

Social Security arrives in the country: resistance and limitations in Spain during the late Franco regime (1959-1975)

A Segurança Social chegou ao campo: resistências e limitações na Espanha do segundo franquismo (1959-1975) (resumo: p. 14)

La Seguridad Social llegó al campo: resistencias y limitaciones en la España del segundo franquismo (1959-1975) (resumen: p. 14)

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The objective of the article is to analyze two aspects of healthcare in rural Spain during the second period of the Franco dictatorship (1959–1975). Firstly, we analyze the introduction of the Special Agrarian Social Security Regime (1966), which provided healthcare to rural workers. Until then, rural workers had been excluded from the Compulsory Health Insurance (1944), which provided healthcare to industrial and other low-income workers. Secondly, we analyze the position of rural doctors against the extension of health coverage to rural workers. To achieve both objectives, we analyze the limitations of medical practice in the rural milieu and how Franco's dictatorship unsuccessfully managed these limitations. We have used several sources: legal regulations, publications of official professional associations, press devoted to medical practice, sociological reports, and archival records.

Keywords: Health services accessibility. Rural health services. Physicians. Spain. History 20th century.



Introduction

Lack of healthcare for the rural population, a secular problem of the territories that formed the Kingdom of Spain^(c), was not solved with the implementation of the Compulsory Health Insurance (SOE, according to its Spanish acronym)¹ in 1944^(d), after the Spanish Civil War (1936–1939). It was a Bismarck-like healthcare system that, for the first time in the country, it socialized the fascist healthcare provided by the dictatorial regime established by General Francisco Franco^{2,4}. Thus, the assistance of the SOE was under the Ministry of Labor, although it was managed through an autonomous body, the National Welfare Institute (INP, according to its Spanish acronym). However, it wasn't until the Special Agrarian Social Security Regime, implemented in (1966)⁵, and its successive modifications, implemented in (1970-71)^{6,7}, that the welfare situation of rural workers began to improve, although not without serious financing problems⁸. Healthcare inequalities between the rural and urban areas did not improve ostensibly until the General Health Law was approved in 1986, during the democratic period. Despite this law, many inequalities remained⁹.

The implementation of the SOE significantly changed the professional situation of the physicians, due to varying employers and the demand of the population. Both aspects influenced the medical practice, resulting in changes that not always were well accepted by doctors.

The objective of this article is to analyze the limitations of the assistance provided in the rural areas at the time, and the doctors' resistance against its extension in the second period of the Dictatorship (1959-1975)^(e), in which there was a strong exodus from the rural areas to the cities. The sources used for the analysis have been the vast governmental publications –that sheds light on the unsuccessful attempts to ensure the availability of doctors and other healthcare workers in rural areas–, publications from official professional associations, such as the *Boletín del Consejo General de Colegios de Médicos de España (Boletín)*, the regular press focused on medical practice (*Profesión Médica*, *Tribuna Médica*), documents from the municipal archives of the province of Alicante regarding the performance of healthcare workers and, lastly, reports on the situation of rural assistance throughout the nation.

To understand the changes experienced by the rural population and physicians under the gradual extension of healthcare insurance to incorporate the rural population, it is necessary to briefly describe the situation before the SOE was implemented. The access to healthcare of the Spanish population was extremely unequal due to socioeconomic and geographical reasons¹⁰. Private healthcare, with payment per medical act, was only available to the predominantly urban middle and upper classes. For physicians, this meant the idealisation of the medical practice, forged throughout the nineteenth century, although for most it was a wish rather than a reality¹¹. In the urban industrial settings, the available option was the associations of mutual assistance, the successor of the brotherhoods and of other types of mutual aid societies, which provided medical and pharmaceutical assistance, among other services^{3,12}. According to the Health Law of 1849¹³, charity hospitals in provincial capitals and other municipal charitable bodies provided healthcare to the poor communities. In the rural areas, district practitioners

^(c) However, the existing difficulties did not imply a total absence of professionals in rural areas. Several studies have shown that the healthcare needs of small and medium-sized towns were covered by a dense network of health professionals, especially surgeons trained through a guild system outside the university.

^(d) The SOE was established in 1944, although the law creating it was published at the end of 1942.

^(e) Identifying the different periods within a long dictatorship (1939-1975), such as that of General Franco after his victory in the Civil War, is problematic. However, there is certain consensus regarding the second period, which started after the autarkic economic model was dissolved and Spain joined the liberal economy.



were responsible for the healthcare of these populations. Their official title with roots in the late Middle Ages¹⁴ was *médicos titulares*, and it evolved to a governmental body, the Public Home-based Care (APD), which was accessed by nation-wide merit competition¹⁵. Thanks to the municipal charities, these physicians were the only option in many rural municipalities, a role that was not relevant in urban areas. Because of this, they attended to those in need as well as the rest of the inhabitants of these municipalities under different payment systems that covered all possible issues (annual, quarterly, etc.), called the *igualada*. The SOE overlapped with the network of workers' mutual system, the charitable institutions, the APD practitioners, and the *igualada*. There were many consequences of this process in rural areas.

The implementation of the SOE and its limitations in rural areas

The creation and implementation of the SOE was the materialization of the most ambitious assistance project developed by the Dictatorship. Its objective was to provide healthcare to industrial workers with low incomes, called “financially weak”, which, according to the estimates by Pons and Vilar³, constituted a quarter of the Spanish population. The healthcare network for the newly insured (contributing workers) and beneficiaries (their relatives), was articulated in two ways. On the one hand, a total of 17.000 doctors were hired, on a part-time basis, to care the insured employees. On the other hand, the pre-existing and well-established charity network, which comprised practitioners, midwives, pharmacists, and healthcare assistants took on a more relevant role⁽⁶⁾. Thus, from 1948, the APDs were also designated as SOE practitioners. In urban areas, and from an economic point of view, combining the free exercise of the profession and the exercise under the SOE was well received, as it offered another source of income in a labor context marked by multiple employment^{15,16}. Despite this, physicians greatly disagreed with the socialization of medicine, as we have analyzed in other works, especially when the salary thresholds for affiliation to the SOE gradually increased and, therefore, a greater number of workers were included in the system¹⁵.

Although field workers were not explicitly excluded from the healthcare provided by the SOE, they were unable to access it due to their status as temporary workers. As a result, the limited implementation of the SOE in rural areas did not result in remarkable changes in the medical care of the rural community, as the organization remained under the scope of the traditional charitable system and the aforementioned *igualada*. The legislation echoed the differences between the services offered in the urban areas to the detriment of the rural communities, as reflected in the preamble to the Law on the Bases of National Health, enacted in 1944¹⁷.

⁽⁶⁾ For the present study, we will focus on the physicians



Issues of medical practice in rural areas according to its protagonists

In this context, APD doctors clearly and repeatedly marked the differences that existed between professionals who practiced in urban areas versus rural areas. The rural/urban rift affected the entire population, as evidenced by the massive and generalized migration flow from the countryside to the city that took place during this period. However, given that the district doctors followed the reversed path –from university to the rural community– and enjoyed a certain status that allowed them to express their concerns, we are now able to understand the issues from their perspective¹⁵.

The most notorious characteristic of the medical practice in the field during this period was the personal and professional estrangement from the urban practice. Professionally, scientific-experimental medicine was linked to hospitals¹⁸, institutions necessarily located in urban areas. Meanwhile, the healthcare provided in the rural areas was mainly general medicine, which took place in the home, in small dispensaries, or in the doctor's own home, who had an office specifically for this purpose. Thus, the gradually expanding “hyper specialty” was not usual practice in smaller communities, where it was practically anecdotal¹⁹. This remoteness was also evidenced in the impossibility of maintaining contact with other colleagues and learning about the latest medical news at the scientific congresses since they could hardly attend. During training, only the journals from the pharmaceutical laboratories and, over the years, the visitors, were the link between rural practice and the advances in medical knowledge and practices²⁰.

Personally, staying in small towns was perceived as an exile, a palpable feeling widely reflected in the sources. Given the university training of doctors and their social aspirations, participating in the social and cultural life in rural communities was difficult. As per the request of the professional journal *Tribuna Médica*, writer Ángel María de Lera reported wrote a series of reports regarding professional life in the rural communities, that appeared during 1965 and were later collected and published in a single volume. These articles intended to convey, through interviews, the lives of the district doctors in the exercise of their profession in isolated rural areas. The interviewees repeatedly conveyed the feeling of abandonment, as Francisco Javier Vadell Miranda, practicing in Salomó (Tarragona), highlighted:

In the current situation of rural medicine, perhaps what distresses us the most is loneliness. Complete solitude, without support; concerned loneliness weighing down as punishment. We are alone in the midst of a social and cultural scenario that is completely foreign to us [...] concerning the material or economic aspect, the helplessness could not be more terrifying²¹. (p. 84)

This loneliness that they expressed through different means also involved their wives, who sometimes worked as assistants in their practice without receiving any type of institutional recognition. It was frequently mentioned that their offspring were sent away after primary school to continue with their studies.



Sometimes, the arrival of a foreign practitioner to a municipality with its own social dynamics gave rise to open or hidden conflicts with the residents, other practicing physicians, and non-regulated health workers. Occasionally they would also feel misunderstood by part of a population clinging to what they considered atavistic beliefs. In one of the articles published in the *Boletín*, Mariano Jiménez Ruiz, APD in Urda (Toledo), a town of about 5.500 inhabitants, expressed in a story how “the concepts of the minds of the villagers” were imposed on medical science²². The narrative –centered on a case of typhoid fever– showed the delicate balance of hegemony and subordination between the patients and the doctor, who could tilt in favor of the former.

In the opinion of the physicians, this situation hindered their practice, of similar importance as of the apostles, who were supposed to bring the light of scientific knowledge to the profane territory. In these terms, Santiago Ibarz Grao, APD in Peralta de Alcofea (Huesca), described in fiery words the different disagreements that arose upon his arrival in the municipality, which he had faced as part of “that army of ‘medicine missionaries’ that was to carry the banner of science and charity to all corners of our nation”²³ (p. 49). We have dealt extensively with this missional conception of the rural doctor in previous works^{15,24}.

In addition to the professional and personal exile of the practitioners in rural areas, the most frequent complaints found in the medical press referred to their fees. Determining their average income is not easy, as there are numerous variables involved such as the size of the community, the number of neighbors under the *igualada*, the clientele that paid per act, and multiple employment, that in any case, did not reach the level of the cities. Also, the General Health Board (DGS, according to its Spanish acronym) updated their salaries at different times during this period, making it difficult to draw general conclusions. According to the information gathered in *Por los caminos de la medicina rural* (Along the Paths of Rural Medicine), salaries ranged between 1.650 and 11.000 *pesetas* per month²¹. It’s worth noting that in 1965, the minimum interprofessional monthly income was 2.520 *pesetas* per month²⁵. Despite this amount, an overwhelming majority considered that their income was insufficient, as –according to their testimonies– they were available twenty-four hours a day, seven days a week, 365 days of the year, and were not legally entitled to vacation days.

Regulatory attempts to improve rural assistance

On top of the issues that directly affected the medical profession in rural areas, there were also organizational deficits that the Francoist authorities tried to address. To this end, exhaustive legislative work was carried out to centralize, rationalize, and control the practice of the APD physicians.

Apart from very specific measures that regulated rural healthcare¹⁵, the most important milestone was that the government assumed payment of the fees of the district doctors. Until then, the municipalities or provincial administrations (*Diputaciones*) were responsible for paying the salaries of the physicians but, due to financial difficulties, they accumulated



considerable debts with the healthcare workers. Because of this, the DGS^(g) took over the payment of salaries to the APDs. In 1941²⁶, included the smallest municipalities and, by 1961²⁷, it was already extended to include all district doctors regardless of the size of the locality in which they worked, thus culminating the centralizing process.

The authorities also attempted to control and put an end to one of the main ills afflicting rural healthcare: absenteeism of village doctors without previous notice. The preamble of the regulation approved focused on putting an end to this situation described it as an “anomalous and chaotic government”²⁸. This situation tried to be remedied by requiring the practitioners to notify any absence of more than twentyfour hours. For this purpose, two record books under the control of the municipalities were created, one for introductions and one for terminations. These books contained information regarding their permits, the duration of the permits, the granting authority (Provincial Healthcare Headquarters or DGS), and the destination. At the same time, a disciplinary regime was established to punish the unjustified abandonment of the work post with financial and administrative fines.

Understanding the actual degree of implementation of these measures is challenging, given the fragmentation and dispersion of historical sources in small municipalities. In the cases where these record books have been kept, such as, for example, in the Alicante town of Onil^(h), we can verify that absences were effectively controlled as the medical absences’ entries match the return to the workplace⁽ⁱ⁾. However, only two years are recorded, 1952 and 1953, which prevents us from drawing any broader conclusions in this regard. Despite the long period of time recorded, the existing data for the municipality of Hondón de los Frailes^(j), provides information limited to the designation of the practitioner and his subsequent termination, with hardly any data on temporary absences^(k).

The documentation, however, allows us to confirm the high degree of intermittency that characterized the practitioners of rural areas. Thus, in Hondón de los Frailes, between 1947 and 1965, fifteen different regular physicians were appointed, some of them occupying the position in several different periods. This was a problem that persisted throughout the entire period covered by this study, evidencing an unsuccessful legislative action by the Dictatorship. The district doctor positions in smaller towns were particularly unattractive due to the low income and the greater isolation so that they were generally fulfilled by young recent graduates who abandoned their assignment as soon as they had the chance²⁰.

About the rationalization, the reorganization of healthcare constituted one of the issues most mentioned in the professional press. The rural healthcare was organized based on “medical districts”, a territorial demarcation comprising one or more municipalities, whose population had to be assisted by the practitioner. These districts could be “open” if other physicians could practice freely, or “closed” if only the APD practitioner was allowed to practice, something that sought to guarantee to the latter the economic income generated by the work outside the care of the poor. The long-awaited reform was to establish a rational system that would avoid work overload for rural physicians, limiting as much as possible the constant travel within and outside the district, and ensuring the economic income of the district doctors. This reform, which was delayed, took place in a rural world

^(g) The DGS was under the Ministry of the Interior, and it dealt with public health, district doctors and other healthcare workers.

^(h) A town located in the province of Alicante, with a population of 2.919 inhabitants in 1950, which was home to significant industrial activity.

⁽ⁱ⁾ Municipal Archive of Onil, *Libro-registro de presentaciones de médicos*, 884/1, and *Libro-registro de salidas de médicos*, 884/2.

^(j) Also located in the province of Alicante, with a population of about 600 inhabitants in 1950, it had a predominantly agricultural activity

^(k) Municipal Archive of Hondón de los Frailes, *Libro-registro de salidas de médicos*, 227/17, and *Libro-registro de presentaciones de médicos*, 227/18



increasingly depopulated by migration to the cities. The reorganization of the districts began in 1967²⁹ and it was approved the following year. This reorganization entailed the elimination of four hundred and sixty-four positions that were added to another nearby district with a larger population³⁰. The objective of this modification was to ensure the presence of physicians in the municipalities and that the income of the professionals would increase by increasing the number of insured persons, peers, and potential private patients, on a pay-per-doctor basis. Although these measures led to a decrease in the number of available healthcare positions in small municipalities, these positions often remained unfilled for long periods and when they were filled, it was only for short periods of time.

This reform gave rise to conflicts, such as the one that occurred in the town of Onil. In May 1967, the Preliminary Draft for the restructuring of the medical districts³¹ was published, eliminating one of the two positions in the municipality. In this and other surrounding municipalities, such as Ibi, a flourishing industry based on the manufacture of toys had developed, which led to a demographic increase. Thus, unlike so many other places in rural Spain, Onil had seen an increase in its population, which went from 3,202 in 1960 to 3,838 in 1966, according to the municipal census. The City Council pleaded to the restructuring project before the Provincial Healthcare Headquarters, intending to maintain the two designated positions^(l). Along with the demographic defense, the plea emphasized on the “many work-related accidents” caused by the outstanding manufacturing activity and the specific care they required. The industrial economic sector also offered their support, which was recorded through the adhesion that was signed and sealed by up to thirty-eight companies, almost all of them dedicated to the manufacture of dolls. Two fundamental pillars of the Franco regime also joined the request: the Spanish Syndical Organization and the Falange, the only trade union and party allowed by the Dictatorship. Likewise, the General Association of Household Heads expressed its disagreement with losing a practitioner and the resulting economic loss. They argued that each doctor saw about eighty or ninety patients a day, causing long waits at the dispensary, a circumstance that would worsen if the reform were to persist.

^(l) Municipal Archive of Onil, Expediente de reclamación instruido por la amortización de una plaza de médico titular, 884/4.

All the problems related to the medical exercise in rural areas we have mentioned contrasted with the notable local status that doctors held during the period under study. Despite the constant complaints in the professional press about the loss of authority, at the beginning of the democratic transition, physicians enjoyed the greatest prestige among the community, far ahead of other recognized professionals such as teachers, veterinarians, pharmacists, priests, the city council secretary, and healthcare assistants. This distinguished position, based on their education and the importance of healthcare for the community, was the counterpoint to the shortcomings of life in rural areas.

It was not uncommon for district doctors who settled in a town to end up holding positions of responsibility, such as mayor, or receiving varied honors such as naming streets or squares. The latter is the case of José Sanmiguel Tarazona in the town of Sant Joan d'Alacant^(m), who worked in this town from 1946 until his retirement in 1968. Upon unanimously granting the title in 1975, the City Council emphasized the traits of the ideal type of rural doctor, highlighting their “great work, not only in healthcare, but also as a human” as the “legendary figure of the family doctor” and their role as a “friendly, loved

^(m) Town located in the province of Alicante, with about 3.912 inhabitants in 1950.



and respected doctor” offering the community “understanding, science, affection and, above all, unreserved dedication to their profession”⁽ⁿ⁾.

The tributes paid to rural doctors by municipal corporations or medical associations were, to a certain extent commonplace and contrasted with the complex situation of an activity carried out in an agrarian environment in obvious decline. The ambitious project of the “great” national monument to the rural doctor (1964) was an example of that situation. The Medical Association of Guadalajara had the initiative and found the enthusiastic support of the whole profession through the General Council of Medical Associations, the Ministry of Labor, and the DGS. The monument was a big equestrian figure (the sculpture measured 55 feet) located in one of the typical rural areas of Spain, the province of Guadalajara, and it attempted to display the attributes that adorned the image of the rural practitioners³². The endeavor received considerable media coverage in the general and press dealing with medical practice but soon fell into oblivion. At the end of 1966 the Dictatorship decreed a salary increase for the district doctors, and the monument, which was conceived as recognition and a labor claim, became meaningless.

⁽ⁿ⁾ Municipal Archive of Sant Joan d'Alacant, *Nombramiento de hijo adoptivo a José Sanmiguel Tarazona*, 1115-07.

Expansion of healthcare to farm workers

There were many attempts to extend healthcare to rural areas, but all were faced with technical or logistical problems, as well as the seasonal nature of farm labor, the resistance of agricultural employers, contribution fraud, and systemic financing deficits. As a result, the agricultural sector joined the insurance system later than the industry and service sectors. The implementation of the National Agricultural Welfare Service of 1958 and the National Agrarian Welfare³³ the year later, was delayed and failed to improve the situation, even reducing the number of contributors⁸.

It was not until 1966, with the approval of the law on the Special Agrarian Social Security Regime, that an attempt was made to provide healthcare to farmworkers “as similar as possible” to the healthcare provided to workers in the industry and the service sector, according to the Law on the Bases of Social Security³⁴. The preamble to the regulation on the Special Agrarian Social Security Regime expressly manifested the need to maintain an agricultural labor force presently at risk of being compromised because of the current migratory flow:

The economic-social reality of the Spanish country demands an urgent social policy aimed at revaluing its human factor. The depopulation of the country is a well-known fact, with a progressive tendency to an aging workforce insufficiently qualified for the specific jobs of the field. This makes it difficult to achieve an adequate efficiency index that would contribute to the normal performance of the available manpower⁵.



This measure –which had been in the making since the approval of the Law of Bases–, was closely followed by the medical profession, especially by the district doctors, who saw the payments under the *igualada* reduced –their main source of income– as the result of the greater national coverage.

Numerous examples clearly illustrate this resistance. For example, in the column of *Tribuna Médica* dedicated to interviewing presidents of Regional Medical Associations, the interviewees stated their disagreement with the advances of Social Security in rural areas. Marcelino Martín Luelmo, president of the Zamora Medical Association, pointed out how they had “raised the alarm” before the General Council of Medical Associations due to the plans to extend healthcare coverage in the country³⁵. We can also find statements along the same lines in the *Boletín*, for example, in an unsigned article: “Difficult times for the rural doctor: Social Security advances relentlessly”³⁶ (p. 17). This text analyzed the repercussions of extending healthcare to rural areas, a policy that was the culmination of previous attempts to implement a system of rural protection. We found similar thoughts in *Profesión Médica*, such as that of the president of the College of Physicians of Cuenca, E. Valero, who predicted the conversion of the rural doctor into just another migrant who moved from the country to the city, in search of better job opportunities³⁷.

Antonio Salamanca Rodríguez, national representative of the APD Medical Corps in the General Council of Medical Associations of Spain, noted that these attempts dated back to the entry into force of the SOE in 1944, which reduced the income from the *igualada* to a quarter. These estimates are not very credible and must be considered with the intention to safeguard the income generated by the *igualada*. It is worth noting how in the late Franco era, district doctors still considered the Insurance as the beginning of the end of their profession as they knew it. They felt it threatened the archetypal that they themselves had built and that Antonio Salamanca summarized as “human, intimate, cordial medicine of direct contact, which the rural doctor or the district doctor can provide as opposed to the scientific medicine applied to the masses, at fixed and scheduled times” and that the socialized medicine represented³⁸.

Conclusion

As demonstrated, healthcare in rural areas was neglected in within the healthcare structure during the Dictatorship. Thus, while in urban areas the most ambitious social policy project of the early Franco regime –the SOE– was deployed, although not without difficulties, the structures of charitable assistance were still fundamental in the country. At the same time, the situation was exacerbated by an important migration flow from the countryside to the city, which progressively emptied the rural world.

The study of the different realities that emerged as a result of this process is inevitably burdened by the absence of patients’ voices. However, after reviewing other sources, we have been able to approach the perspective of the medical personnel responsible for providing care in small communities and, also, the legislation enacted by the Government to try to reorganize the district doctors and include agricultural workers in the healthcare coverage. Thus, physicians who practiced in the rural sector were lavish in their accounts of the increasing distance that separated them from



the physicians in urban areas. Rural medicine was foreign to the knowledge learned in universities, progressively based on medical specialties and with hospitals as the epicenter. Daily practice in rural Spain was characterized by precarious resources, endless working days, low wages, and lack of rest. Moreover, the professionals perceived their life as an exile in a foreign and often hostile environment.

The national policy and regulations sought to centralize the organizational structures of rural healthcare and to pursue the neglect detected in many medical districts and reorganize them. While the centralization process was completed –although it was a secular transformation–, the new classification of the medical districts was limited to the elimination of practitioner positions, provoking the objection of some of the population. At the same time, the neglect of care in the country remained a reality until the end of the Dictatorship. This situation contrasted with the attempts to extend healthcare coverage to the rural areas, especially through the Special Agrarian Social Security Regime. The district doctors perceived these attempts as the final blow to their profession, which decline had begun with the timid implementation of the SOE in the rural areas and which had been severely affected by the process of depopulation and the advance of Social Security, limiting the income they received from the *iguala*.

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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O objetivo do artigo é analisar dois aspectos da atenção à saúde na Espanha rural durante o segundo período da ditadura de Franco (1959-1975). Em primeiro lugar, analisamos a introdução do Regime Especial de Previdência Social Agrária (1966), que proporcionou assistência médica aos trabalhadores rurais. Até então, eram excluídos do Seguro Obrigatório de Saúde (1944), destinado aos operários da indústria e demais trabalhadores com baixos salários. Em segundo lugar, analisamos a oposição dos médicos rurais à extensão da cobertura de saúde aos trabalhadores agrícolas. Para alcançar ambos os objetivos, analisamos as limitações da prática médica no meio rural e como a ditadura tentou resolver esses problemas, sem sucesso. As fontes utilizadas são: disposições legislativas, publicações de associações profissionais oficiais, imprensa dedicada a discutir problemas da prática médica, relatórios sociológicos e documentação arquivística.

Palavras chave: Acesso aos serviços de saúde. Serviços de saúde rural. Médicos. Espanha. História do século XX.

El objetivo del artículo es analizar dos aspectos de la asistencia sanitaria en el medio rural español durante el segundo periodo de la dictadura franquista (1959-1975). Primero analizamos la implantación del Régimen Especial Agrario de la Seguridad Social (1966), que proporcionó asistencia sanitaria a los trabajadores del campo. Hasta entonces, habían sido excluidos del Seguro Obligatorio de Enfermedad (1944), destinado a obreros industriales y otros asalariados con bajos ingresos. En segundo lugar, analizamos la oposición de los médicos rurales a la ampliación de la cobertura sanitaria a los trabajadores agrícolas. Para lograr ambos objetivos analizamos las limitaciones del ejercicio médico en el ámbito rural y cómo la Dictadura intentó solucionar infructuosamente estos problemas. Las fuentes empleadas han sido: disposiciones legislativas, publicaciones de los colegios profesionales oficiales, prensa dedicada a discutir problemas del ejercicio médico, informes sociológicos y documentación de archivo.

Palabras clave: Accesibilidad a los servicios de salud. Servicios de salud rural. Médicos. España. Historia del siglo XX.