaria Colonial, the ACS construction company and Auto Club Repsol (the largest automobile club in Spain). ABC newspaper, 2 December 2005, p. 91.

[16] This operation involved an investment of 1,075 million euros, and also meant that Mutua Madrileña had become the second general insurance company in the country, with a premium income of 3,641 million euros in 2012. El País newspaper, 25 July 2012. As a result of its strategic plan 2012-2014 the group obtained 60 per cent of its income outside Madrid thanks to the integration of SegurCaixa Adeslas. ABC newspaper, 19 May 2012.

[17] See the link: https://www.einforma.com/informacion-empresa/cajasol-seguros-generales-reaseguros (accessed in May 2022).

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Sanitas was in second position on the podium in 2020, with a market share of 15.54 per cent. Sanitas was founded in 1954 by a group of Spanish doctors (Pons-Pons and Vilar-Rodríguez 2014).[18] In 1988, 40 per cent of the capital of Sanitas was acquired by COFIR (*Corporación Financiera Reunida*), linked to the Italian magnate Carlos Benedetti and in which the «Los Albertos» business group were also shareholders. These operations heralded the start of the company's process of financialisation. Differences of opinion between the new shareholders and the Gómez family led to the sale of the shares of the founder's heirs to the British mutual company Bupa.[19] By 1989 Bupa had acquired almost all the shares of Sanitas.[20] Bupa was formed in 1947, when seventeen British provident associations merged to provide healthcare for the general public. It is a private company limited by guarantee; that is, it has no shareholders and any profits (after tax) are reinvested in the business. The services offered by Bupa began as private health insurance, offering policies to individuals, companies and other organisations, and eventually expanded to include privately run hospitals, outpatient clinics, health assessments, GP services, dental centres, digital health, care for the elderly and other health services. Since then, it has penetrated numerous private health markets around the world, although its headquarters remain in London.[21]

In 2018, Sanitas initiated a process of diversification with the acquisition of various health services and access to the management of hospitals. Within this process, Sanitas acquired Nectar Seguros,[22] a Spanish private health insurer, and the Sevillian group Ginemed, an IVF and fertility company with 18 clinics in Spain and Portugal.[23] As part of its strategy of diversification (which included ownership of hospitals, management of public hospitals, homes for the elderly, marketing of supplementary health services and occupational risk prevention) it increased its stake in hospitals with the acquisition from Ribera Salud of 50 per cent of Hospital de Torrejón in Madrid and 40 per cent of Hospital de Manises in Valencia.[24] Likewise, it participated actively in the process of privatisation of the management of public hospitals. In 2013, the autonomous community of Madrid conferred it the management of Hospital de Henares, in Coslada.[25] In 2022, it already had four hospitals of its own and was building a fifth in Madrid that it expects to inaugurate in 2025.[26]

The podium was completed by Asisa, with a market share of 13.53 per cent in 2020. The cooperative Lavinia-Asisa was created in Barcelona in 1977 with similar goals of inter-

[18] Its business leader was Marcial Gómez Gil (1906-1990). For his business career and his management of Sanitas, see Pons (2000). After its sale to Bupa, his son remained as President of Sanitas until his dismissal a year later due to discrepancies with the criteria of the British company. ABC Newspaper, 5 October 1989, p. 49. The dispute between Bupa and the former owners continued with legal action for breach of contract of sale of the shares of Sanitas. ABC Newspaper, 7 July 1990, p. 75.

[19] For the role of this mutual in British health insurance, see Doyle and Bull (2000, pp. 563-565). For more on the sales transaction of 40 per cent of Sanitas between Cofir and Bupa for the value of 9,000 million euros, see ABC newspaper, 23 December 1988.

[20] For an exhaustive list of the mergers, see Pons-Pons and Vilar-Rodríguez (2014, Table 4.41, pp. 419-420).

[21] Annual Company Report (2020) published in March 2021, link: https://www.bupa.com/~/media/files/site-specific-files/our-performance/pdfs/financial-results-2020/informe-anual-y-cuentas.pdf

[22] See following link: https://www.inese.es/dgsfp-y-competencia-autorizan-la-compra-de-nectar-por-sanitas/

[23] See following link: https://www.eleconomista.es/empresas-finanzas/noticias/9584778/12/18/Sanitas-arrebata-a-Vithas-las-clinicas-de-fertilidad-Ginemed.html. In 2021 GeneraLife, group of fertility clinics owned by Investindustrial bought Ginemed from Sanitas.

[24] Cinco Días Newspaper, 28 July 2004 and 16 November 2012. In 2008 Sanitas had 459 clinics and medical centres (40 Sanitas preference centres and 2 of its own hospitals, Sanitas La Zarzuela and Sanitas La Moraleja; both in Madrid), see Olivas (2008).

[25] Cinco Días newspaper, 12 August 2013.

[26] These are hospitals in Madrid (La Moraleja, La Zarzuela and Virgen del Mar) and one in Barcelona (Hospital Sanitas CIMA).

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cooperation in healthcare, promoted by the company Asistencia Sanitaria Interprovincial and, in particular, by Dr José Espriu Castelló. Lavinia was a doctors' cooperative which operated under the trade name Asisa. Its main aim was to cover the healthcare demand created throughout Spain by the three mutual funds of state employees, namely ISFAS (armed forces), MUFACE (civil servants) and MUGEJU (judiciary) (Carreño 1996).

The processes of mergers and incorporation of international capital considered above, even though they were decisive, do not explain all the cases of consolidation of the large companies in the healthcare sector. The case of Asisa is exceptional. Its growth was based on a cooperative movement. Asisa (Asistencia Sanitaria Interprovincial) was constituted as an interprovincial *igualatorio* (doctors' association) in 1973 in the form of a stock company, although all its shares were the property of the cooperative, called Lavinia, comprised of registered doctors. In 1984, 18,000 doctors were members of the Asisa cooperative, each one with a share. The entity had a delegate committee in each province, elected at a general assembly by the members of the cooperative. The cooperative did not get directly involved with the investment of multinationals and bank capital, although it did sign agreements to develop and market various types of healthcare products with ING Nationale Nederlanden, a company of the ING group, in 2002.[27] In 2007, it decided to diversify into life products, an unusual step among health companies.[28] This process of diversification included the operation of a network of its own hospitals (15 clinics in 2008 and one shared) and the management of public hospitals (in Valencia-Torrevieja- and Elche-Crevillent-).[29] These hospitals would later be managed under the name of the HLA hospital group. One of the more recent acquisitions was the purchase of Hospital La Salud in Cádiz from Alter Capital in July 2020.[30] Despite receiving some purchase offers, the Lavinia cooperative continued as the owner—with entirely Spanish capital of national scope—reaching third place in the ranking of the healthcare branch in 2020, with a market share of around 15 per cent of total premiums.[31] However, in recent years Asisa has included internationalisation as one of the pillars of its business strategy, with presence in Europe and Latin America and, in 2019, it concluded an agreement with Faisal Holding, an investment group from the United Arab Emirates, for the development of dental clinics.[32] Consequently, Asisa has also been affected by the process of financialisation, although only in part of its business, for the time being.

4. Conclusion

This study has made it possible to analyse the development strategies of private health provision in relation to public healthcare activity in the case of Spain from a long-term perspective. The analysis has revealed the common trend shared with other Western European countries. Thus, until the last third of the 20th century, fragmentation predominated in the health branch of the Spanish insurance market due to the existence of a

[27] The agreement consisted of the incorporation of Asisa's medical team into the ING Nationale-Nederlanden product called Salud Premium. With this deal, the insurers of Salud Premium could resort to the more than 36,000 doctors and health workers who worked in Asisa's 16 own clinics and 600 associated clinics throughout the country. ING, for its part, was to distribute the product designed by Asisa through its network. Cinco Días newspaper, 21 March 2002.

[28] Cinco Días Newspaper, 25 November 2007.

[29] Olivas, «El ramo de salud», pp. 18-19. One of the most representative hospitals was Hospital Moncloa, under its ownership since 1984. ABC Newspaper, 14 February 2014, p. 98.

[30] A hospital of 40 beds that allowed it to expand its healthcare network in Andalusia. ABC Newspaper, 4 July 2020, p. 49.

[31] In December 1988, Asisa received a purchase offer from Ruiz Mateos worth 5,000 million pesetas, which in the end did not go ahead. See the following link: http://elpais.com/diario/1988/12/07/economia/597452407_850215.html

[32] ABC Newspaper, 3 August 2019, p. 49.

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multitude of provincial and regional companies. From this point on, two processes can be observed. On the one hand, from the end of the 20th century, the health branch acquired fundamental strategic importance for private general insurance companies in a context of drastic cuts to health expenditure and the welfare state itself being called into question. This business opportunity sparked a process of concentration of health insurance companies at national level, driven by the provision of services to the mutual funds of public servants and the demands of the incorporation of Spain into the European Union in 1986. On the other hand, from the late 20th century, health insurance multinationals penetrated the Spanish market. This process immersed the health branch in Spain into the great processes of globalisation of the sector, characterised by a financialisation of capital promoted by the bank investment funds. This phenomenon was stimulated by the economic crisis in the early 21st century (with drastic government cuts in healthcare spending in Spain).

Since 2020, the trend of constant growth of health insurance premiums due to cuts in public healthcare budgets, longer waiting lists for surgery and other factors such as an ageing population have been joined by the effects of the COVID-19 pandemic, which have led to the collapse of a public health service that has borne most of the healthcare provision and cost. The private insurance companies have taken advantage of the new situation and the growth in demand for healthcare services, by means of offering low-cost policies. This formula has enabled them to increase their sales, driven by the population's growing concern over a possible collapse of primary healthcare centres and the hospital network. In Spain in just one year, health insurance premiums went from accounting for 11.41 per cent of total premiums in the insurance sector in 2019 to 12.96 per cent in 2020. As for non-life branches, they went from 19.26 to 20.23 per cent (Table 4). Sanitas, for example, the second largest Spanish company with health policies, closed 2021 with the acquisition of 377,000 new clients, 121,000 more than the previous year (47 per cent more) and an operating profit of 206 billion euros, 16 per cent more than the previous year.[33]

The increasing profits of the health insurance branch have led to the companies in this field, initially created by medical professionals, attracting the interest of the banking sector and insurance multinationals. It has been possible to verify this in the case of the four most important companies in this branch in Spain, which have gone from being independent companies to being part of large international financial groups. This is a complex process, given that many of these groups also form part of investment fund operations that produce constant changes in the funding structures of companies. The phenomenon of financialisation has modified the objectives of the health insurance companies themselves, which doctors had originally founded to provide stability, professional prestige and income for themselves, as well as to ensure the quality and prestige of patient care. On the contrary, venture capital funds are gauged basically by short-term profitability on the basis of reducing costs. It seems clear that this phenomenon benefits the availability of capital, and the diversification and expansion of companies, but it is not so clear that this guarantees the medical interests of the client/patient, as doctors and healthcare specialists are further removed from the strategic decisions of health insurance companies. The weight of venture capital in private health insurance and the weaknesses of public health insurance will condition access to, and the quality of, healthcare coverage for a large part of the population in the future.

[33] An important influence has been its alliance to sell insurance through branches of the banks BBVA and Banco Sabadell and agreements with other insurers such as Santalucía and Zurich, as well as the profits from the provision of services (hospitals, consultations, dental clinics, homes, etc.). Cinco Días Newspaper, 7 April 2022.

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