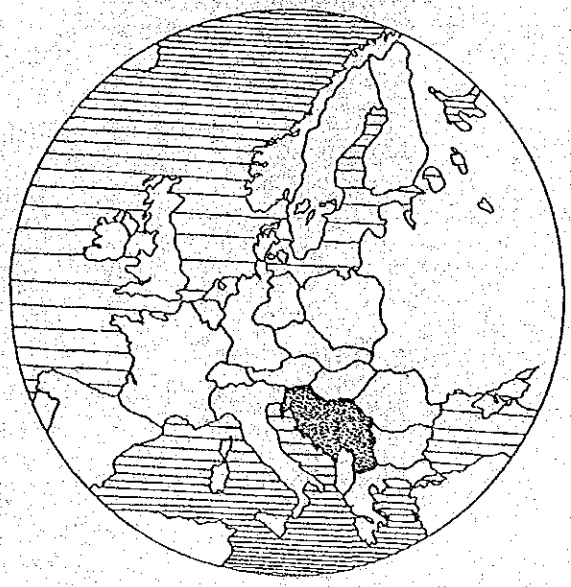
CENTRE FOR HEALTH COOPERATION
WITH NON-ALIGNED AND DEVELOPING
COUNTRIES

TCDC FOR HEALTH FOR ALL SERIES

S. LETICA & B. SKUPNJAK
/ EDITORS /

HEALTH SYSTEM IN YUGOSLAVIA



ZAGREB 1984

AUTHORS

Želimir Jakšić
Karmela Krleža-Jerić
Slaven Letica
Mladen Mitak
Donna Parmelee
Boško Popović
Berislav Skupnjak
Milan Škrbić

LANGUAGE EDITOR
Donna Parmelee

TABLE OF CONTENTS

HEALTH SYSTEM IN YUGOSLAVIA

POLITICAL AND ADMINISTRATIVE
STRUCTURES OF SFR YUGOSLAVIA

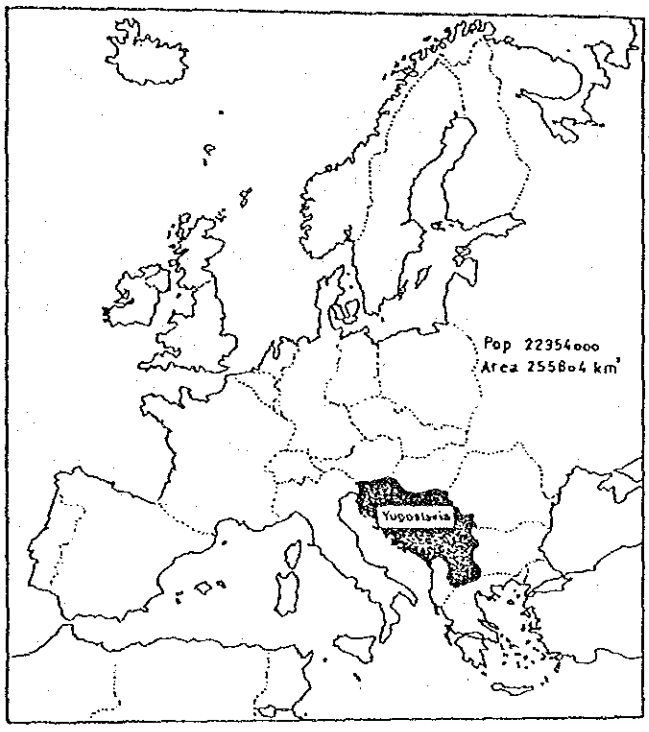
Slaven Letica

1. COUNTRY PROFILE

1.1. Geographical Position[1]

The territory of Yugoslavia spreads over five different geographical regions in Central (Alpine) and Southeastern Europe (Pannonian, Adriatic-Mediterranean, Dinaric and Rodopian). The old definition of Yugoslavia's geographical position described it as one of the Balkan countries due to the fact that most of the country was located to the south of the Danube and Sava rivers, once considered the north frontier of the so-called Balkan Peninsula which itself was - from a geographical point of view - quite a vague notion. The modern definition places Yugoslavia among the Danubian - Mediterranean countries, and this is the best and most complete one as far as its position in Europe and the world is concerned (see Map 1).

MAP 1: Location of Yugoslavia in Europe



1 The following section is quoted from: The World Atlas - A New Insight into the Earth, University Press Liber, Zagreb, 1984, p. 36.

The greatest part of today's territory of the Socialist Federal Republic of Yugoslavia was established after the First World War of lands which up to then had been parts of other countries and at different levels of economic development. These lands, however did share a common ethnic affinity and, in most cases, common languages were spoken by their inhabitants.

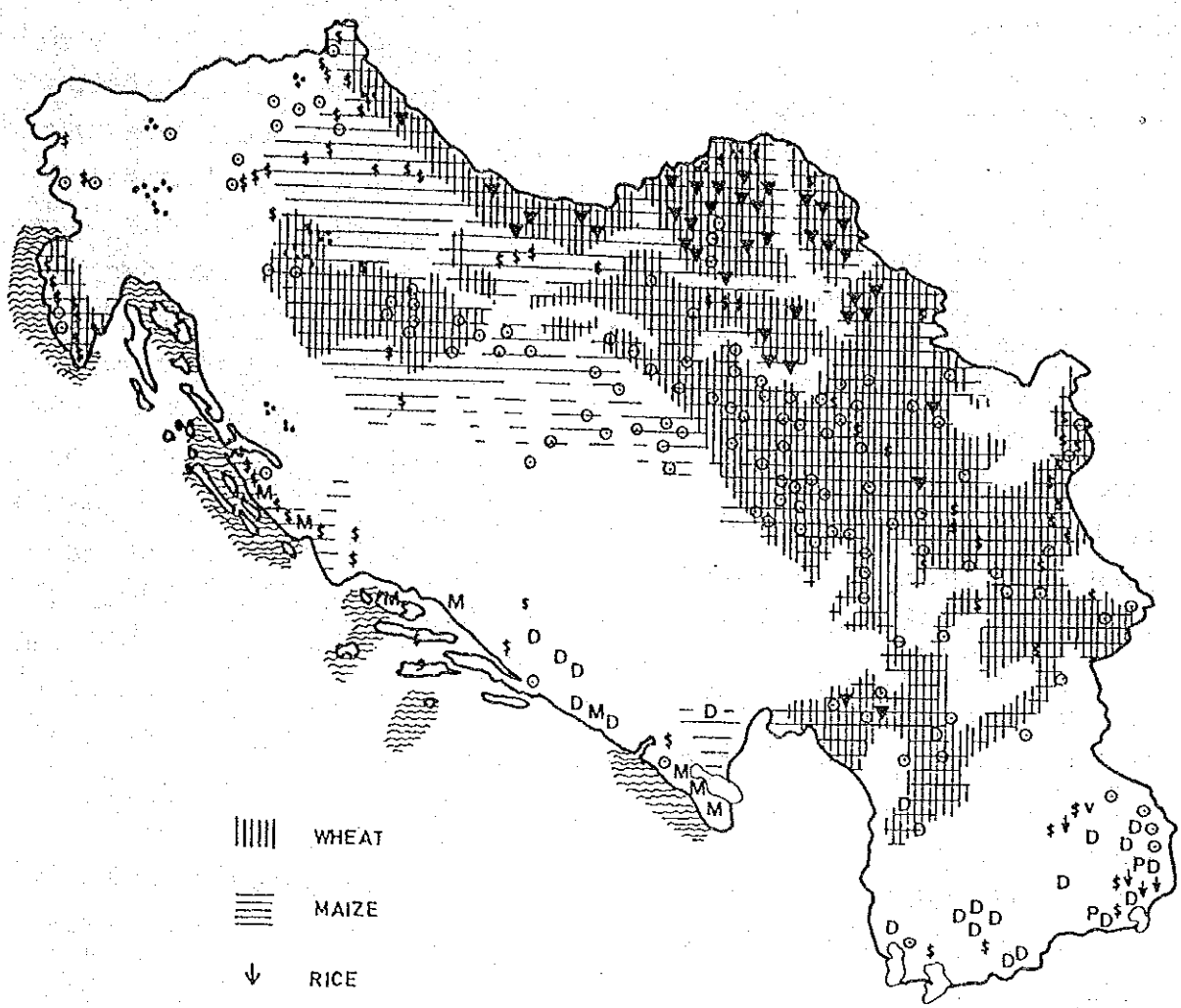
The first united state of Yugoslavia (1918-1941) was a great disappointment to all patriots from all of the nations in it. The unsolved status of the nations and nationalities, the despotic centralist monarchy and the inability of the ruling class to stimulate development of the productive forces led the country towards the abyss which took place in 1941.

Yugoslavia is mostly a mountainous country, since the largest portion of its territory (about 72 percent lies 200 meters above sea-level). More than 56 percent of the territory is covered by low and medium-height hills up to 1,000 meters. However, mountains higher than 1,000 meters make up only 16 percent of its territory. This is very important because climatic conditions are a serious obstacle to agricultural development and to permanent residence only above 1,000 meters, although high mountains have their value for stock-breeding and tourism (see Map 2 for current distribution of agriculture and fishing in Yugoslavia; Editor's note) This relief, with its high-mountain zone which runs like a steep wall along the Adriatic coast, as well as the geographical position of Yugoslavia in relation to transcontinental air currents contribute to climatic variation. Namely, in Yugoslavia one finds Adriatic-Mediterranean , Alpine-Dinaric, Pannonian, Peripannonian and Aegean-Mediterranean climates.

In Yugoslavia, 70 percent of the rivers empty into the Danube river, 21 percent into the Adriatic Sea, and 9 percent into the Aegean Sea. The watershed cannot be precisely determined since there is considerable karst with underground streams.

The Adriatic coast, including its islands, is more than 6,000 km long, although in a straight line from the Miljski Peninsula to the Bojana river it is only 750 km. The sea is transparent and bright blue but biologically poor (despite the abundance of organic species).

AGRICULTURE AND FISHING



1.2. Cultural Background (Identity)

For centuries the geographical position of Yugoslavia has played a dominant role in the social, political and cultural identity of its inhabitants. Living in areas where military, political and economic interests of East and West (in the past) and of North and South (at the present) have been in conflict, the peoples in what is now Yugoslavia have constantly been fighting to preserve their territory and their social and cultural identity. The influence of various civilizations constantly fighting for supremacy in the Balkans is evident even today in the culture and habits of the Yugoslav peoples: in architecture, language, nutritional habits, religion, education, health care, etc. The cultural and social unity of the nations in Yugoslavia has been torn between homogeneity (ethnic affinity, economic interests) and heterogeneity (different cultures and foreign interests). Until 1941, the conflict between the Byzantine-East and European-West seemed to be an eternal destiny and unsolvable problem. Today this "confict" is a part of the country's interesting social and cultural background. In Yugoslavia nowadays live six nations and ten odd nationalities ("national minorities"), who speak "four plus two" official languages, write in two alphabets and practice four major religions and several smaller ones. Their homogeneity stems from common economic, political, ideological, social and cultural interests.

1.3. Language

In Yugoslavia there are three languages in official use: Croatian/Serbian (Serbian/Croatian), Slovenian and Macedonian. The Macedonian language is spoken in Macedonia, and Slovenian in Slovenia. The Croats, Moslems, Montenegrins and Serbs speak one and the same language as far as phonetics and linguistics are concerned, but there are two standard forms (languages): the Croatian standard language (Croatian or Serbian, Croato-Serbian) in Croatia and the Serbian standard language (Serbo-Croatian) in Serbia, and two subversions in Bosnia and Hercegovina and Montenegro. There are two official alphabets in use: Latin and Cyrillic. The languages of the various nationalities are

also treated as equal in the regions where they are spoken and are used in education, legislation, administration, etc.

1.4. National Structure

The multi-national composition of its population is a distinctive feature of the SFR of Yugoslavia. In 1981, the figures were as follows: Serbs -8,140,507 (36.3 percent), Croats - 4,428,043 (19.7 percent); Macedonians - 1,341,598 (6.0 percent); Moslems - 1,999,890 (8,9 percent); Slovenians - 1,753,571 (7,8 percent); and Montenegrins - 579,043 (2.6 percent). There were 1,219,024 (5.4 percent) persons nationally declared as "Yugoslavs". The nationalities ("national minorities") were : Albanians - 1,730,878 (7,7 percent); Hungarians - 426,867 (1,9 percent); Turks -101,291; Slovaks - 80,334; Bulgarians - 36,189; Romanians - 54,955; Ruthenians - 23,286; Czechs - 19,624; Italians - 15,132; others 251,377. The geographical distribution of nations and nationalities in 1971 is shown in Map 3.

1.5. Religions

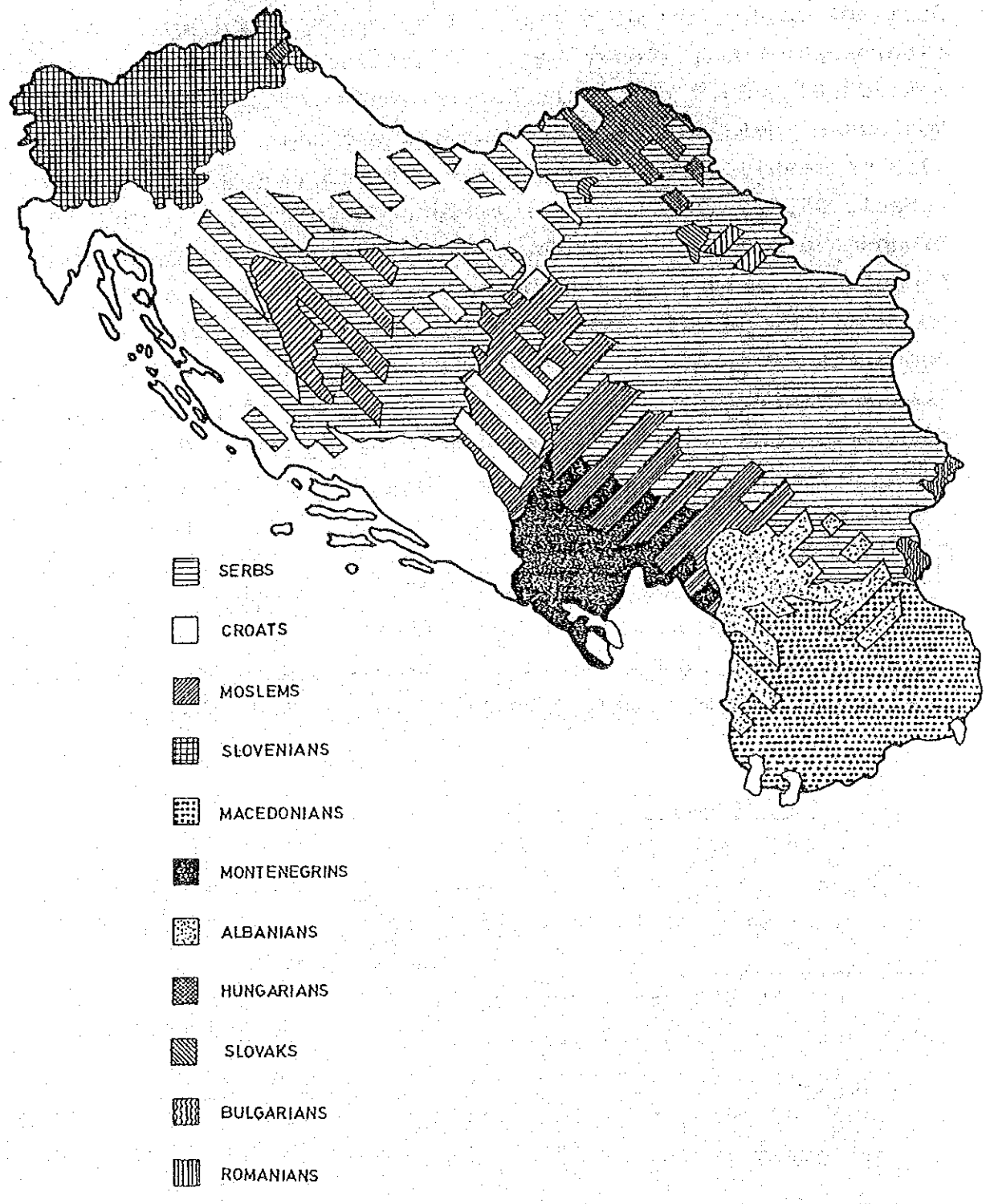
The Serbian Orthodox Church, the Roman Catholic Church, Islam and the Macedonian Orthodox Church are the largest in terms of numbers of adherents. There are also several other smaller religious groups (Baptists, Methodists, etc.).

1.6. The Ownership System

In Yugoslavia a mixed ownership system is in use. There are three types of ownership: social, private and personal. The means of production in nonagricultural sectors are largely socially - owned[2]. The private nonagricultural sector comprises only some 180,000 small "enterprises" (handicrafts, tourism, catering) employing 2.0 percent of total labour force. Private ownership is predominant in agriculture, where 83 percent of the land, 87 percent of the cattle and 94 percent of the tractors are privately owned. In 1981, the private agricultural sector

[2]Social ownership must be distinguished from state and public ownership; socially-owned means of production can be freely used and managed by all workers through the self-management system.

NATIONS AND NATIONALITIES IN 1981



employed 2.9 million people and the public agricultural sector only 200,400 people. Finally, personal ownership relates to ownership of property for personal use and consumption. For example, flats and houses are personal property. Out of 3.1 million flats constructed during period from 1953-1981, only 33 percent are socially-owned while 67 percent are personal property. It should be noted that the status of employees and "employers" in the private and public sectors is legally and economically equal (with regard to tax policy, price policy, credit policy, etc.).

1.7. The Socioeconomic System - Main Principles

(a) The Federal State System

"The Socialist Federal Republic of Yugoslavia is a federal state having the form of a state community of voluntarily united nations and their Socialist Republics, and of the Socialist Autonomous Provinces of Vojvodina and Kosovo, which are constituent parts of the Socialist Republic of Serbia, based on the power of and self-management by the working class and all working people; it is at the same time a socialist self-management democratic community of working people and citizens and of nations and nationalities having equal rights".[3]

(b) The Status of Man in Associated Labour[4]

"Man's economic and social status shall be determined by labour and the results of labour, on the basis of equal rights and responsibilities.

No one may gain any material or other benefits, directly or indirectly, by exploiting the labour of others.

---

[3] 1974 Constitution of SFR Yugoslavia, Article 1.

[4] Associated labour is a term used to denote all institutional forms of association of labour by workers who, organized on a self-management basis, perform with socially-owned resources economic and non-economic activities, and also to denote all other forms of pooling of labour and resources by working people on these foundations.

No one may in any way make it impossible for a worker to decide or restrict in deciding,on an equal footing with other workers, on his labour and the conditions and results of his labour!"[5]

(c) The Self-Management System

Self-management is certainly the most significant "diferentia specifica" of the Yugoslav political system. Instead of state management (typical for state-real socialism) or professional-private management (characteristic to capitalist private enterprise), Yugoslavia cherishes self-management as a management system which corresponds with the social ownership system. Self-management was initiated in 1950 and was then called workers' management. Workers' rights to make decisions about the distribution of income and business policy were at first confined to approximately 30 percent of business decisions. Nowadays, self-management in both its formal and legal aspects applies to decision-making about important economic and political matters, since self-management as a form of direct democracy has been extended to self-management communities of interests (see below) and territorial - political communities. In every-day practise, self-management as a form of direct "workers' rule"confronts interests of governmental and para-governmental administration and bureaucracy.

Slaven Letica

2. SOCIOECONOMIC CHANGES AND DEVELOPMENT

2.1. Socioeconomic Reforms in the New Yugoslavia

In order to understand socioeconomic development of Yugoslavia during the period from 1945-1984, it is necessary to at least briefly describe economic conditions in the Old Yugoslavia (1918-1941). Although Old Yugoslavia was an agrarian country where 75 percent of the population lived from farming, cattle-breeding, forestry and fishery, there was almost no agrarian policy (referring to prices, purchase, export, import, etc.). Industrial policy was rather simple and primitive. Investment and development policy was under the control of foreign capital, which in joint stock companies nominally

[5] 1974 Constitution of SFR Yugoslavia, Article 11.

amounted to only 51.5 percent but in fact was represented much more heavily. French, Belgian, German and English capital dominated coal mining. Copper, gold and pyrite mines were under the control of French (Bor) and Belgian (Majdanpek) capital , while bauxite processing was controlled by Swiss, American and Hungarian capital. The situation was similar in banking business and commerce. However, in many industries such as the aircraft industry, textiles, food processing, and timber and wood processing the domination of foreign capital was not so strong. While foreign capital played a domineering role, its absolute amount was not large, totalling 500 million U.S. dollars for the whole period from 1918-1941. It is important to note that such an undeveloped and autarkic economy secured a positive balance of payments almost every year with rare exceptions.

The Second World War only intensified Yugoslavia's problems of economic and social under development. The economic impact can be measured in loss of man-power, destruction of productive capacity, exploitation by the occupying powers and disintegration of the country as an economic unit. To illustrate the dimensions of wartime losses, approximately 1.7 million Yugoslavs, or 11 percent of the prewar population, were killed, fled or expelled. Almost 300,000 farms and over a third of equipment and industrial facilities were destroyed. And , as much as 25 percent of the Yugoslav population was homeless, with more than a fifth of all prewar housing rendered uninhabitable.[1]

Faced with this disastrous economic situation, in 1945 the Yugoslav Communist Party began to make plans for the long range development of the country. First of all, it was necessary to bring the economy into accordance with "the character of the government", i.e., to put forward legal and economic principles of a "people's state - owned property and economy" that would correspond with the interests of an already established "government of the people". Already in 1945 a state sector was

---

[1]Donna E. Parmelee, Medicine Under Yugoslav Self managing Socialism, University Microfilms International, Ann Arbour, 1983, p. 19.

formed by the "confiscation of property of traitors". By confiscating property of all enemies and their collaborators and of those who profited from the war, the government came into possession of over 80 percent of industry, 100 percent of public transport, banking, business, wholesale and foreign trade. The first Nationalization Law of November 6, 1946 turned the remaining capitalist enterprises into property of the government. After that , only 3,100 larger firms remained in private hands.

Reforms were also initiated in the agricultural sector. The Law on Agrarian Reform and Resettlement of August 23, 1945 deprived kulaks of surplus land exceeding 25-30 hectares, the Church of surplus land exceeding 10 hectares and owners who did not till their fields of surplus land exceeding 3-5 hectares.[2] As the result of the Agrarian Reform, the government took possession of over 1,400,000 hectares; 800,000 hectares were divided among 316,000 families in accordance with the slogan "land must be given to those who till it". Publicly-owned farms were established from the remaining 600,000 hectares. Since land surplus did not territorially correspond with the "surplus" of landless peasants, a resettlement took place. About 60,000 families were moved from Dalmatia, Lika, Bosnia and Hercegovina and Montenegro to Vojvodina and Slavonia.

These changes were only the first step to make "the character of the economy" correspond with that of the government. The next steps were currency, monetary, credit and tax reforms which enabled the government to gain control over the financial system and accumulation. These reforms made it possible to exercise a policy of so-called "primitive socialist accumulation", i.e. to deprive the private sector (mostly agricultural) of surplus labour to the benefit of government-owned industrial sector.

---

[2] Since the second Agrarian Reform in 1953, private ownership of land has been limited to 10 hectares.

2.2. Economic Development

Applying a classic typology of development models (wealth-oriented model, growth-oriented model, basic-needs-oriented model, growth-of-state-power-oriented model, model oriented toward social changes), it can be said that in Yugoslavia from 1945 until 1984 a nonselective composite development model has been employed, namely: growth-oriented + social changes-oriented.

Forty years (1945-1984) is a period long enough to display all the advantages and disadvantages of the chosen development model. The development strategy employed in Yugoslavia was as follows: rapid deagrarization + even more rapid industrialization (up to 1960, heavy industry and power industry; from 1961 on, processing industry) + educational revolution. This strategy needed an adjustment of investment, education, tax and price policy (lower prices in agriculture than in industry). Table 1 summarizes the results of these policies (see Table 1).

Rapid growth of GNP and employment as the first objectives of the development strategy was fulfilled already by 1980. Growth rates exceeded average growth rates in other European and developed countries (see Table 2).

TABLE 1: ECONOMIC INDICATORS FOR YUGOSLAVIA, 1952 - 1981

Year	GNP per capita ($)[a]	Agricultural input to GNP (%)	Private sector input to GNP (%)	Consumption (personal) ratio (%)	Investment ratio (%)	Public expenditure ratio (%)	Unemployment ratio (%)[b]	Debt in millions of $
1952	485	30.4	30.5	55.1	30.3	20.6	1.0	-
1960	758	28.2	28.4	51.7	32.4	10.9	1.9	-
1965	1154	20.2	19.5	50.5	27.4	7.6	2.8	1243
1970	1536	17.8	18.5	54.9	32.9	9.3	3.6	2350
1975	1965	15.6	16.1	54.7	32.4	9.9	5.8	6584
1980	2430	13.4	13.7	52.7	35.1	9.2	8.1	18395
1981	2420	13.6	13.8	51.8	31.1	9.0	8.3	20168

[a] At constant 1980 US dollar (original data in constant 1972 YU dinars; exchange rate assumed 7.3395)

[b] $$\text{Unemployment ratio} = \frac{\text{number of unemployed persons}}{\text{number of active population}} \times 100$$

Source: Statistical Yearbook of Yugoslavia,
Federal Statistical Office, Belgrade, Various years.

TABLE 2: GROWTH RATES FOR GNP AND EXMPLOYMENT AND INFLATION RATES, 1948 - 1982

Year	GNP	Employment	Inflation rate
1948 - 1952	2.0	8.0	-
1953 - 1956	6.6	6.3	2.3
1957 - 1960	11.3	7.6	3.0
1961 - 1965	6.8	4.3	11.1
1966 - 1970	5.8	1.0	10.0
1971 - 1975	5.9	4.3	20.2
1976 - 1980	5.7	3.6	17.7
1981 - 1982	1.1	2.7	37.7
1948 - 1982	5.8	4.8	12.5[a]

[a] 1954 - 1982

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, various years.

At the same time, some of the negative effects of this rapid and nonselective growth have gradually become evident:

1. Unemployment (and emigration) have increased. Unemployment began to rise at the beginning of the 1960s because the rate of deagrarization exceeded the rate of industialization (see Table 3). The decrease in the number of people whose livelihood was based on agriculture (in the villages) resulted in pressure on industrializing cities. This has given rise to two problems: a housing problem and an employment problem. Since these problems could not be solved within the country from 1960 to 1970, the Yugoslav government has practised a policy of mass

economic emigration that has had several positive short-term social and economic effects: it (a) reduced latent unemployment; (b) eased the housing problem in cities; (c) improved the balance of payment situation (workers send home from one to three million dollars per year).

TABLE 3: DEAGRARIZATION AND URBANIZATION RATES 1948 - 1981

Year	Agricultural population (%)	Urban population (%)
1948	67.2	21.7 (1953)
1961	49.6	28.3
1971	38.2	38.6
1981	19.9	46.5

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, 1984.

2. Inflation was a serious economic problem during the period from 1971 - 1980, when the average inflation rate was 19 percent (see Table 2). Since 1981 inflation has become a social and political problem because the inflation rate has been constantly increasing, first to 40 percent, then to 50 percent and is now exceeding 60 percent.

3. Zero-growth (economic crisis) began in 1980. Yugoslavia has entered an era of economic crisis characterized by zero-growth of GNP, a decline in the standard of living, a decrease investments and a relatively large foreign debt. How seriously the development model and economy are jeopardized can be illustrated by data on the dependence of Yugoslavia on importation of basic strategic goods:

- Food	20-30%
- Energy	30-40%
- Raw materials and manufacturing components	40-50%
- Technology	50-70%

Slaven Letica

3. HEALTH STATUS OF THE POPULATION

Concurrently with socioeconomic development, the structure and health status of the Yugoslav population have undergone profound changes. The birth rate has declined for most of the period from 1921-1982, but in recent years has levelled off at around 16.5 per 1,000 people. The death rate dropped from 20.9 in 1921 to 9.0 per 1,000 in 1961. Since then the death rate has not changed significantly. The infant mortality rate for Yugoslavia as a whole has steadily declined from a high of 164.5 infant deaths per 1,000 live births in 1931 to an estimated 29.9 in 1982,but then increased slightly to an estimated 31.7 in 1983. Simultaneously, life expectancy at birth has increased from 56.9 years for males and 59.3 year for females for the period from 1952 - 1954, to 67.7 and 73.2, respectively for 1979-80 (see Table 1 and 2 and Graphs 1 and 2).

GRAPH 1

Natural Increase of the Population

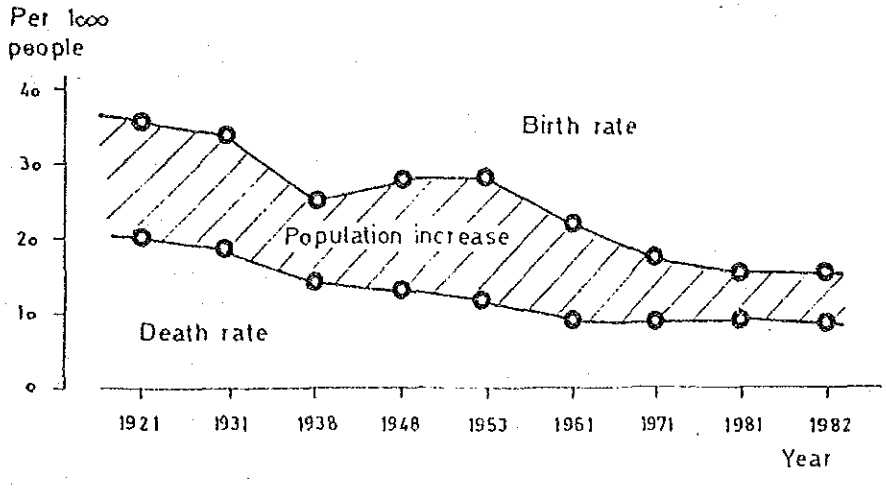


TABLE 1: DEMOGRAPHIC INDICATORS FOR OLD AND NEW YUGOSLAVIA, 1921 - 1982

Year	Population Total[a] (000)	Reproduction rates Crude birth rate	Crude death rate	Growth rate	Life expectancy Males	Females	Infant mortality rate	Population density
1921	12,059	36,7	20.9	15.8	-	-	-	-
1931	13,982	33.6	19.8	13.8	45.0	46.1	164.5	-
1939	15,596	25.9	14.9	11.0	-	-	132.3	-
1948	15,901	28.1	13.5	14.6	48.6	53.0	-	61.9
1953	17,048	28.4	12.4	16.0	56.9	59.3	109.8	66.4
1961	18,612	22.7	9.0	13.7	62.3	65.4	82.0	72.5
1971	20,574	18.2	8.7	9.5	65.4	70.2	49.5	80.2
1981	22.471	16.4	9.0	7.5	67.7	73.4	30.8	87.7
1982[b]	22,646	16.5	8.9	7.6	-	-	29.9	87.6

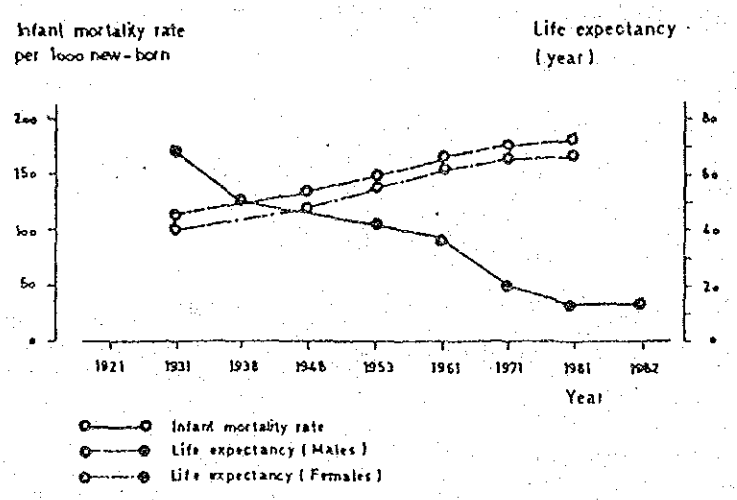
[a] For 1921,1931 and 1939 - The territory of the Old Yugoslavia

[b] Estimated data.

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, various years.

GRAPH 2

Infant Mortality Rate and Life Expectancy

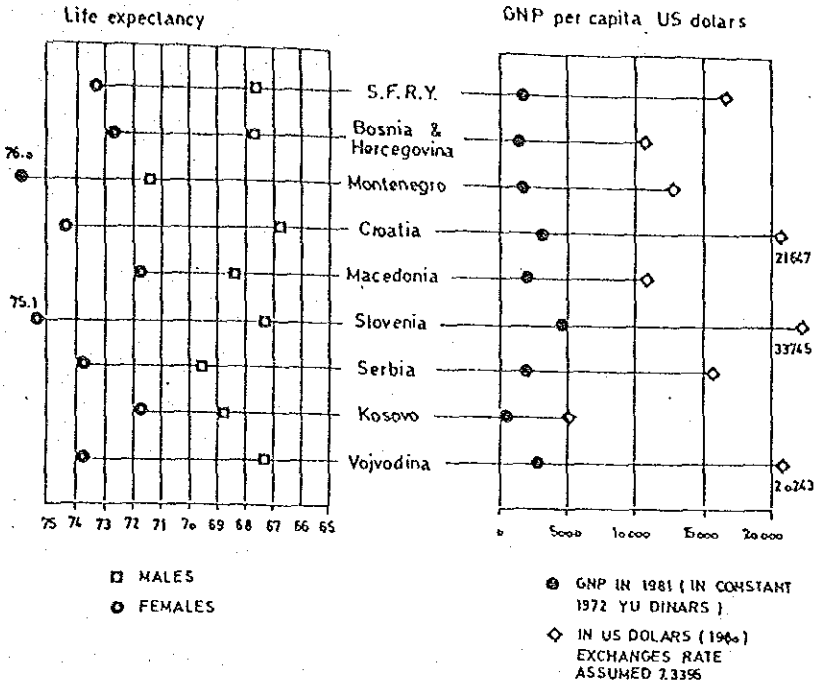


Source: Table 1.

It should be noted , however, that there are great differences in life expectancy and infant mortality rates among the republics, provinces and regions of Yugoslavia. The differences have their roots in an uneven level of socioeconomic development, as can be seen from data presented in Graphs 3 and 4 and in Table 2.

GRAPH 3

Life Expectancy and GNP per Capita in S.F.R.Y. in 1981



Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, 1983, pp. 44,57.

GRAPH 4

Illiteracy Rate and Infant Mortality Rate in 1981

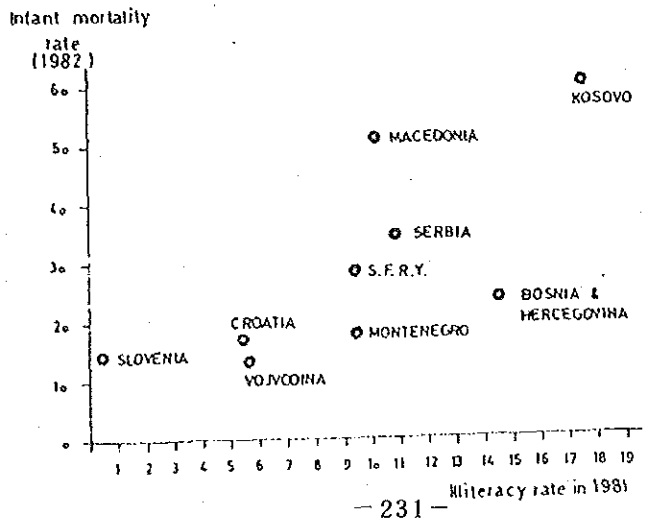


TABLE 2: GNP IN DINARS (1981) AND US DOLLARS (1980), AND LIFE EXPECTANCY (1979-1980), BY REPUBLIC AND PROVINCE

	GNP		Life expectancy (1979-1980)	
	in dinars[a] (1981)	in dollars[b] (1980)	males	females
YUGOSLAVIA	17,193	2,343	67,7	73,2
BOSNIA AND HERCEGOVINA	11,547	1,573	67,7	72,6
CROATIA	21,647	2,949	66,9	74,2
KOSOVO	5,013	683	68,7	71,8
MACEDONIA	11,490	1,506	68.4	71.8
MONTENEGRO	13,484	1,837	71,4	76.0
SERBIA	16,824	2,292	69.5	73.9
SLOVENIA	33.745	4.598	67.3	75.1
VOJVODINA	20,243	2,758	67.4	73.7

[a]In constant 1972 Yugoslav dinars

[b]Exchange rate assumed: 7.3395.

Source: Statistical Year book of Yugoslavia, Federal Statistical Office, Belgrade, various years.

Literacy (as a general indicator of social and cultural development) and infant mortality likewise vary considerably among the Yugoslav republics and provinces (see Table 3).

TABLE 3: ILLITERACY RATE (1981) AND INFANT MORTALITY RATE (1982), BY REPUBLIC AND PROVINCE

	Illiteracy rate (%) (1981)	Infant mortality rate (1982)
YUGOSLAVIA	9.5	29.9
BOSNIA AND HERCEGOVINA	14.5	24.3
CROATIA	5.6	18.6
KOSOVO	17.6	62.0
MACEDONIA	10.9	53.0
MONTENEGRO	9.4	19.6
SERBIA	11.1	34.2
SLOVENIA	0.8	15.2
VOJVODINA	5.8	14.0

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, 1984.

Furthermore, even within the same republic or province there are substantial differences in health status indicators. To illustrate, Table 4 shows the range in infant mortality rates (highest and lowest) for communes in each of the republics and provinces. Of course, statistics on infant mortality are constantly changing so that the data given for 1981 do not necessarily illustrate stable relationships of mortality.

TABLE 4: RANGE IN INFANT MORTALITY RATES FOR YUGOSLAV COMMUNES IN 1981, BY REPUBLIC AND PROVINCE

Bosnia and Hercegovina		Croatia		Kosovo	
Čajniće	81.5	Vis	60.0	Kačanik	117.8
Grude	4.8	Novi Marof	5.2	Lepanović	30.5
		(Pazin	5.4)		
Macedonia		**Montenegro**		**Serbia**	
Tetovo	87.9		41.6	Preševo	101.1
Valandovo	13.3	Danilovgrad	5.6	Kúčevo	3.4
Slovenia				**Vojvodina**	
Cerknica	33.7			Sečanj	37.7
Kamnik	4.0			Bač	4.1

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, 1984, pp.612-21.

Morbidity and mortality data for Yugoslavia are now similar to these of developed countries (except for higher infant mortality than is found in developed countries). Immediately after 1945 morbidity and mortality data had all the characteristics of developing countries (see Table 5, Graph 5).

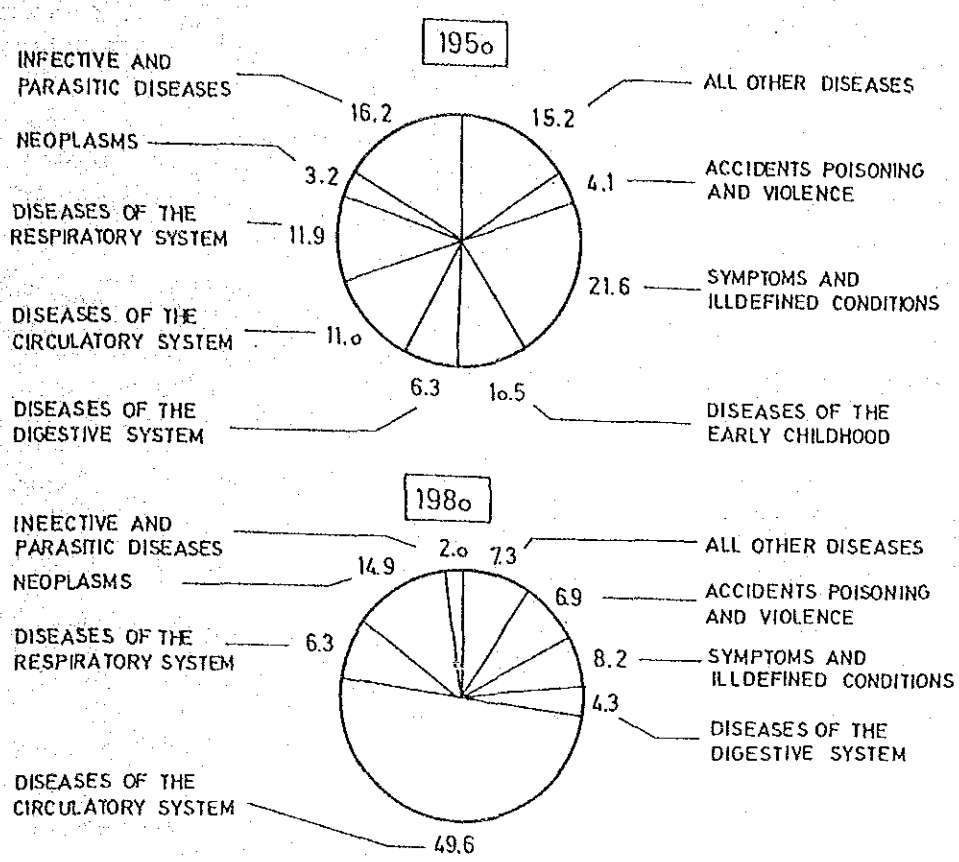
TABLE 5: DEATH BY CAUSES IN YUGOSLAVIA, 1950 and 1980

Main disease category	1959	1980
Infectious and parasitic diseases	16.2	2.0
Neoplasms	3.2	14.9
Diseases of the respiratory system	11.9	6.3
Diseases of the circulatory system	11.0	49.6
Diseases of the digestive system	6.3	4.3
Diseases of the early childhood	10.5	-
Symptoms and illdefined conditions	21.6	8.2
Accidents, poisoning and violence	4.1	6.9
All other diseases	15.2	7.3

Source: Statistical Yearbook of Yugoslavia, Federal Statistical Office, Belgrade, various years.

GRAPH 5

Death by Causes in Yugoslavia in 1950 and 1980



Slaven Letica and Berislav Skupnjak

4. YUGOSLAV HEALTH CARE IDEOLOGY - BASIC PRINCIPLES

The contemporary Yugoslav public health care ideology (doctrine) stems from three equally important political and theoretical sources:

1. It implies some classic principles of working class social policy (the principle of having the "same rights" to health care, "free" health care, etc.);
2. It follows and further develops socio-medical and public health theory of the prewar Yugoslav social medicine (best expressed in the work of Andrija Štampar");
3. It embraces modern international ideas on the optimum strategy for health care development (first of all, the WHO's ideas and suggestions).

Andrija Štampar's health care ideology can be briefly expressed through his ten principles of health service which he issued in 1926:

1. To keep the population informed is more important than to make laws.
2. The most important thing is to prepare a community to have a proper notion about health problems.
3. Questions concerning public health care and actions to be taken are not the physician's monopoly; everyone has to be engaged in solving them. Only joint efforts can improve public health.
4. A physician should be chiefly a social worker; individual treatment cannot achieve much; social therapy can lead to success.
5. A physician must not depend financially on his patients since it would prevent him from performing his duties.
6. When public health is in question, there must be no difference between rich and poor.
7. Health care should be organized so that the physician will seek out the patient and not vice versa, because this is the only way to cover a larger number of those for whose health we are responsible.
8. A physician should be instructor to the people.
9. Public health care is more important from an economic rather than a humanitarian point of vies.
10. A physician's place is where people live, not in laboratories and offices.

Translated into modern technical terms, these ten principles concisely express the contemporary primary health care (PHC) concept: a population (and not individual) approach to the solution of health problems, an intersectoral approach to health care, active participation of the entire population in health care programmes, etc.

As modern and advanced today are Štampar's attitudes towards "international health", which implicitly or explicity express ideas of "Health for all by the year 2000"(HFA/2000) and Technical Cooperation among Developing Countries (TCDC). For example, as Štampar observed in 1948: "During the last 25 years of my work and co-operation in the field of international health, I have keenly felt that great results in our strivings for more and better health can be obtained by an interchange of thoughts and experiences. Science has taught us how to secure health for everyone, but the results of this scientific research cannot become reality and materialize before the existing economic, social and other relations among peoples have been further improved. During my numerous journeys all over the world I have realized that we can learn so much from one another. It is obvious that we cannot proceed to the solution of health problems in the same way in all countries. Each country has its own peculiarities and what may be good for one may not be so good for another. But one basic truth applies to all of them and that is that every individual has a fundamental right to health."[1]

Practical work on the development of a PHC system in the prewar and postwar period resulted in formulation of an integral ideology which can be described by analysis of its major principles, i.e.;

1. The principle of granting rights to health and health care,
2. The principle of an intersectoral approach to the solution of health problems,
3. The principle of unity and integrity in medicine,

[1] Third Plenary Meeting, 25 June, 1948.

4. The principle of rational organization and division of labour in the health care domain,
5. The principle of common responsibility - community and individual self-reliance and participation in the planning, organisation, operation and control of health care,
6. The principle of PHC as the centre of a health care system.

4.1. The Principle of Granting Individual (Civil) Rights to Health and Health Care

In Yugoslavia, the concept of a human right to health and health care stems from the principle of the same rights for all citizens, not from the principle of equality. This means that the ideology and legal - political system allow for certain inequalities in providing health care. However, these inequalities should reflect different results of labour and not the citizen's biological and social characteristics (sex, race, class, etc.).

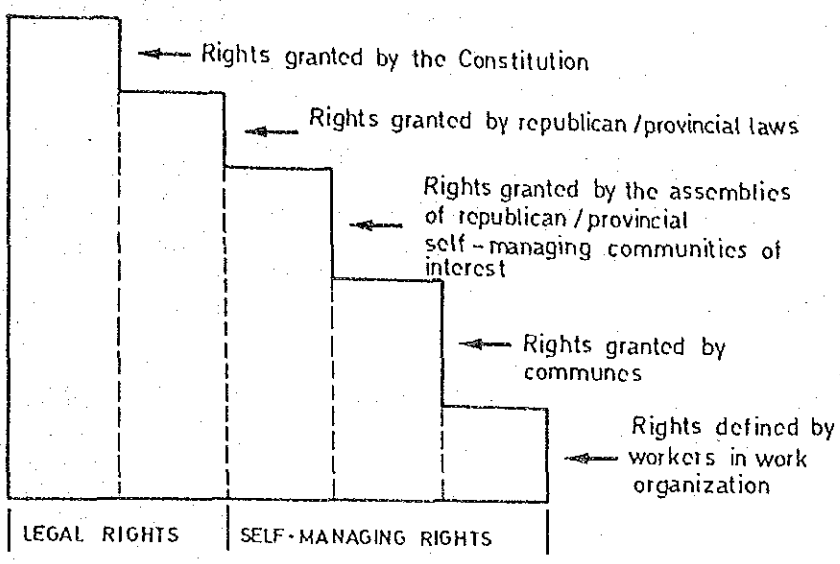
Citizens' rights to health and health care are regulated by a number of legal provisions:

1. Fundamental rights are in principle regulated by the Constitution of the SFR of Yugoslavia and the Constitutions of the Socialist Republics/Socialist Autonomous Provinces;
2. Fundamental real rights are regulated in each republic and autonomous province by laws on health insurance and health care (as well as laws on industrial safety, labour relations, etc.),
3. The assemblies of republican and provincial self - managing communities of interest may grant some additional rights (in relation to the legal "minimum");
4. The assemblies of self-managing communities of interests in each commune may extend rights as stated under (1), (2) and (3);
5. Finally, each work organization is authorized to grant some additional rights through its selfmanagement by-laws.

The structure of rights to health, health care and health insurance is summarized in graph 6.

GRAPH 6

STRUCTURE OF RIGHTS TO HEALTH IN THE YUGOSLAV LEGISLATION



Numerous rights concerning health improvement and health care are granted by the Federal and Republic/Provincial Constitutions. Here we quote the most significant constitutional rights:

1) Everyone has a right to health care;
2. Working men and women have a right to working conditions that provide for their physical and moral integrity and security;
3. Workers have a right to health care and other aspects of protection and personal safety at work. Youth, women and invalids enjoy special industrial safety;
4. Through social insurance and in accordance with the law, workers have a right to health care and other rights in case of illness, pregnancy, decrease or loss of working ability, unemployment and old age and rights to

other forms of social insurance and, for members of their families a right to health care, survivors' pensions and other rights provided by social insurance;

5. Laws regulate the cases in which citizens who are not insured have a right to health care financed from social resources;
6. Mothers and children benefit from special social welfare;
7. People have a right to live and work in healthy surroundings, and society provides the conditions to implement this right, etc.

Although initially there was variation in insurance coverage for different categorics of beneficiaries, the new health insurance and health care system after the 1980 has considerably diminished differences in rights among basic social groups (workers, i.e. employed persons; farmers; private craftsmen and "others").

The system of individual rights to health care and health insurance[2] is extremely complex. Nevertheless, the political-legal basis of the individual rights concept can be described in a very simplifed way:

a) the whole population is insured against all basic health risks; i.e. workers, craftsmen and farmers have the right to use all types of health care at the level of the general practitioner and his/her team in the local community;

b) workers and working people (that is, all gainfully employed persons) are guaranteed a standard level of rights to use so-called "specific health care of workers, which is a condition for work and production" (this is mainly preventive health care);

c) the whole population has the right to stationary health care;

---

[2] With ratification of the 1974 Constitution, the right to promulgate laws in the field of health care and health insurance was totally transferred from the federal level to the level of the republics and provinces. Here we analyze the 1980 Law on Health Care and Health Insurance of Croatia, but basic statements are valid for the country as a whole.

d) the following persons have the right to use polyclinical-consultative care;

- children until the age of 15 years and youth until completion of compulsory education;
- women in relation to pregnancy, birth, motherhood and family planning;
- all citizens suffering from chronic diseases which have to be reported;
- all persons suffering from mental diseases which represent a danger to their life, the lives of other citizens and property;
- persons suffering from distrophy and related muscular and neuromuscular diseases;
- all persons suffering from malignant diseases, endemic nephropathy and diabetes.

e) workers (gainfully employed) have the right to 100% sick pay at the expense of the health insurance system for all diseases for which sick leave does not exceed 30 days. For occupational diseases, a sick child under 7, maternity leave, hospital treatment and some other cases, the health insurance system allocates sick pay from the first day of sick leave. In all other cases of sick leave up to 30 days, sick pay is paid directly by the work organization.

f) besides the above-mentioned rights, workers also have the right to travel allowances, rehabilitation, etc.

g) members of the family, as a rule, have the same rights as the insuree, with the exception of the right to sick pay.

Quality of health care is defined by the following attributes: adequate, accessible and timely health care. The responsibility of health workers for high quality health care is especially emphasized in Yugoslav health legislation.

The right to health care regardless of its general content and quality (imposed by the possibilities of the community) always presupposes the EQUALITY OF USERS. The application of this axiom (on the absolute equality of users) is today and will be tomorrow the basic problem in fulfilling the right to health care in Yugoslavia. In other words, the disproportion between the possibilities of health care and users' demands is generally present to the disadvantage of possibilities. In more complex

procedures such as highly sophisticated technology, therapeutic procedures and rehabilitation, this disproportion is even more dramatic. In such a situation, the problem of selecting users becomes a complex necessity. The choice of selection criteria and selection practices are especially complex from the ethical point of view for those procedures and measures dealing with the dilemma of life and death (and there are ever more such dilemmas in modern medicine and health care).

Given awareness of the problem of (actual and potential) inequality of users, the new Law on Health Care and Health Insurance (1980) for the first time tries to legally establish a "standard-right to health care"; that is, a "standard level of health care". The intention of the legislators is quite clear. In a situation where the disproportion between needs and possibilities is growing, at least a temporary solution would be to guarantee (optimal and minimal) average rights to utilization of health care services. The health standard is established by law as a self-managing-legal category. It is set in plans (for a medium-term period) which specify the quantity and quality of use of legally established types of health care and other rights in health care utilization.

4.2. An Intersectoral Approach to the Solution of Health Problems

In accordance with the generally accepted attitude that health results from the impact of numerous factors (hereditary, environmental, social, medical), the Yugoslav health care systems employs an intersectoral approach. The intersectoral approach is present at all levels and in all forms of health care:

a) health care policy is run by bodies (councils for health and social policy) whose members are health professionals as well as experts in other health-related activities: agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors;

b) an intersectoral approach is employed in implementation of heatlh care measures as well.

4.3. Unity and Integrity in Medicine

For a long time, there has been a dangerous tendency in Yugoslav socio-medical theory and health policy to separate preventive from curative medicine. Experience has proved that there cannot be a good preventive physician who at the same time has no contact with general clinical medicine or any of its specialities, and vice versa, there cannot be a good clinical physician who is not acquainted with preventive aspects of his/her speciality and who simultaneously does not do his/her best to prevent illness. If preventive and curative methods are considered as joint efforts in providing health care services to individuals, families and society, the only distinction is when to employ them. The former is necessary to eliminate a cause of illness; the latter is essential after the occurvence of illness or during its development. Always bearing in mind that illness is the result of many factors, and does not have a sole cause (a bacteriological era standpoint), modern health doctrine insists on the unity of preventive and curative methods in health care.

Experience has shown that such unity is indispensable since:

1. Early detection and proper treatment of infection sources are preventive activities because they prevent the further spread of disease;

2. Early treatment often prevents a development of illness and complications meaning that it is a preventive activity;

3. Early physical and mental rehabilitation implies quicker recovery and gaining of working ability, so it often prevents disablement and death ;

4. Regular systematic checkups on the population in order to detect illness at its early stage when it has not yet manifested itself represent one of most successful methods of integration of preventive and curative measures, since all detected cases can be treated at once;

5. Illness prevention by mass immunization or inoculation is a preventive measure, but it is almost always performed by the general practitioner.

In Yugoslavia, we have attempted to bridge the gap between preventive and curative medicine in "Homes of health" and in medical centres. We discuss these institutions in a later section.

4.4. Rational Organization and Division of Labour in the Health Care System

The Yugoslav health care delivery organizational chart is outlined in graph 7.

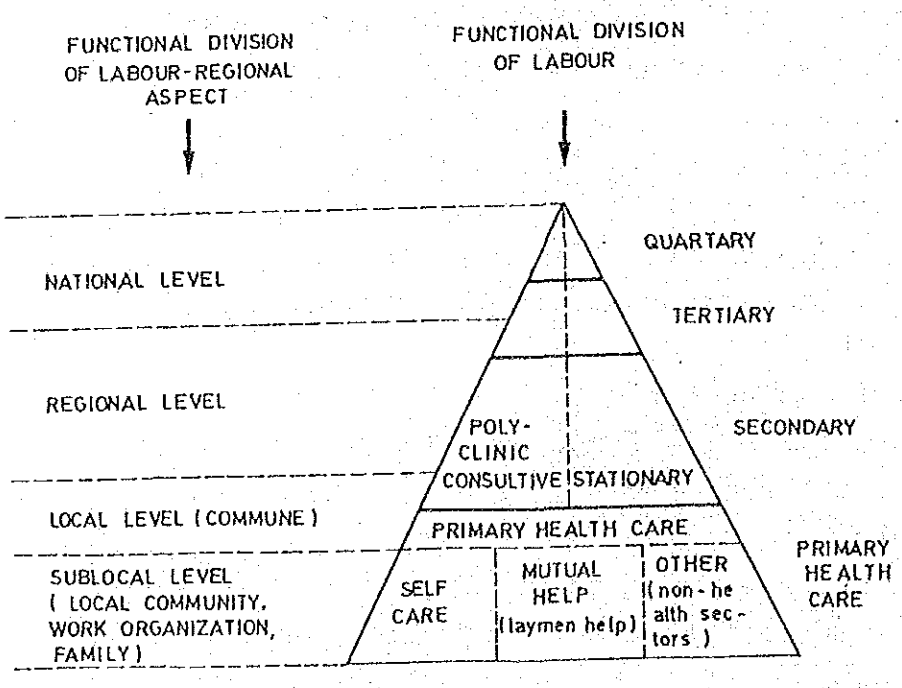
The main objective of this new organizational model which was introduced in the 1980s is an attempt to rationalize health activity. Health care is implemented through three integrated and functionally interdependent aspects of health services.

a) primary health care;

b) poly-clinic-consultative health care; and

STRUCTURE OF HEALTH CARE DELIVERY IN YUGOSLAVIA

GRAPH 7



c) stationary health care.

Primary health care

Primary health care is the first line of health care through which users can gain direct access to the health system. To a large extent this level provides continuous care for healthy and ill individuals in their natural social surrounding (family, nursery, kindergarden, homes, school, workplace, local community). With regard to the present and predictable future characteristics of morbidity and medical technology, such primary health care is provided by teams of health professionals and o/ther workers in the health sector. These teams work in local communities;in work organizations; in schools and other institutions which take care of preschoolers and school children; and in social institutions where people permanently live or temporary reside. Of course, they co-operate with other social factors which contribute to the quality of life of contemporary human beings, and play a key role in integrating all efforts aimed at improving health and maintaining it.

Primary health care is implemented through:

a) general practitioners and their teams in local communities;

b) occupational medicine physicians and their teams in basic organizations of associated labour ;

c) school medicine physicians and their teams in educational institutions;

d) pediatricians and their teams in institutions providing care for children; pediatricians (i.e. preschoolers' physicians) can also serve as general practitioners and provide primary health care for preschoolers in their place of residence;

e) general practitioners with suitable teams in social institutions where people permanently or temporary live;

f) stomatologists with suitable teams in local communities, basic organizations of associated labour (both material and non-material) and educational organizations of associated labour;

g) emergency medicine physicians with their teams in specially organized units in large urban areas or in special locations (e.g. along highways).

There are no precise boundaries in the division of labour

among these primary physicians. Very often, especially in less developed areas, a local community general practitioner provides health care in place of all the other primary physicians.

Polyclinic-consultative health care

In the new concept of health care, polyclinic activity plays a very important role. Its development to an optimum level is a prerequisite for a rational division of labour in the health field and a decisive factor in the rationalization of health consumption. It is the most natural link between wide - spread integrated and continuous primary health care (with emphasis on ambulatory and home treatment) and limited and expensive hospital facilities which should be developed and used rationally and cost-effectively. The development of polyclinic-consultative services (with regard to the state of art of medical technology and changes in health requirements) has to based on the following principles:

a) availability,
b) highly - qualified expert opinion, and
c) rational utilization of expensive equipment.

These principles lead to the development of polyclinic-consultative services as an extremely important part in the overall activity of stationary health institutions. Construction of polyclinic facilities in stationary health institutions must be given highest priority in the context of health investments. These facilities must be available to both users and primary physicians alike, so that they can take an active part in these services and thus improve the quality of their own work and unburden the polyclinic. All prominent, even the top, specialists should participate in polyclinic-consultative activity in order to make themselves available to primary physicians and patients. Polyclinic-consultative activity should also be closely connected with diagnostic-laboratory facilities which could be used in stationary treatment and by primary physicians. Of course, that will result in the functional integration of diagnostic-laboratory activity and its rational division of labour.

Stationary health care

In accordance with the contemporary health care concept, stationary health care in Yugoslavia has to be organized and developed through three major types of stationary institutions:

a) hospitals for the treatment of acute conditions and diseases

Their personnel and equipment must be such as to assure efficient health care with as short a length-of-stay in the hospital as possible, and with maximum patient flow. Among this type of hospitals, top clinical medical institutions have a prominent position, and their development must be carefully planned at the republic level;

b) stationary institutions for the treatment of chronic diseases that require long hospitalization and follow-up care

Such stationary institutions should have a rather different structure of premises, equipment and personnel. They must be oriented to engage less specialized staff and to pay more attention to nursing. It would be quite natural and desirable from a medical point of view for these institutions to be an integral part of acute disease hospitals;

c) socio-medical institutions of various types from old folks' homes to institutions for the handicapped, where emphasis is on nursing but without neglecting professional medical care.

4.5. Community and Individual Self-reliance and Participation in the Planning, Organization, Operation and Control of Health Care

Given changes in morbidity patterns (domination of chronic diseases caused by many factors), changes in conditions of life and work, higher cultural and educational level of the population and scientific, technological and organizational changes in medicine, health care problems can be successfuly solved only in the context of a collective responsibility for health. This responsibility is shared by workers in basic organizations of associated labour and local communities, individuals and their families, narrow and broader communities

where people live and work, socio-political communities and society as a whole. This concept is based on the knowledge that workers in basic organizations of associated labour and local communities as well as individuals and their families can essentially contribute to improvement of health and the quality of life if they harmonize their habits, behaviour and relations with postulates of healthy living and actively participate in the overall process of health improvement and health care. In such a way new potentials and resources can be engaged, consumption can be rationalized, dependence on institutionalized medicine can be reduced and relationships within it can become more human. These are the main prerequisites for more efficient and effective health care.

In the sense, the health care system in Yugoslavia gives an opportunity to workers in basic organizations of associated labour and citizens in local communities to participate directly in all phases of health planning and policy-making processes: determination of health needs;planning of health care and priority scheduling; assurance of finances for implementation of health programmes; and establishment of closer relationships among basic organizations of associated labour (material and non-material), local communities and health institutions. Workers are also responsible for improving and maintaining individual and collective health through active health self-care (by changing their behaviour, improving surroundings where they work and live;actively participating in the process of diagnosis treatment, rehabilitation, etc.). Thus, a specific quality of the Yugoslav health care system, in contrast to others, arises from the fact that citizens in local communities or communes have the right to make decisions concerning financing and construction (location) of health institutions as well as the functions of these institutions.

4.6. Primary Health Care as the Centre of Health Care System

The purpose of carrying out changes in the organization of the Yugoslav health care system is to place primary health care in the centre of the entire health care

system. General practitioners' teams in the local community (i.e. in residential areas), on the one hand, and teams of physicians of general practice and occupational health in work organizations, on the other hand, are given the exclusive right (in collaboration with patients) to make all essential medical and health-legal decisions: whether the patient needs a physician -specialist, stationary (hospital) treatment, or a sick leave; which drugs and therapeutic aids, etc.

The tasks of primary health care of the population and specific (preventive) health care of workers which have strategic, investment and other priorities in the health development system are precisely prescribed by law. On the one hand, primary health care tasks are to:

- participate in increasing psychophysical and working capacities of workers, schoolchildren and students, youth, sportsmen and other people, carry out health care measures, take care of the health status and improvement of health, ensure and assess their capability for work, schooling and sport;

- participate in carrying out preventive and especially hygienic and epidemiological health care measures;

- carry out health care measures of preschool children, take care of their health status and improvement of health and participate in increasing their psychophysical capacities;

- provide pre-natal, natal and post-natal care and other health needs of women;

- carry out health care measures and take care of the improvement and maintenance of the health status of War Veterans;

- carry out health care measures of retarded persons;

- point out the unfavourable influence of the environment on the health status and working capability of users;

- provide emergency medical aid;

- carry out treatment in consulting rooms, or in the patient's home;

- follow-up the implementation of preventive, curative and rehabilitation measures;

- carry out measures of prevention and treatment of the mouth and teeth;
- organize drug supply;
- refer users to consultative-specialist examinations and to stationary and other care; and
- coordinate and carry out necessary diagnostic and therapeutic procedures.

On the other hand specific (preventive), health care of workers tasks include:
- medical examinations for determining general and special health capabilities;
- systematic examinations (check-up) of workers according to sex, age, working capacities and occupational diseases, accidents at work and chronic diseases;
- examinations of workers which are compulsory because of environmental sanitation, protection of consumers (users) and other compulsory examinations;
- examinations for determining health capabilities of workers for carrying out particular jobs or responsibilities of organizations of associated labour regarding regulations of protection at work;
- assessment of working conditions in particular jobs (effects of dust, noise, light, etc.) for protection against occupational diseases;
- providing on-site first (medical) aid to a worker who becomes ill or is injured at work;
- health education of workers;
- improvement of hygienic conditions in certain jobs and workers' nutritional and housing conditions;
- assessing the need to refer workers to take organized active rests in order to improve their health and working capabilities and determining their health status after these rests;
- arranging an organized active rest of workers including measures and procedures of early rehabilitation; and
- other preventive measures (optional vaccination, optional systematic examination, etc.).

It was expected that changes in the organization of certain types of health care would have the following immediate positive economic and health consequences:

- the pressure of patients on superspecialized health care would decrease;
- temporary and total disability for work would decrease (given priority to preventive health care of workers);
- a rational division of labour in primary health care among auxiliary medical personnel, nurses and physicians would develop. However, the period in which the new system has been functioning has shown certain positive effects but not to the extent the political decision-makers and creators of the new system had expected. Very briefly, the effects are as follows:

- the pressure on clinical and preclinical specialist medicine has not decreased, although the pressure on primary health care has significantly increased;
- absenteeism due to illness has not diminished but the long-term trend of its growth has been stopped; and
- certain communication problems have appeared in determining users' (patients') rights to drugs , specialist examinations, sick leaves, etc.

Želimir Jakšić, Slaven Letica and Berislav Skuonjak

5. HEALTH CARE INFRASTRUCTURE: TYPES AND FUNCTIONS OF HEALTH INSTITUTIONS

The Yugoslav health care system includes a relatively large number of different health institutions which are engaged in a variety of activities and health care programmes. The different types of health care institutions are:

1. Private practice;
2. Local health stations;
3. "Homes of health", i.e. integrated community health centres for provision of PHC;
4. Hospitals (general and specialized);
5. Medical centres, i.e. community health centres for provision of outpatient and inpatient health care services;
6. Institutes of public health;
7. Specialized institutes (for cancer treatment, drug control, protection against ionizing radiation, occupational medicine, mother and child care, school children health, etc.);
8. Rehabilitation centres;
9. Pharmacies;
10. Treatment establishments at spas and health resorts.

1. Private practice exists only in Croatia, and even there legislation has been enacted to gradually abolish it. There are some 300 offices, 200 of which are dentists' office while the rest are specialized in some branch of medicine, e.g. pediatrics, gynecology, internal medicine, surgery, etc.

2. Local health stations are the smallest outpatient units which are usually an integral part of a health or medical centre. They can be situated in:

- work organizations where they are health institutions or organizational units for one or several work

organizations providing health care for workers according to principles of occupational medicine and primary health care;

- local communities where they are organizational units of health centres or medical centres providing general medical care, emergency treatment and home care. They provide general practitioner services, preventive and guidance services, dispensary care programmes for MCH, school children health, occupational health care, epidemiological services according to local needs.

In some communes where there is no home of health, local health stations take over the former's duties and usually comprise the following organizational units:

- one or several general practitioner offices,
- guidance unit for children,
- guidance unit for women and expectant mothers,
- dentist office,
- laboratory for basic tests.

3. Homes of health (previously Homes of People's Health) is a direct translation from Serbo-Croatian, but these institutions are the same as integrated community health centres in western health care systems. Homes of health provide all outpatient and domiciliary health care services applying dispensary methods of work. As a rule there is one home of health in every Yugoslav commune (there were 527 communes in 1982); only exceptionally is there one home of health for two communes.

"Yugoslavia has a long experience with the work of community health centres (CHC). The social and hygienic service which Štampar had created in the 1920s represents the first operating example of health centres of a specific character. These health centres were called Homes of People's Health ("Domovi narodnog zdravlja"). They were established shortly after the announcement of concepts on health centres (e.g. Report by Lord Dawson of Penn) and dispensary method of work (integrated preventive and curative services) in the U.S.S.R. The concept was however under the influence of a very strong orientation towards the people and community so that (especially because of that) it underlined special forms and objectives

of health care. The concept of Homes of people's Health has considerably changed since the 1920s. These changes have given rise to new and different managerial and organizational problems. Despite many difficulties and criticism, there still is one form of health services integrated at the level of commune. But the question is - as it was several times in the past - to what extent should health centres be changed in the future."[1]

"The development of health centres in Yugoslavia can be divided into three major periods, though each of these periods focused on different problems. These periods are as follows:

- the beginnings of Homes of people's health from the 1920s till the Second World War when they were part of the hygiene service and were predominantly engaged in preventive activities;
- health centres organized after 1952 as integrated institutions providing all outpatient services. It was in this period that medical centres were established as well which integrated health units of an area;
- the last ten-year period characterized by changes in all social services owing to extended rights to health care and new ways of financing that led to changes in the nature and organization of homes of health and medical centres. The process is still in progress with many managerial and organizational dilemmas."[2]

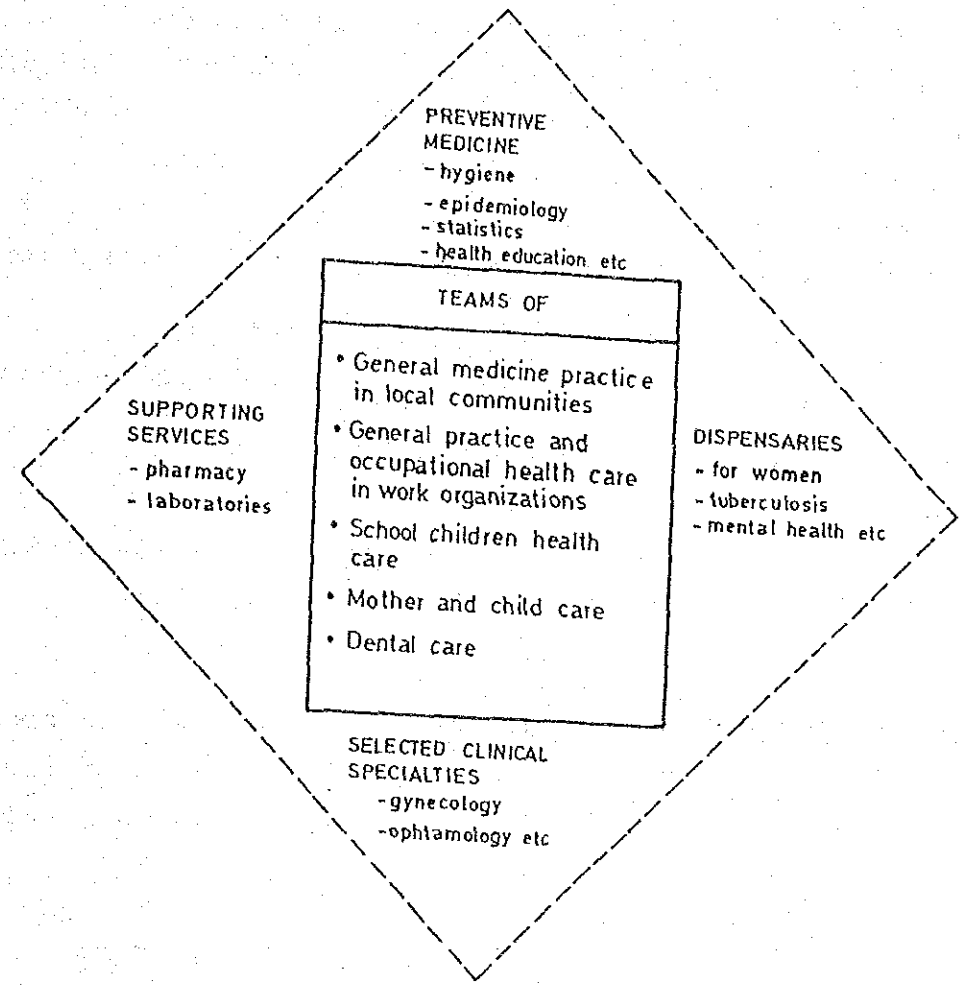
The organizational structure of a modern home of health is shown in graph 8

---

[1] "Home of health as a form of an integrated community health centre for provision of PHC", A.Š. School of Public Health, Zagreb, 1981.

[2] Ibid.

Graph 8 ORGANIZATIONAL STRUCTURE OF A HOME OF HEALTH



A modern home of health provides:

- analysis of health conditions, research in hygiene, sanitation, living and working conditions of the population of a commune and proposals of adequate health programmes;
- general medical care through teams of general practitioners including domiciliary care and home nursing;
- consulting specialist services independently or through cooperation with medical centres and hospitals;
- integrated care applying dispensary methods for expectant mothers, infants, school children and young people, workers and other groups at risk;
- dispensary care for certain social diseases (e.g. tuberculosis, trachoma, mental disorders, etc.);
- hygienic and epidemiologic measures and health education;
- dental care.

In every home of health there is a diagnostic unit (X-ray and laboratories) and a statistical unit. In some republics, homes of health include a maternity ward and general medicine ward for inpatient examination and treatment.

4. Medical centres were organized after the 1950s as combined and integrated health institutions where all services provided by homes of health, institutes of public health and hospitals were united. They provided organizational or at least functional integration of outpatient and inpatient services, preventive, curative, and social services. Different services may comprise specific wards, specialist services, dispensary units and parts of preventive services (e.g. MCH services) under a single management. Medical centres are intended to integrate various aspects of health care and contribute to the more rational development of health care services in a given area. Common plans and programmes, single management, etc. provide for integration of primary health care with secondary and tertiary health care.

5. Hospital and other inpatient institutions

The functions and structure of hospitals in Yugoslavia are not different from those in other countries. There are four types of inpatient institutions:

- general hospitals provide inpatient treatment of the ill and injured, specialist services and preventive measures. They have at least internal medicine, surgery, pediatrics and gynecology wards;

- specialized hospitals treat only patients suffering from specific diseases (such as tuberculosis) or provide health care for certain groups of the population (e.g. children);

- clinical hospitals or clinics, in addition to providing health services, are engaged in teaching, professional training of physicians and other health workers and scientific research;

- inpatient units of primary health care centres provide treatment and delivery services. They cannot have more than 100 beds.

6. Institutes of public health are engaged in statistical and research work. They perform epidemiological research, preventive health services (e.g. immunizations), hygienic measures, etc. In addition to a federal institute of public health, there are eight republic/provincial institutes and several city/regional institutes of public health.

7. Specialized institutes can be health as well as manufacturing institutions (e.g. the Institute of Immunology) purely health care institutions, research institutions and preventive para-health institutions such as:

- mother and child institute
- cancer institutions
- rehabilitation institute,
- blood transfusion institute, etc.

8.-10. In addition, there are institutions which specialize in rehabilitation, a large network of pharmacies throughout the

country, and treatment facilities in spas and health resorts. Their functions are similar to those found in other countries.

Finally, we would note a recent innovation in health care delivery: the establishment of non-institutionalized physicians and health teams. Namely, new health legislation in some republics permits enterprises to employ individual physicians or team of health workers with no obligation to organize formal health units.

Slaven Letica

6. HEALTH CARE INSTITUTIONS: FORMATION AND MANAGEMENT STRUCTURE

6.1. The Formation and Management of Health Institutions

Health institutions are founded by socio-political communities (the local community, commune, republic) and work organizations. In some republics, physicians and stomatologists can set up private offices in which they carry out private practice. Private practice is permitted where the need for it exists, and when all professional, spatial and technical conditions set by law have been met. The private physician can employ at the most two middle and high grade medical workers in his/her office, and cannot have inpatient facilities. The physician who works in private practice cannot at the same time work in the socially-organized health sector.

The health institution (health station, health centre, medical centre, pharmacy, etc) is made up of health and other workers who work in that institution and to whom the utilization and management of social resources has been entrusted. A given health institution may consist of two or more basic organizations of associated labor. A basic organization of associated labor includes a complete, functionally-linked totality in the process of providing health care (the primary health care service in a health centre, a centre for cardiovascular diseases, the internal medicine ward in a general hospital, etc.). The basic organization of associated labor is the fundamental unit of associated labor and the bearer of all rights and duties. It is only by means of a free decision by workers in a basic organization of associated labor that its rights can be transferred to a work organization as an association of two or more basic organizations of associated labor, or to a composite organization of associated labor as an union of organizations of associated labor.

Workers in a basic organization of associated labor manage it directly by referenda and through the workers' assembly, and indirectly through the council and management board. Each basic organization of associated labor independently realizes and distributes income.

In a health institution consisting of two or more basic organizations of associated labor, a council is responsible for management and is made up of delegates from each of the basic organizations. Decisions are made by consensus, but the delegation from each basic organization of associated labor has the right to veto any decision of the council which it considers to be unacceptable. Such a council in an organization with several basic organizations carries out all management functions including enactment of plans and programs for development of the institution and the statute regulating relations in the institution, and the selection and recall of the management board and director. The management board and director have a coordinating function and are responsible for the execution of policies defined by the council. However, the most important decisions are made directly by the workers, as a rule, through referenda (the statute of the work organizations, regulations on distribution of revenues and personal income, regulations on work relations, etc.).

6.1.1. The Internal Organization and Functioning of Health Institutions

The internal organization of each health institution must be geared toward two broad objectives: first, functional integration, i.e. the organization necessary to achieve the objectives of the institutions, and second, social integration, i.e. the organization necessary for the internal management of the institution. Accordingly, self-management will be discussed here in regard to both functional and social integration in health institutions.

6.1.2. Functional Integration

Functional integration relates to that part of the organization which discharges the institution's public obligations, providing certain services in accordance with its goals and objectives. This implies the provision of the necessary resources in terms of personnel, facilities, and equipment and their fusion into an operational entity. The principles of autonomy and self-management mean self-determination of the institution in these respects. However, since the objectives of the institution implicitly or explicitly imply a commitment to

the population served, these cannot be determined entirely by the health institution alone: its social role can be determined only in the context of the needs of the community it serves. Its self-determination, therefore, is shared or supplemented by a professional collegiate body which, though advisory, nevertheless significantly influences decision-making in the institution.

To fulfill the institution's commitment both to the community and to the needs of internal management, two organs have been created to serve these respective functions; the council and the management board. The council includes external members representing civic authorities, self-managing communities of interest, and other allied organizations, according to the statute governing the health institution which specifies the agencies to be represented. The external members, constituting one-fifth of the total membership of the council, are not eligible for the chairmanship of the council. The council defines the institution's short and long-term objectives and is responsible for the appointment, control and dissolution of the professional management of the institution.

The management board, introduced by legislation in 1961 consists exclusively of members of the staff of the institution, thus including the nonprofessional staff in the management role. While the council deals with the external relations of the institution, the management board is concerned with the internal management.

6.1.3. Social Integration

The concern with functional integration and professional management, both designed to better enable the institution to serve the community may easily overshadow the problems of social integration within the institution and lead to the neglect of reconciliation among group interests and resolution of intergroup conflict. It is felt that such problems can be successfully solved in health institutions, as in any other institution, by self-regulation and self-management.

It is true that an institution's activities aimed at its functional integration, i.e. the fulfillment of its obligations toward the community, will in themselves affect the

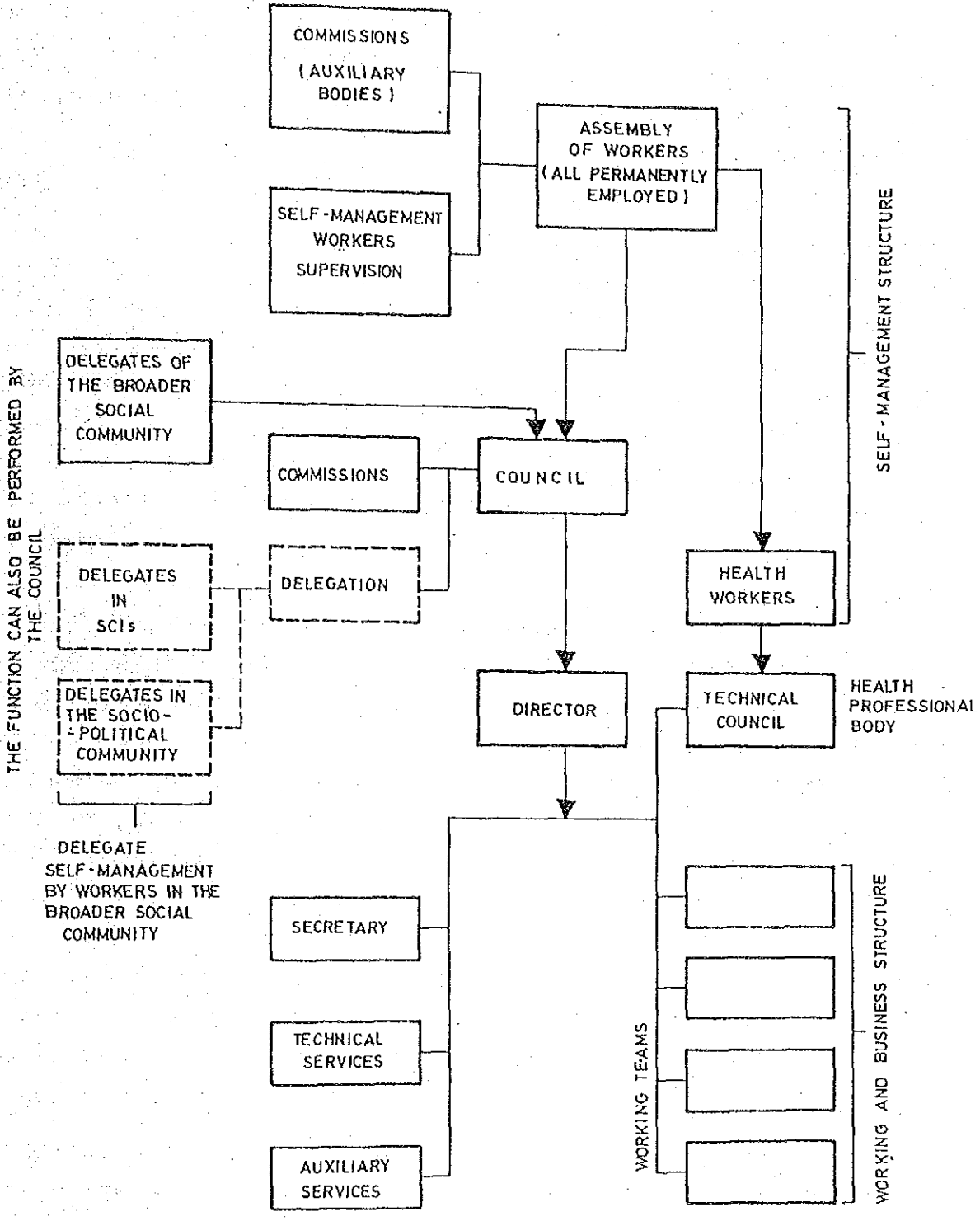
institution's internal organization. But to achieve a satisfactory resolution of internal stresses, a deliberate effort is necessary.

Internal management is the task of the workers employed in the institution. This task may be performed either directly by the workers, or through their representatives in management organs. In the first case, it is done at meetings of the workers, by referenda, or through other forms of ascertaining the workers wishes or opinions. Management organs, on the other hand, have their scope of activity defined by the institution's statute, which also regulates the period of function of these organs as well as the procedures relating to their election and dissolution.

The present model of self-management in a health institution is shown in Figure 1,

Figure 1

DIAGRAMMATIC SURVEY OF SELF-MANAGEMENT AND MANAGEMENT IN HEALTH INSTITUTIONS



6.1.4. The New Role of the Self-Managing Institution

The statute establishing a health institution stipulates the mode of participation by representatives of interested organizations and community agencies in management of the institution. It names the organizations and agencies to be represented, the strength of their representation, and importantly, the matters on which their participation is required. It follows that under the new law these community representatives are no longer considered as "watchdogs" on behalf of the community but rather as partners in the management and decision making of the institution.

This organizational structure enables the institution to be autonomous in the management of its operation, and, at the same time, to achieve its objectives and maintain maximum efficiency. The health institution's autonomy is based on self-financing, i.e., raising its revenue through payments for services it provides by the consumers of these services. Hence, its continued existence and successful development depend entirely on the efficiency of its operation. This then becomes the institution's foremost aim, dictating management considerations directed toward raising the quality of the services offered and lowering the cost by means of increased efficiency in its organization. While the former strictly centralized and bureaucratic (etatist) system of management in health institutions was guided by the observance of legal rules and the fulfillment of norms, the new self-managing health institution operates more independently, in a way which will secure better and cheaper health services to fulfill the needs of its community and of the agencies to which it relates. Consequently, management has to concern itself not only with the internal organization and functional integration aimed at offering better and more efficient health services, but also with the study of health needs and disease trends. It has by its very nature to create an organization capable of coping with current needs and geared to projected changes in health problems among the population.

From the point of view of the administrative efficiency of the health institutions, problems of social integration are especially important for internal relations, the reconciliation of group interests, and the solution to intergroup conflicts.

Their successful resolution by selfmanagement is a basic prerequisite for the successful long-term operation of the health institution.

If the proposals are questioned at any level, they are submitted for study to interested agencies and organizations such as medical, dental, pharmaceutical, or biochemical faculties or other scientific institutions or professional organizations. In this way coordination among the various health institutions is achieved in establishing priorities and bringing the program in line with the available resources.

The present system of planning by collaboration among independent health institutions is basically different from the previous system of administrative programming for health protection which by its very nature, was centralized and autocratic. Administrative programming, even when based on the results of scientific research and analysis, is defective because it fails to motivate the participants to creative initiative toward accomplishing their objectives in the most efficient and effective ways. It is, furthermore, irrational because of its lack of effective control. The greater advantage of independent, self-managed health institutions, coordinating their health protection activities, lies in the greater likelihood of fulfilling the objectives of the health protection program. Since each participating institution is enabled to realize the objectives it has set for itself, it is much more highly motivated. Under this system, health institutions are equal partners in the creation of the health protection programs and not subordinate to higher authorities or health insurance institutions.

6.2. Self-Management Agreements and Social Compacts (Internal Norms) in Health Institutions

Self-management agreements and social compacts are in respect to their (constitutionally-determined) legal and political nature original Yugoslav legal instruments of the law of self-management. This new law essentially differs from classical public (civil and state-socialist) law. For it should be noted that the state in Yugoslavia regulates through its legal norms only the most important social relations by laying down system-

related legal principles and general frameworks for legal regulation. All other relations are regulated by workers in enterprises through self-management agreements, internal rules, and similar enactments (see Figure 2). The legal aspects of the system are now regulated by associated labour within the framework of the law of self-management, rather than by the state.

Health institutions, being within associated labour, also adopt their own self-management enactments. Internal economic and social relations, the system of payment, labour relationships, disciplinary responsibility, etc., are regulated by workers in every organization by means of 25-30 such internal legal acts.

External affairs and planning, development, interest-based and other relations are regulated by organizations by self-management agreements and social compacts.

When self-management agreements are involved, personal expression of views by workers in legal entities concerned is obligatory. Such agreements are legally valid if they are approved by an absolute majority of the workers or organizations concerned.

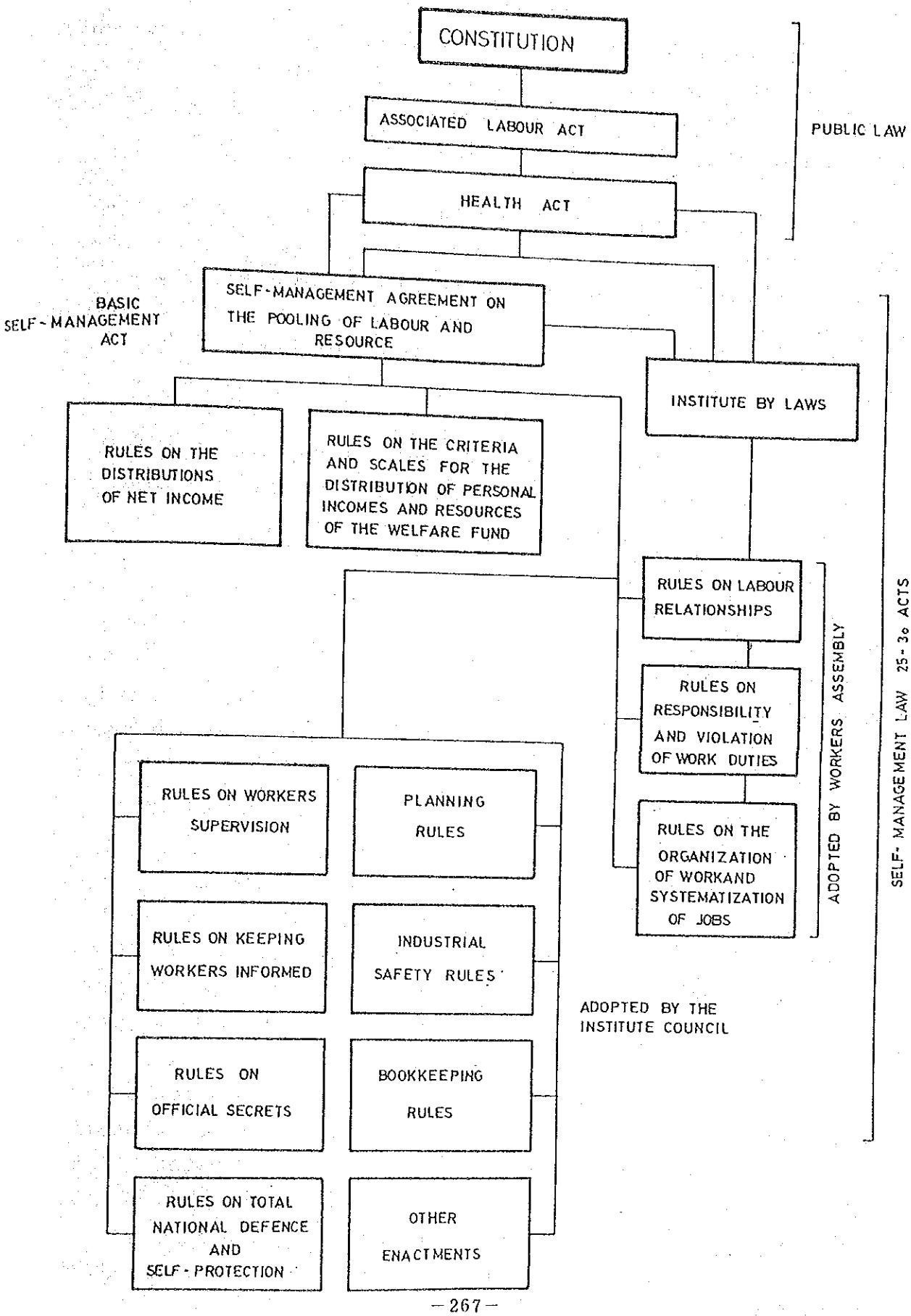
6.3. Income

In the Yugoslav legal and political system (and this also relates to health care and development) income is not only a financial, business-accounting category. It also has a broader social, political, legal and economic significance and content.

Article 45, section 1, of the 1976 Associated Labour Act defines income as follows: "Income is that part of society's total product which workers in basic organizations earn in monetary form as the social recognition of the results of their own and total social labour under conditions of the socialist mode of commodity production, and which workers in basic organizations manage on the basis of their right to work with social resources".

Figure 2

SCHEME OF THE MODEL SYSTEM OF LEGAL AND SELF-MANAGEMENT REGULATIONS TO AN AVERAGE HEALTH INSTITUTION



The same Article defines three basic functions of income in the Yugoslav social system:

1. Income is: (a) the material base of self-management; (b) one of the basic motives for workers' labour; and (c) the basic scale for measuring the effectiveness of productive and/or other activities;

2. Income is both the basis and source of funds: (a) for the "salaries" and other receipts of workers, (b) for "financing" the satisfaction of so-called collective social needs (education, science, culture, etc.), and (c) for "financing" general social needs (conventional budgetary resources for "military and government expenditure");

3. Income is the basis for and the content of social planning in scientific and other institutions, and in communities of interest and territorial communities.

The Associated Labour Act and republican and provincial laws regulate the forms (in Yugoslav legal terminology: basic criteria and scales) of acquisition and distribution of income and net income. In Figure 3, we present a simplified diagraf of the system of acquisition and distribution of income in a typical health institution.

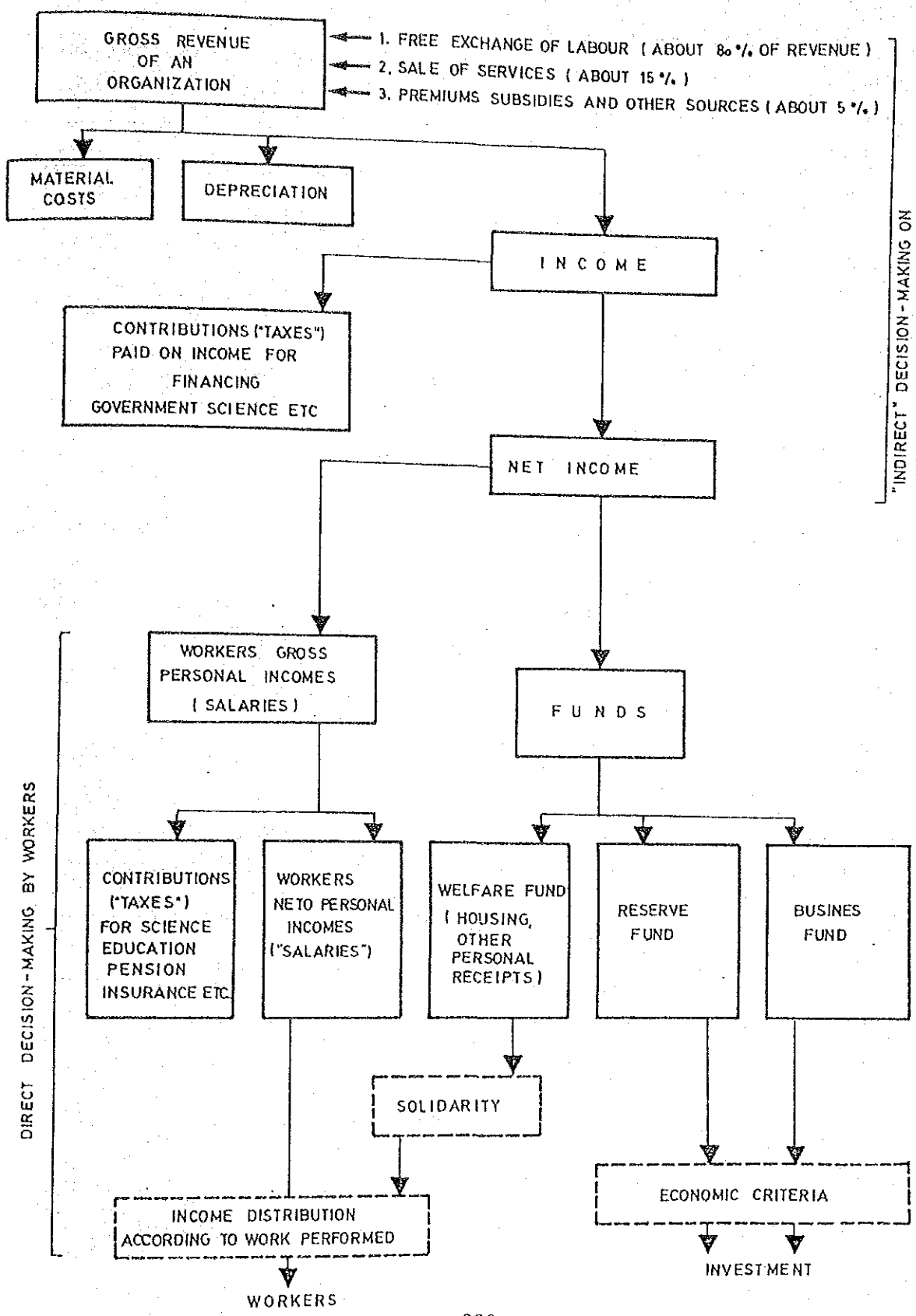
6.4. Distribution of Personal Income (Remuneration) of Health Workers

The point of departure for the "system of remuneration" of health workers is the constitutional concept of income distribution according to labour input, or according to the results of labour achieved. The basic elements of the system of income distribution are spelled out in the Associated Labour Act.

In keeping with these basic statutary provisions, workers in all basic organization of associated labour concerned with health care determine by self-management enactments (internal norms) their own criteria for remuneration. The Associated Labour Act contains two key provisions which determine the basic elements of the Yugoslav system of remuneration and stimulation of workers.

Figure 3

SYSTEM OF ACQUISITION AND DISTRIBUTION IN INCOME IN HEALTH INSTITUTIONS IN YUGOSLAVIA



Article 126: "A worker's personal income ("salary" , Editor's note) shall be determined in accordance with the results of his labour and according to the contribution he has personally made with his current labour (output currently realized, Editor's note) and the management of and doing business with social resources... to a rise in the income of his basic organization ("the firm's earning", Editor's note), in conformity with the principle of income distribution according to work performed, and proportionately to the rise in the productivity of his own labour and the labour of workers in other basic organizations with whom he has pooled labour and resources and to the rise in total social labour.

In addition to the principle of income distribution according to work performed, workers in basic organizations shall also apply the principle of solidarity....".

Article 130: "Workers who through innovations, rationalization and other forms of creativity in work with social resources contribute to a rise in the income of a basic organization, shall be entitled to a special reward in the basic organization, under conditions determined by self-management enactments in conformity with law".

The two above-cited articles of the Associated Labour Act oblige all organizations of associated labour, i.e. all "enterprises" in Yugoslavia, to pass an enactment (norms) on workers' "salaries" and a separate enactment on the "salaries" of creative workers.

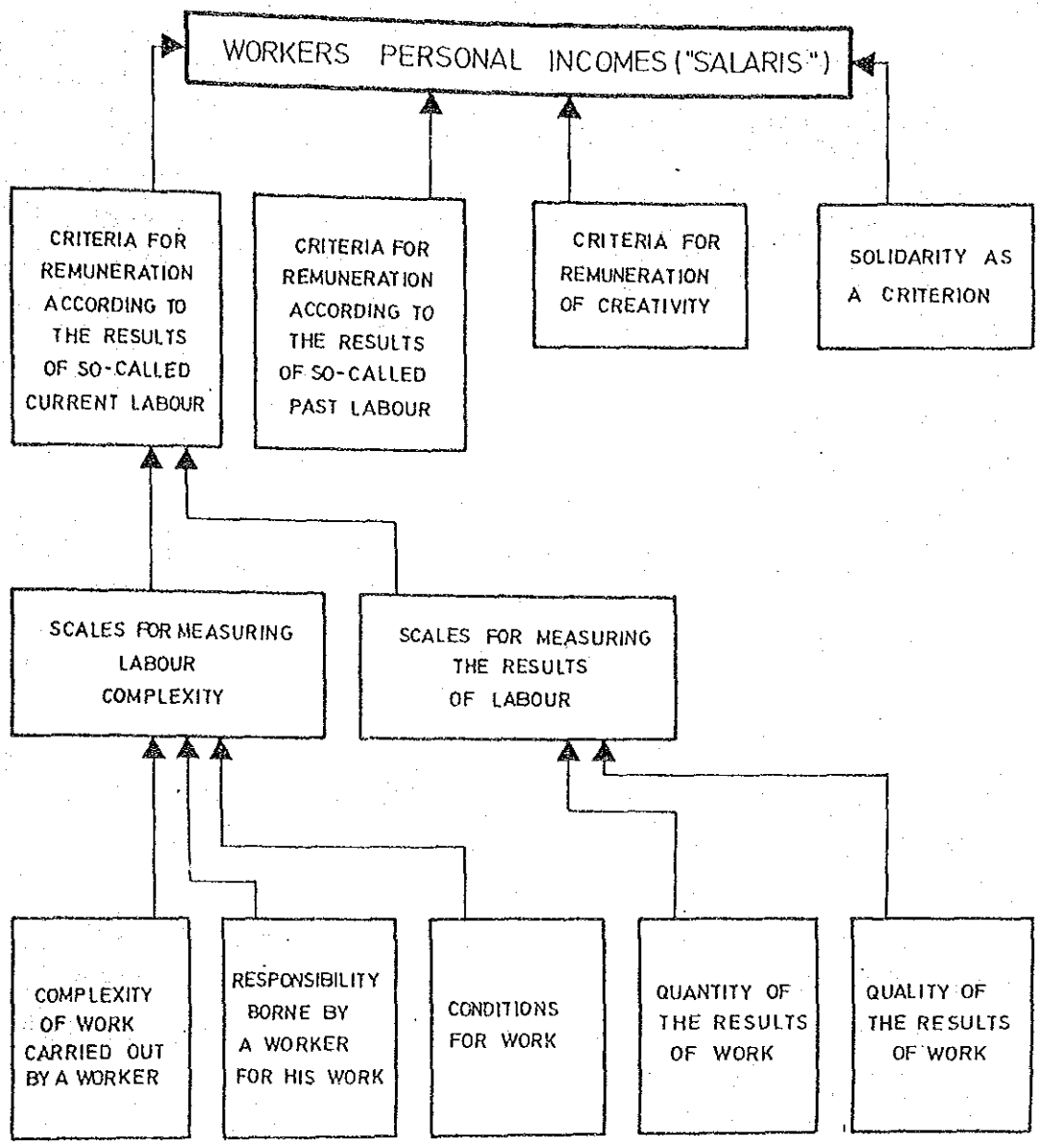
All these specific systems of "payment"must have the same criteria and the same scales for "salaries" as determined by the Associated Labour Act.

This general scales are shown in Figure 4.

Every health care institution is free to regulate by its internal rules its own system of workers' remuneration.

Figure 4

DIAGRAMMATIC SURVEY OF THE YUGOSLAV SYSTEM OF REMUNERATION OF HEALTH WORKERS - ELEMENTS OF THE SYSTEM



Since it is not always possible fully to objectify and normatively to regulate and programme health work, the above described normative concept has in many respects not been realized in practice. Because of this, in most cases remuneration is carried out in accordance with the qualifications of workers, and possibly also according to their contribution to the "earnings" of their institutes.

7. HEALTH CARE ADMINISTRATION AND MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT (MPNHD)

Since 1945 there have been two tendencies in the development of the health system and MPNHD in Yugoslavia:

1. A process of removal of government controls from health policy, i.e. the transfer of rights to make political decisions from "classic" government bodies (ministries, etc.) to self-managing bodies; and
2. A process of decentralization: fewer and fewer decisions have been made at the federal and republican levels, while their number has increased at the commune and local community level.

Boško Popović and Milan Škrbić

7.1. The Development of the Health Care System (1945 - 1980s)

During the post-war period of development in Yugoslavia, major changes have occurred in the socio-economic system which have been accompanied by corresponding changes in the health care system. These changes had important repercussions on the organization and financing of health care.

With regard to changes in the Yugoslav health care system, the post-war period may be divided into several phases. Each of these phases has its characteristic form of health service organization and characteristic manner of allocating resources for health care and payment for health services.

7.1.1. The Phase of Tripartite Organization and Financing

The first phase in the development of the health care system lasted from 1945 to 1948, and was characterized by a tripartite system of organization and financing of health care. During this period, health care developed along three lines: the public (state) health service, the social insurance health service and private practice. In the main, this system of

organization and financing was very similar to the system which had developed in the interwar period.

The public (state) health service included all institutions which had previously functioned as state institutions (a large number of hospitals, all health centres, institutes of hygiene, some polyclinics and health stations), as well as private and religious health institutions which were nationalized immediately after the war (hospitals and sanatoriums). These health institutions were financed through budgets at various socio-political levels (the commune, district, region, republic). The public (state) health services were responsible for all preventive health care measures for the entire population which were financed directly from budgetary resources. In addition, it provided curative health care in all cases when this was sought. These curative services were partially paid for by the social insurance funds (for those employed in the state sector and dependent members of their families), partially by direct payments by users (individual farmers and independent craftsmen) and in part provided free of charge using budgetary resources (for all indigent and socially endangered citizens and for those patients suffering from infectious and certain social diseases).

The social insurance health service (the District Offices for the Insurance of Workers, the "Bratinska Blagajna" of Miners, the Railway Employees Health Insurance) included those health institutions which had been owned by individual social insurance associations (outpatient facilities, hospitals, nursing homes, spas and health resorts, and health stations). It also included a large number of private physicians who provided health care services to insurees in their own offices on a contract basis.

Moreover, the social insurance associations covered the costs of services rendered to their members in state health institutions. These associations were autonomous vis-a-vis the state, and their health institutions remained separate from those operated by the state. They were directly financed by the insurance funds raised by means of contributions from employed persons. Less than one-fourth of the Yugoslav population was

covered by social insurance during this period.

Although a separate element in the structure of the health services at this time, private medical practice was not sharply distinguished from the social insurance and state health services. Most physicians engaged in private practice had regular working relations with state health institutions and those of the social insurance associations, or worked on a contract basis for the social insurance service. In the main, private practice was engaged in after regular working hours in health institutions. However, since a large part of the population was not covered by social insurance, private practice still represented an important part in the health care system. Due to the great shortage of physicians at that time, the state took a very tolerant position toward such practice.

The costs of health services were determined by state organs. Costs were relatively low, and as such did not serve as a major stumbling block to utilization of health services. In addition, the state health institutions also provided health care to the indigent, and physicians in private practice used the traditional "sliding scale of prices" based on the patient's ability to pay for services. The major factors limiting utilization of health care services were the shortages of personnel and spatial capacity, their maldistribution, and the low level of aspirations of the population in regard to health care.

It was during this period that state intervention and regulation in health care became stronger. The basis for this increased state influence in the health sector could be found in Article 36 of the 1946 Constitution which stated: "The state is responsible for improving the health of the people through organization and supervision of health services, hospitals, pharmacies, sanitoriums, nursing homes and other health institutions". Through its administrative apparatus (ministries, representatives and other central and local authorities), the state decidedly influenced all the important functions and developments in the health sector by strengthening its role in the areas of organization, supervision, financing and planning of health care.

7.1.2. The Phase of Administrative Management and Budgetary Financing

This phase in the development of the system of financing health care lasted from 1948 to 1952, and was characterized by administrative management of health services and budgetary financing of health care. The social insurance health service was united with that run by the state. All infants, small children, mothers, school children, the handicapped, old people as well as all suffering from acute infectious diseases, active tuberculosis, venereal diseases, trachoma, malignancies and mental illness had the right to free health care in state institutions.

Social insurance became an integral part of the state administration, with financial resources for social insurance flowing into budgets at the level of the republics. Expenditures for health care of insurees were paid for out of the republic budgets, a portion of which was based on contribution for social insurance.

In this manner, the state assumed total responsibility for financing health care of insurees in addition to its responsibility for preventive health care measures and for free services provided to those who were not insured as noted above. For the remaining health care services, users paid directly for the care they received in health institutions or offices of private practitioners.

During this period, the largest share of financial resources for the work of health institutions was obtained directly from budgets of communes, districts, republics and the federation. Health institutions were ranked according to importance as communal, district, republic or federal. At the same time , this meant that they were financed from communal, district, republic and federal budgets, respectively.

Investments in the health sector were assured from the budgets. Amortization was generally not included in the annual financial plans of health institutions nor calculated in