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The Once and Future Health System
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Myths and Realities
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The Once and Future Health System in the Former Yugoslavia: Myths and Realities

MUHAMED SARIC and VICTOR G. RODWIN

WITH horrors of the Yugoslav civil war spilling daily over TV screens and newspapers, it is difficult to imagine that the former Yugoslavia was once hailed as an innovator in politics as well as in health care organization. Prior to the wave of revolutions that swept Eastern Europe in 1989, Yugoslavia was usually distinguished from other East European countries as having developed a unique model of socialism—one characterized by an independent, non-aligned position in foreign affairs and market-oriented workers' self-management in the domestic economy. Likewise, most citizens of Yugoslavia claimed that their health care system was as original as their political system and that it was neither private nor state-run (1).

Most of the existing literature on the financing and organization of Yugoslavia's health system perpetuated three images: (1) social ownership of "self-managing" provider organizations; (2) a commitment to primary health care; and (3) a faith in what might be called the "march of progress"—the health system's continuous expansion and improvement (2). In contrast to this picture, we present an alternative view.

Despite social ownership, the way the system was financed and organized was not much different from that of countries having a national health service. The system of virtually universal entitlement to basic health services and the quasi-monopsonistic position of the health insurance funds rather than ownership appear to have determined the behavior of health care workers and beneficiaries.

Also, the commitment to primary care was mainly rhetorical, supported neither by appropriate organizational arrangements nor by the allocation of resources.

Finally, in the last years of Yugoslavia's existence, its health system was characterized by contraction rather than expansion.

In summary, most former Yugoslavs lived with the illusion of sharing a unique model of society, much as they imagined that their patchwork of ethnic and religious groups could exist in a single nation-state.

THE LITERATURE ON THE YUGOSLAV HEALTH SYSTEM

Stretched along the Adriatic coast across from Italy, the pre-1991 Yugoslavia was a country of 24 million people in southeastern Europe, with Albania and Greece on its southern frontier, Romania and Bulgaria to the east, and Austria and Hungary on its northern border. Since 1945, it had been a federation of six republics: Bosnia and Herzegovina, Croatia, Macedonia, Montenegro, Slovenia, Serbia; two autonomous provinces (Kosovo and Vojvodina) were attached to the republic of Serbia (3).

Most research on the Yugoslav health system—in the United States as well as in Yugoslavia—emphasized the unique attributes of the former Yugoslavia's market socialism and workers' self-management in comparison to Western capitalism and Soviet-style socialism.

On the American side, economist Benjamin Ward identified, in the early 1970s, what would become a recurring motif in subsequent American writings on the former Yugoslav health system (4). Although very sympathetic to the experience of what he called "the Sweden of the Balkans," Ward noted the country's shortcomings: favoring of the urban working class over other social groups; over-representing the technical and administrative elite in supposedly workers' councils; and increasing inequalities as a result of political decentralization and market orientation.

A decade later, sociologist Donna Parmelee provided detailed information on the decision-making process in one of the former Yugoslavia's many health insurance funds. In spite of its proclaimed goal to increase consumer participation, she found that the influence of the community and of consumers on health planning remained weak (5). Most planning was still performed by government and quasi-governmental institutes. Nevertheless, the system of health care financing through so-called "self-managing communities of interest" (SIZ), involving representatives of both providers and consumers, struck her as promising. Public health specialists Himmelstein, Lang and Woolhandler were also sanguine about these presumably democratic institutions (6).

Subsequently, Parmelee presented supporting evidence for Ward's finding on the privileged position of the urban industrial class in Yugoslavia. Immediately following World War II, for example, agricultural workers, who represented an overwhelming majority of the population, were disadvantaged: they lacked any form of health insurance. During the 1960s, the situation improved somewhat when farmers were allowed to join the public health insurance system. However, they still had fewer health benefits than fully insured workers and their dependents. Only by the early 1970s did differences in coverage begin to erode (7).

Parmelee's initial enthusiasm for the Yugoslav health system gradually gave way to bitter criticism. She blamed the decentralization of health care financing and planning for a host of problems: persistent deficits among health insurance funds; inequalities in health status across the country; uncoordinated allocation of health resources; and, as she put it, "unemployed health workers despite unmet health needs" (8). Her suggestion that the state play a larger role in the health sector was bluntly rejected by Yugoslav policy analysts (9).

On the Yugoslav side, Cedo Vukmanovic published a complete (and somewhat idealized) description of the health system in 1972 (10). However, since the former Yugoslavia introduced major changes in the organization and financing of its health system in 1974, the paper became rapidly out of date. Slaven Letica and colleagues undertook the ambitious project of presenting the most recent form of the pre-1991 Yugoslav health care system. Their monograph provides an unprecedented wealth of technical details (11). Most of them, however, are hard to understand, let alone evaluate, because of the use of arcane political and economic jargon and the absence of standard terminology. Indeed, one suspects that this monograph, along with many other Yugoslav presentations of the health care system, create the illusion that many institutions of the former Yugoslavia are unique because they bear unusual names (12)!

The more important research on the Yugoslav health system—both in the former Yugoslavia and in the United States—fails to provide a realistic sense of the financing and organization of Yugoslav health care. American analysts have not disclosed the way the system works, and Yugoslav analysts created myths about the system based on an ideologically biased image of its uniqueness. Our aim is to dispel these myths by showing how the system did, in fact, operate.

SOCIAL OWNERSHIP

Immediately following World War II, Yugoslavia virtually abolished private ownership and transferred most of these property rights to the state. By the 1950s, however, the country changed course and developed a unique type of property: social ownership (13). Workers were given the right to manage supposedly autonomous enterprises and to use the enterprise's assets to generate as much income as possible. The property title was granted to "society," a term that has never been explicitly defined. The legal distinction between "employers" and "employees" disappeared. Nevertheless, workers have never assumed the role of real entrepreneurs due to lack of transferable property rights (14).

A communist distaste for things past and a tendency to equate novelty with efficiency and achievement was a driving force behind the revolutionary transformation in ownership. The change was supposed to affect all spheres of society, including health care. But, as we argue, this novel type of ownership did not generate a new pattern of behavior among health care workers and beneficiaries.

Organization of the health system

Health care institutions owed their organizational structure to the general model of the Yugoslav firm. Firms, in theory, were autonomous entities *vis-à-vis* the state. They used "social" capital and employed labor according to technological needs. They provided goods and services in response to market signals. Workers were authorized to select from their ranks a workers' council and a management board. The health institution's workers' council, unlike that in other sectors of the economy, also included representatives of the local government and local political bodies.

This model was never fully implemented, as most health institutions were established directly by municipal or republican governments. For some health facilities, the government provided capital directly; for the others, it orchestrated referenda through which health care consumers decided to donate a certain percentage of their salary to the health institution's account (15). Unfortunately, these resources were reported in national statistics as if they had originated from institutional revenues (16).

Whatever the source, the government played a crucial role in the al-

location of capital. A republic's Ministry of Health reviewed all construction plans. The local government influenced the decision-making process in health institutions through government representatives on the institution's workers' council. No decision regarding capital expenditures could have been made without the approval of the majority of external members of the council. Under such circumstances, health workers were left with managing only day-to-day activities.

In 1958, private medical practice was outlawed in Yugoslavia with the exception of Croatia, where a small number of physicians had been allowed to maintain their practice. All practicing physicians were integrated into the socialized sector, where they have become "tenured" staff employees reimbursed on a salaried basis (17).

In principle, health institutions in the social sector were allowed to hire and fire workers without permission from the state. In addition, doctors and other health workers were paid according to pay-scales developed by each health institution. In reality, however, republican and federal laws—passed with the intention of alleviating high unemployment rates—required health institutions to add new workers to their work force each year irrespective of the institution's need for labor (18). Other regulations made firing virtually impossible. With respect to wages, the federal government quite frequently imposed freezes. Moreover, republican governments regulated the range between the highest and the lowest salaries in health institutions.

In summary, despite social ownership, state intervention had become more the rule than the exception. For this reason, "socially owned" health institutions ended up as powerless appendages to the government, and the distinction between social and conventional public ownership all but disappeared.

Financing the Health System

Within Yugoslavia's insurance industry there were two types of carriers: (1) socially owned, for-profit enterprises in property and life insurance; and (2) socially owned "self-managing communities of interest" (SIZ), which provided health insurance, social security and disability insurance (19). While the former functioned in a manner similar to that of American commercial insurance, the latter were peculiar to the former Yugoslavia's political system. But closer examination indicates a substantial discrepancy between the theory of the SIZ and its actual operation.

The Theory of the SIZ. As envisioned by the 1974 Yugoslav Constitution, the SIZ was a non-governmental institution which served as the principal conduit for financing health and other social services. It was organized around a well defined territory, usually comprised of several neighboring municipalities (communes) with an average population of 50,000. It was governed by two councils of elected delegates—a council of providers and a council of consumers. In the health sector, the SIZ functioned as a health insurance fund. Health care workers were represented on the council of providers and lay representatives on the council of consumers.

The health SIZ was managed by a permanent administrative unit comprised of professional administrators who were, in principle, accountable only to the delegates and not to the government. Their major role was supposed to be a technical one. Premiums, allegedly set by the two councils of the SIZ, were collected from workers in all three sectors of the country's economy: the socialized sector, the private agricultural sector, and the private non-agricultural sector.

The vast majority of Yugoslavs worked in the socialized sector (20). Contrary to the basic premise of social ownership, the health care financing scheme revealed that the traditional distinction between "employees" and "employers" was, in fact, made in the socialized sector. On the employee side, health insurance was a part of everyone's benefit package. Payroll taxes were levied on a compulsory basis. Some 8 percent of each employee's wage was deducted, and together with the employer's contribution, this sum was allocated to the local unit of the health care SIZ. Employers contributed through a health care tax levied on the firm's total revenues.

Subscription to the health SIZ was also compulsory for a large group of private agricultural workers. Due to insufficient premiums, a substantial portion of this group's actuarial risk was covered through subsidies from municipal government. Only in the non-agricultural private sector, which represented just a fraction of the Yugoslav economy and included small businesses and self-employed professionals, was health insurance organized on a voluntary basis.

The rate-setting system among all classes of employees was community oriented: subscribers were expected to pay—regardless of their individual utilization rates—for all health care costs that occur in the community plus administrative costs. With regard to benefits, the health SIZ provided comprehensive and universal coverage. But

the quality of services differed significantly from one part of the country to another. The difference arose from the fact that salaries across the country varied more than the payroll tax levied by individual SIZs. Within each republic, inequalities between individual health plans (SIZs) were somewhat alleviated through cross-subsidies financed by a special republican fund.

Health institutions negotiated with the local SIZ for annual budgets. When providing services for the population living outside the area, providers were allowed to charge the patient's SIZ on a fee-for-service basis. Municipal government reserved the right to intervene in the event that the two parties reached what was vaguely defined as a "socially harmful" contract.

From Theory to Practice. In practice, the autonomy of the SIZ in relation to the state was severely restricted. Premiums—presumably agreed upon between representatives of providers and consumers—were established by the administrative unit of the SIZ, approved by local government, and then rubber-stamped by the councils. The maximum annual rate of contribution to the fund from both employees and employers was regulated by the republican and federal government.

COMMITMENT TO PRIMARY CARE

The role of the former Yugoslav federal government in the health sector was minor compared to that of the republics. Each republic passed its own health care statutes regulating all aspects of the health care system including health insurance. Despite such decentralized regulation, however, the entire former Yugoslavia's health care system—at least at the ideological level—was organized around primary health care.

Each republic required every commune—the smallest administrative unit in Yugoslavia—to provide primary health care, and it specified its scope. In addition, each republic stipulated the entitlements of its citizens to health care services at no out-of-pocket cost. Most beneficiaries were entitled to receive health education, basic outpatient medical services, basic reproductive health services, and hospital care (21). At the organizational level, the privileged position of primary care versus the hospital and specialist sectors had been fostered by assigning a gate-keeper role to all primary care physicians.

The rhetorical commitment to primary care was not reflected in resource allocation. In 1986, for example, the amount spent on pri-

mary care was relatively low and, even if combined with specialist outpatient care, represented only about one third of total health care expenditures (22). The 60% share spent on hospitals was virtually identical to that allocated in most OECD countries, e.g. Italy—a country known for its oversized hospital sector (23).

The hospital-centered nature of the Yugoslav health care system reflects serious organizational failures at the primary care level. Although primary physicians, who were originally drawn from the ranks of general practitioners, were formerly given the role of gate-keepers, they have not been successful in keeping most patients at the primary care level for two reasons. First, the legal definition of the primary physician which, over time, had expanded to include higher-paid obstetricians, pediatricians, gynecologists and occupational health specialists, has led to the dominance of specialists in primary care. Second, the referral pattern provided neither constraints nor incentives for primary physicians to keep patients at the system's front line.

The Dominance of Specialists

The distribution of primary care physicians in 1987 (48% GPs, 23% occupational health specialists, 13% pediatricians, 10% school health specialists, 6% OB/GYN) reflected an ongoing debate about what kind of physician should work in primary care and, by extension, how they should be organized (24). One school of thought—impressed by the British health care system—had supported a concept in which comprehensive primary care for the population living in a defined territory should be provided exclusively by general practitioners (GPs) based in neighborhood health centers (NHCs) (25). However, in the network of Soviet-like polyclinics, which was slowly disappearing, a specialists' lobby, backed by administrators, had argued that gynecologists, obstetricians, pediatricians, dermatologists and occupational health specialists should also be a part of primary care (26).

To satisfy proponents of both schools, the concept of primary care for a geographically defined population had to be reconciled by lawmakers in each republic with alternative selection criteria relying on occupation, gender and age. As a result—along with NHCs—outpatient maternal, child health, and occupational health clinics were granted the status of primary health care units to which patients could come directly, thereby bypassing GPs.

The portion of the population that received primary care in NHCs

was further decreased by the existence of special outpatient health care clinics that were financed, equipped and managed by employers. These clinics were the major source of primary care for the employees of Yugoslavia's large enterprises. Using its purchasing and political power, big business had succeeded in building a parallel health care system that obviated their reliance on both public facilities and, more importantly, public health insurance (SIZ).

The expansive definitions of primary care allowed by republican governments resulted in the growth of specialists working in primary care. Moreover, the market share of NHCs declined significantly and consisted largely of housewives and retired workers. As a consequence, what remained of primary care was far from a comprehensive system for a population defined by a region.

The Unconstrained Referral Pattern

The growth of specialists in primary care was exacerbated by the effects of a referral system that sent both patients and GPs toward the specialist sector.

The former Yugoslavia's health system did not restrict general practitioners in the number of patients they were allowed to refer for specialist consultations. Nor did it give financial or other incentives for primary care physicians to keep patients at the front-line of the system. Any savings in health care costs, for example, that may have resulted from fewer specialist consultations required by individual primary care physicians were not recouped in the primary care sector. The quantity and quality of services provided was a minor determinant of the physician's salary. General practitioners (GPs) working in the same setting and having the same level of experience had virtually identical salaries. Only a major difference in years of experience accounted for a higher salary.

This reimbursement formula encouraged GPs to decrease their work load by referring patients to specialists. Reliance on specialists diminished the GP's need for further education. Conversely, lack of postgraduate training and continuing education created a higher demand for specialist services. This vicious circle undermined the primary physician's status and self-esteem. "Dispatchers," a term for GPs used by their patients, properly described how low their status had fallen.

To improve their status, GPs working in primary health care sought a residency as soon as possible, and eventually a permanent position, in a hospital or in an outpatient clinic. Alternatively, they even went back to the primary care network, but this time as better-paid specialists. This pattern contributed to the specialization of Yugoslav medical care as illustrated by the decrease in the general practitioner to specialist ratio from 2.00 in 1953 to 0.76 in 1987 (27). Taking into account the specialists' emphasis on complex diagnostic and therapeutic procedures, the consequences of this trend were not difficult to predict: an allocation of health care resources that favored hospitals rather than primary care.

THE MARCH OF PROGRESS

Health policy in the former Yugoslavia was based on the promise of growth: expansion of existing health facilities and construction of new ones, an increase in the supply of health care workers and drugs and, ultimately, an improvement in health status. The promise was repeated so often that people came to consider such social benefits "to be their natural due," a major premise of socialism (28).

By 1978, the number of hospital beds, in comparison to 1939, tripled from 19 to 60 beds per 10,000 population; the number of medical schools rose from three to eleven, resulting in a five-fold increase in the number of physicians; and health insurance was extended to cover 82 percent of the population (29). The infant mortality rate of 35.6 per 1,000 population in 1978 was only one-fourth of the pre-World War II figure. Moreover, diphtheria, malaria and typhus had been eliminated (30).

By the end of the 1970s, however, the rhetorical character of the march of progress clashed with the allocation of the GNP. In contrast to Western Europe and the United States, Yugoslavia experienced a downward trend in the percentage of GNP devoted to health over the last twenty years. In 1969, health expenditures amounted to 7.1 percent of the country's GNP; in 1975, 5.7 percent; and in 1987, only 3.95 percent (31).

This downward trend, which reflected the country's severe economic crisis, precipitated by Yugoslavia's \$20-billion debt to Western creditors, affected health care providers as well as the population's access to care.

Effects on Health Care Providers

Heavily dependent on Western technology and raw materials, Yugoslavia's pharmaceutical industry was one of the first targets of the economic crisis. Shortages of essential drugs, first noted in 1981, remained a major problem until the very last days of the country's existence (32). Hospitals, as well, despite the high proportion of health care resources devoted to them, were not spared from chronic shortages in medical supplies and hotel services (33). In 1985, for example, a lack of syringes, needles and sutures forced physicians to avoid giving injections and to delay surgical operations.

Health care providers, operating in relatively small markets monopolized by the SIZs and regulated by local government, were not able to control the prices of their services to the same extent as the industrial sector. As a result, the salaries of health care workers, particularly physicians, were kept low. Furthermore, specialists' salaries were only slightly higher than those of GPs, who made little more than nurses and blue-collar workers (34). In the mid-1980s, manpower accounted for 40.6 percent of total health care expenditures—only two-thirds of what is usually spent on personnel in Western industrialized nations (35).

Effects on Access to Health Care

Most former Yugoslavs took "free" health care for granted and considered it a major achievement of socialism. Any attempt to impose formal or financial barriers to health services created vigorous political opposition. Nevertheless, as the economic crisis deepened, the tendency to introduce such barriers became more and more appealing to the authorities. In the last years of the country's existence, second-opinion schemes and various forms of financial barriers were tried.

Second-Opinion Strategies. As a rule, Yugoslav workers had almost unlimited paid sick leaves. Their salaries did not suffer if their absence could be justified by medical reasons. Since moonlighting or private agriculture at home often provided higher financial gains than their regular jobs, workers were encouraged to simulate sickness and abuse the health system. Although the SIZ was not the only party that bore the burden of sick leave costs (sick leaves up to thirty days were paid by employers), sick leave compensation accounted for some five to ten percent of total SIZ expenditures (36).

To tackle this problem, some SIZs passed regulations limiting the primary physician's right to approve sick leaves to a period of up to fifteen days. For sick leaves beyond the fifteenth day, the patient was referred to a special medical commission for a second opinion (37). The results of this policy, however, were disappointing. Workers were able to avoid the second-opinion commission by splitting their long sick leaves into two-week multiples. Thus, medically excused absenteeism remained as prevalent as it had been before (38).

Cost-Sharing by Consumers. Since there were virtually no direct financial barriers to enter the health system, SIZ-sponsored health plans were facing problems of high medical care utilization. In response, they attempted to increase patients' cost awareness. While the concept of deductibles was foreign to the country's practice, co-payments ("participation" in Yugoslav parlance) gained in popularity.

The list of situations where co-payments were required by an average SIZ always included drugs (a small, fixed amount per prescription), abortions (60 percent of the price), cosmetic operations (90 percent), and various prosthetic devices (10–80 percent) (39). Although the percentages may seem high, out-of-pocket payments accounted for less than three percent of total health care expenditures in 1986 (40).

As Yugoslavia's existence was nearing its end, there was an effort across the country to expand the list and to include even regular visits to physicians and some forms of acute hospital care. The lists were enlarged but, due to political pressure, the original proposal was scaled down and many beneficiaries exempted—the unemployed, World War II veterans, patients with chronic disease, welfare recipients; and so forth (41).

CONCLUDING OBSERVATIONS

In a period of *glasnost*, it is misleading to portray the former Yugoslav health system as one characterized by social ownership, a commitment to primary care, and a march of progress. In reality, the pre-1991 Yugoslav health system was similar to other European health systems, particularly the poorer ones such as Greece, Spain and Portugal. Like these systems, it had somehow to reconcile its promise to cover virtually all of its population with extensive health care benefits, and its financial, organizational and managerial capacity to deliver on this promise.

As fewer and fewer resources were devoted to health care, the decline in services could only have been offset, if not countered, by a more efficient allocation of these resources. This would likely have required redistributing health care resources from the expensive hospital and specialist sector toward more cost-effective kinds of primary care. It would also likely have required finding ways to motivate employees and to improve health services management.

At the present time (winter 1993), Serbia has been preoccupied by the pursuit of conquest. Bosnia and Herzegovina and parts of Croatia have been devastated by war. Both Slovenia and Croatia have been more concerned with shedding their communist heritage than with health care reform. To the extent that health care issues have been addressed, these newly independent republics have debated whether to nationalize officially existing "socially owned" health care institutions or to privatize financing as well as ownership. The evidence we have examined, however, suggests that such debates are misleading.

If the newly independent republics in the former Yugoslavia are to maintain universal health coverage, they must realize that broad-based enrollment is a critical characteristic of their countries' health care systems. Even if health care organization is abruptly privatized, high utilization will remain a tremendous problem. Moreover, the drive to demonopolize state health insurance organizations can be justified only if gains in efficiency due to increased competition between various health insurance carriers outweigh losses derived from costly risk selection and market-skimming, which always arises once individuals are given a choice of more than one health plan.

As Eastern European countries and newly independent states go through the current period of transition, privatization of industry as well as social services has become a cornerstone of the new political thinking. But health officials in newly elected governments, as well as American consultants to these governments, should be aware of substituting one ownership myth for another. The Yugoslav experience suggests that the change from state to social ownership did not result in the unique health care system capable of delivering its creators' promises.

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whom served as important sources of insight and inspiration: Doctors Tomas Kozuh and Mateja Kozelj, Professors Slobodan Lang and Slaven Letica (Croatia), Professor Arif Smajkic (as of December 1992 still in Sarajevo), Dr. Berislav Skupnjak and Professor Dr. Grujica Zarkovic (now a refugee from the Siege of Sarajevo, temporarily in Nueherberg, Germany).

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2. The concept of social ownership, announced in the early 1950s, took its final form in the Yugoslav Constitution of 1974; the commitment to primary care was proclaimed in each republic's Health Statute. The "march of progress" was an important assumption behind the idea of socialism.
3. Yugoslavia emerged as a nation following the collapse of the Austro-Hungarian Empire after the First World War. The Southern regions of the Austro-Hungarian Empire joined the Kingdoms of Serbia and Montenegro to form a unitary state governed by the Serbian dynasty. In 1941, when the Axis powers occupied the country, Yugoslavia ceased to exist as a political entity. It reappeared in post-War Europe after the Yugoslav Partisans, led by Marshall Josip Broz Tito, liberated the country. For centuries, Yugoslavia was at the center of conflicts between east and west—the Roman and Ottoman Empires, Christendom and Islam, the Catholic and Eastern Orthodox Churches, Ashkenazic and Sephardic Jewry, capitalism and socialism. Marshall Tito adopted a federal system for the country as a way to accommodate the historical and cultural differences among Yugoslavia's inhabitants. Its population was a complex mix of six major ethnic groups: Croats, Macedonians, Montenegrins, ethnic Muslims, Serbs, and Slovenes; and more than a dozen national minorities.

This ethnic diversity coexisted with a religious and linguistic heterogeneity. Members of both the Serbian and the Macedonian Orthodox Churches, Roman Catholics and Sunni Muslims represented the majority, but Sephardic and Ashkenazi Jews as well as numerous Protestant communities also existed. More than two-thirds of the population spoke one of the three closely related languages—Croatian, Bosnian, or Serbian, but Slovenian, Macedonian, Albanian and Hungarian were spoken as well.

In 1991, first Slovenia, then Croatia; and in 1992, first Bosnia and Herzegovina, then Macedonia, all voted for independence from what had become a Yugoslavia dominated by Serbia. Despite wide international recognition of the independence of the first three republics, the Serbian army invaded all of them. It was swiftly defeated in Slovenia. However, in Bosnia and Herzegovina, the Serbian Army has pursued a policy of "ethnic cleansing." Moreover, it has launched a campaign of terror that has dwarfed anything seen in Europe since the Nazi era. As of this time (winter, 1993), the Serbs of Croatia, Bosnia and Herzegovina have captured one-third of Croatia and two-thirds of Bosnia-Herzegovina.

In April of 1992, Serbia and Montenegro joined to create the "Federal Republic of Yugoslavia," claiming a successorship to the former Yugoslavia, a claim not recognized by Western nations. If allowed by the international community, the new Yugoslavia hopes to incorporate the conquered parts of both Croatia and Bosnia-Herzegovina into what they refer to as "Greater Serbia."

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8. ———, "Whither the State in Yugoslav Health Care?" *Social Science and Medicine* 21 (1985): 719-32.
- Also see:
 - , "Medicine Under Yugoslav Self-Managing Socialism: Does Decentralization + Democratization = Equality?" Paper presented at the 113th Annual Meeting of the American Public Health Association, Washington, D.C. (1985); and
 - , "Yugoslavia: Health Care Under Self-Managing Socialism," in Field, M. G., ed. *Success and Crisis in National Health Systems: A Comparative Approach*. New York: Routledge, Chapman & Hill, 1989.
9. Milanovic, V., and Stambolovic, V. "The Prescription for Yugoslav Medicine," *Social Science and Medicine* 21 (1985): 730-32.
10. Vukmanovic, C. "Decentralized Socialism: Medical Care in Yugoslavia," *International Journal of Health Services* 2 (1972): 35-44.
11. Letica, S., and Skupnjak, B., eds. *Health System in Yugoslavia*, 4th ed.

Zagreb: Centre for Health Cooperation With Non-Aligned and Developing Countries, 1989.

12. For example, a lengthy section on income and physician reimbursement starts with citations from the Yugoslav Associated Labor Act: "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." Despite the section's length, "tenured and salaried staff employees"—a term that would be used in any Western paper to describe the reimbursement of Yugoslav physicians—does not appear once!
13. The most prominent advocate of social ownership was Edvard Kardelj, a Slovenian Communist, who played a decisive role in drafting all the principal legal documents that launched the social ownership system. For his theoretical views, see *Pravci daljnjeg razvoja socijalistickog samoupravljanja* [Directions of Further Development of Socialist Self-Rule], Komunist, Belgrade, 1974.
14. By 1989, the concept of social ownership lost most of its ideological prestige. In its last two years, the Yugoslav government passed a series of laws intended to encourage privatization.
15. Since the institutional separation of enterprise management from the state, in the early 1950s, was not followed by the transfer of the property's title directly to employees, the state has remained *de facto* the only supplier of capital. In this context, neither the entry of new health institutions, nor the dissolution of existing ones, could occur without state approval. To use an analogy from accounting, firms were given responsibility for the income statement while the state remained in charge of the balance sheet. For further elaboration on this point see Lydall, H. *Yugoslavia in Crisis*. Oxford: Clarendon Press, 1989, p. 77.
16. In 1986, according to Letica and Skupnjak, *op. cit.*, 79% of all capital expenditures were reportedly financed by health institutions themselves. Bank and government loans accounted for another 11%, while government transfers (8%) and other miscellaneous sources (2%) made up the rest.
17. By the mid-1980s, however, political attitudes toward private medical practice had gradually changed. First, the government—faced with high unemployment rates among dentists—allowed only these health professionals to open their own clinics. Later, the right to practice private medicine was extended to include other medical specialties as well.
18. According to reports in local newspapers, on average, between 15 and 20% of the work force was unemployed at that time.

19. The same organizational framework of the SIZ was also used for financing social services with no actuarial risk, such as education or child care.
20. According to a World Bank study, in 1981 70% of the work force was employed by the socialized sector. The private agricultural and the private non-agricultural sectors accounted for 25% and 5%, respectively. See: *Yugoslavia—Adjusted Policies and Perspectives*. Washington, DC: The World Bank, 1983.
21. Bosnian, Croatian or Serbian-speaking readers may consult, for instance, sections 22 and 42 of the Health Care Act of Bosnia and Herzegovina (Zakon o zdravstvenoj zastiti) published in *Sluzbeni list SR Bosne i Hercegovine* (Official Register of the SR B&H) Sarajevo: XLII (1986): 531-32; 534-35.
22. Letica and Skupnjak, *op. cit.*, p. 94.
23. Brown, L. "Health Reform, Italian-style," *Health Affairs*, Fall 1984: 76-101.
24. Data are from the Yugoslav Federal Health Care Institute, Belgrade.
25. Dr. A. Smajkic from the University of Sarajevo Medical School was a prominent representative of this school of thought.
26. This view is reflected in the Health Statute of the Republic of Croatia, where a large segment of primary care was shifted from neighborhood-based clinics to school and factory clinics.
27. See Feliks, R., and Dovijanc, P., "Public Health, Health Care, and the Health Service," *Yugoslav Survey*, 19 (1978): 37-56 for 1953 data; and for 1987, *Statisticki godisnjak o narodnom zdravlju i zdravstvenoj zastiti u SFR Jugoslaviji 1987* [Statistical Yearbook on National Health and Health Care in Yugoslavia 1987], Savezni zavod za statistiku [Federal Statistical Bureau], Belgrade, 1988.
28. Late President Tito, as quoted by Sirc, L., *The Yugoslav Economy Under Self-Management*, New York: St. Martin's Press, 1979, p. 141.
29. These data are from the Federal Statistical Bureau of Yugoslavia.
30. Himmelstein, Lang, and Woolhandler, *op. cit.*
31. Vukmanovic, *op. cit.*; Letica and Skupnjak, *op. cit.*, p. 83.
32. Milo, S. "Production and Consumption of Medicines," *Yugoslav Survey*, 22 (1981): 127-36.
33. Personal communication with a number of Yugoslav health workers.
34. Himmelstein, Lang, and Woolhandler, *op. cit.*
35. Letica, and Skupnjak, *op. cit.*, p. 93.
36. *Statisticki godisnjak Jugoslavije* [Statistical Yearbook of Yugoslavia], Savezni zavod za statistiku [Federal Statistical Bureau], Belgrade, various years.
37. This was the case, for instance, with the Sarajevo Health Care SIZ.
38. Jurkovic, P., "The Policy of Financing Social Needs in Recent Years" in

- Macesich et al., eds. *Essays on the Yugoslav Economic Model*. New York: Praeger, 1989, pp. 207-36.
39. These figures refer to Bosnia and Herzegovina but similar ones can be found elsewhere. Source: *Sluzbeni list SR Bosne i Hercegovine* [Register of the Socialist Republic of Bosnia and Herzegovina] Sarajevo: XLIV (1988): 602-3.
40. *Statisticki godisnjak Jugoslavije* [Statistical Yearbook of Yugoslavia], Savezni zavod za statistiku [Federal Statistical Bureau], Belgrade, 1988.
41. In Bosnia and Herzegovina, for instance, patients staying in acute hospitals were at the time required to pay five percent of the per diem rate (for the first twenty days); for specialist visits, a fifty-percent co-payment rate was charged to individuals not referred by primary physicians; in cases of medically unjustifiable home visits, patients were reimbursed for only thirty percent of the fee.

ABSTRACT

This paper debunks three widely believed myths about the former Yugoslavia's health care system: that it was characterized by: (1) social ownership of "self-managing" provider organizations; (2) a commitment to primary health care; and (3) a faith in what might be called the "march of progress"—the health system's continuous expansion and improvement. In contrast to this picture, we present an alternative view and conclude with a word of caution for American consultants and health care reformers in Eastern European countries and newly independent states: If universal health coverage is to be maintained, beware of reforms that do no more than substitute private for public organizational forms.