Ana Vračar Sopo Japaridze Matthew Read

MISDIAGNOSED:

SOCIALIST HEALTH CARE MODELS IN RETROSPECT

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INTRODUCTION:
Health care in a sick system

Everywhere we look today, health care systems show undeniable signs of strain and overextension. Medical professionals report increasing pressure to work more rapidly and longer hours. Nurses are left to care for dozens of patients simultaneously, and the increased burden is not compensated with adequate pay. Patients struggle to find doctors with free appointments and are forced to endure ever longer waiting times, which can be fatal for those requiring urgent care.

These issues have developed despite exorbitant health care spending in many countries. The United Kingdom, for example, has doubled its share of GDP spent on health care since the 1980s, yet conditions have deteriorated for both patients and health workers.[1] *Improvements to life expectancy in England stalled well before the outbreak of the COVID-19 pandemic. For women in the most deprived areas of the country, there has even been a protracted decline in life expectancy.*[2] *Physicians are also reporting the return of diseases such rickets, scabies, and scurvy, which were widespread during the industrial revolution in the 1800s.*[3] *The UK's National Health Service (NHS) itself is suffering severe staff shortages, with more than 100,000 vacancies throughout the country.*[4] *Workplace pressures are reportedly driving half of the country's nurses and a quarter*

1 Vankar P. "Total healthcare expenditure as a share of GDP in the United Kingdom from 1980 to 2023", 9.11.2024. https://www.statista.com/statistics/317708/healthcare-expenditure-as-a-share-of-gdp-in-the-united-kingdom/

2 Marmot M, Allen J, Boytce T, Goldblatt P, Morrison J. "Health Equity in England: The Marmot Review 10 Years On", Institute of Health Equity; 2020. health.org.uk/publications/reports/the-marmot-review-10-years-on

3 Honigsbaum M. "'It is shameful': why the return of Victorian-era diseases to the UK alarms health experts", The Guardian, 18.02.2024. https://www.theguardian.com/society/2024/feb/18/return-of-victorian-era-diseases-to-the-uk-scabies-measles-rickets-scurvy

4 NHS Confederation, "Still no clear plan on NHS staffing to meet the needs of the population", 2021. https://www.nhsconfed.org/news/still-no-clear-plan-nhs-staffing-meet-needs-population

of its doctors to consider switching career.[5] *Why is it that such a wealthy country as the United Kingdom is incapable of preventing Victorian-era diseases and addressing the dire working conditions for medical professionals?*

The situation in continental Europe is equally alarming. In 2023, the president of the Berlin Medical Association warned that "health care for children in Germany is under massive threat".[6] *In the past decades, paediatric departments in Germany's clinics have been closed and jobs have been cut. The number of beds available for children was significantly reduced.*[7] *Practices for primary paediatric care are overloaded and often no longer accepting new patients, leaving many families without a paediatrician at all.*[8] *Why is a country like Germany, which supposedly has a universal multi-payer health care system, unable to provide adequate coverage for children and families?*

Another major health challenge facing families today is the shortage of antibiotics, which has been reported in Europe and beyond. The World Health Organization (WHO) lists antimicrobial resistance as one of the ten greatest threats to global health. In the EU alone, antibiotic-resistant infections kill around 35,000 people every year.[9] *The urgency of this issue is well recognized by researchers, clinicians, and policymakers, and yet there are virtually no new antibiotics in the*

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5 Weyman A, O'Hara R, Nolan P, et al Determining the relative salience of recognised push variables on health professional decisions to leave the UK National Health Service (NHS) using the method of paired comparisons BMJ Open 2023;13:e070016. doi: 10.1136/bmjopen-2022-070016

6 Bundesärztekammer, "Gesundheitsversorgung von Kindern in Gefahr", 18.09.2023. https://www.bundesaerztekammer.de/presse/aktuelles/detail/gesundheitsversorgung-von-kindern-in-gefahr

7 Deutsche Presse Agentur, "Kinderkliniken haben auch 2021 Hunderte Betten abgebaut", 8.12.2022. https://www.zeit.de/news/2022-12/08/kinderkliniken-haben-auch-2021-hunderte-betten-abgebaut

8 Hemer A.-K. and Class S. "Kein Kinderarzt: Wo Eltern verzweifeln" (No paediatrician: where parents despair), ZDF Heute, 22.11.2024. https://www.zdf.de/nachrichten/politik/deutschland/aerztemangel-deutschland-kinderarzt-100.html

9 Press Release: German Center for Infection Research, "Scientists sound the alarm over lack of antibiotics", 17.10.2024. https://www.helmholtz-hzi.de/en/media-center/newsroom/news-detail/scientists-sound-the-alarm-over-lack-of-antibiotics/

research pipeline. In fact, private pharmaceutical companies are increasingly abandoning antibiotic development and production because these drugs can only be used very restrictively so as to delay the development of new resistances. This means that only very small quantities can be sold to patients. The profit margin is simply not great enough to incentivise companies to produce new drugs. Our knowledge of medical science is today greater than ever before, and yet we are increasingly unable to combat everyday infections. How can this be?

The list of contradictions in our current approach to health is long. We could talk about intellectual property rights over vaccines, which greatly slowed down the global fight against COVID-19 and HIV, or about the high out-of-pocket costs for dental care in most countries, which together with an unhealthy diet has left Europe with the highest prevalence of major oral disease globally.[10] *The common thread tying these contradictions together is the commodification of health care. In the doctor's office, the hospital, and the health ministry, private economic interests are interfering with what should be a scientifically grounded decision-making process. The self-employed physician is paid more by insurance companies to prescribe medicine than to consult with patients to prevent diseases in the first place. Hospital staff are told to categorize patients by the "products" they receive and how much the insurance company can be charged. Medical decisions are increasingly made on the basis of what can be billed profitably rather than on the basis of medical criteria. Diseases are turned into commodities. Patients become customers.*

Against this background, this book aims to shed light on a fundamentally different approach to health care. The societies of the so-called "Eastern bloc" in the 20th century were built around principles wholly

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10 As of 2019, the WHO's European Region had the highest prevalence of major oral disease cases (50.1% of the adult population) across all six regions worldwide. https://www.who.int/europe/news/item/20-04-2023-who-europe-calls-for-urgent-action-on-oral-disease-as-highest-rates-globally-are-recorded-in-european-region

different to the ones most of us know today. While the dominant tendency in capitalist societies is towards privatisation, property relations in the East were progressively socialized over time. Landlordism and monopolisation were replaced by cooperative and state ownership. As a result, private economic interests no longer determined the direction of society. The anarchy of the market was replaced by a scientifically grounded planning process. The chapters in this book examine how three different socialist states constructed health care systems within their national and historical contexts.

In the first chapter, Sopo Japaridze describes how the young Soviet government set out to tackle the sickness and impoverishment left behind by Tsarist autocracy and early capitalist development in Georgia. The Soviet Union pioneered a new approach to health care by creating a unitary, centrally led system that was entirely publicly owned. This so-called "Semashko model" was able to eliminate private economic interests from health care and thus focus first and foremost on prevention. Japaridze details how Soviet Georgia gradually improved the health of its population while simultaneously advancing industrialisation and economic growth. No longer subordinated to the necessities of profit extraction, the Soviets developed novel medical fields such as kurortology (literally the study of health retreats) and bacteriophage, which is today garnering renewed interest in light of antimicrobial resistance. The reimposition of capitalism after 1990 threw the health of the Georgian population back by decades, as Japaridze powerfully illustrates. The health care system was once again oriented around market logic and thus began neglecting prevention. The number of visits to the doctor plummeted and the advancements against infectious and parasitic diseases such as tuberculosis were largely reversed. In the post-Soviet states alone, it is estimated that an additional 7 million people died prematurely between 1990 and 1995.[11]

11 Azarova, Aytalina et al. "The effect of rapid privatisation on mortality in mono-industrial towns in post-Soviet Russia: a retrospective cohort study", The Lancet, May 2017. https://www.thelancet.com/journals/lanpub/article/PIIS2468-26671730072-5/fulltext

The chapter on the German Democratic Republic (DDR) provides insight into the concrete workings of a socialist health care system. On the frontline of the Cold War and under the pressures of post-war reconstruction, politicians and activists in East Germany drew on progressive medical traditions from the 19th and early 20th century to formulate a new understanding of health care. A major influence on the DDR's system was the field of social medicine, which advances the idea that our physical and mental health is determined by a wide range of factors such as working conditions, nutrition, housing, education, the character of our social relationships, leisure and cultural behaviour, etc. If these "social determinants of health" can be systematically investigated and addressed, many diseases can be prevented before they manifest. The chapter explains how such principles were followed in schools, workplaces, and neighbourhoods, while also highlighting the challenges inherent in this process. The transition from self-employed doctors in private practices to publicly employed staff in nationalized clinics was decisive for eliminating economic interests from medicine, but it was also met with initial resistance by sections of the medical elite.

Finally, Ana Vračar explains the unique approach to health care in Yugoslavia. As an outlier in the socialist bloc, Yugoslavia moved away from a centralized planning system and began experimenting with economic self-management, which also greatly influenced the country's health care system. In contrast to the unitary Semashko model, Yugoslavia's system was based on decentralisation and local self-governance. To advance these principles, "self-managed interest communities" called samoupravne interesne zajednice (SIZ) were created at municipal and workplace levels that coordinated and financed the provision of care. In the SIZ, health workers and patients collectively deliberated on priorities, funding allocations, and strategies to advance health protection in the local community. Vračar outlines the logic and structures behind the SIZ and highlights some of the challenges that developed under this model, such as regional disparities between wealthier republics and poorer regions. The marketiza-

tion of health care in Yugoslavia – which already began under the dictates of World Bank and International Monetary Fund in the 1980s – brought the profit motive and individualisation back into medicine. The dismantling of community and workplace health services left the population exposed to preventable diseases and led to deteriorating working conditions for health professionals. The latter development has triggered a mass "brain drain" from the former Yugoslav republics, as many professionals migrate to Western Europe.

Tragically, the human cost of capitalist restoration in the East after 1990 and the poor state of health care systems across Europe today have made the efficacy of the socialist approach clear. A holistic and preventive orientation was replaced by the fragmented and commercialised system of health care that we know too well in capitalist states today. By revisiting the historical experiences in Eastern Europe, the contributions in this book show that effective, universal health care can indeed be built around peoples' needs, not profit.

Matthew Read
May 2025

GEORGIA:
Legacy of prevention vs. pay-to-care

Sopo Japaridze

The year 2023 ended on a somber note with the loss of a new Brazilian friend I had made. After exploring the landscapes of Georgia and Armenia on a tour last November, she returned home only to tragically succumb to leptospirosis—a preventable disease. She contracted it from contaminated water during a flood in her impoverished São Paulo neighborhood. The occurrence of leptospirosis and other neglected tropical diseases is driven by "complex interactions among hosts, climate, transport networks, population density, and unplanned urbanization, which result in inadequate infrastructure, social inequalities, and limited access to health services."[12] Larissa and her fellow Brazilians had often marveled at the more developed infrastructure in Georgia, a legacy from the Soviet era, which sharply contrasted with the severe shortcomings in Brazil. This heartbreaking event highlights the broader failures of capitalism and the often-overlooked value of Soviet health heritage and public works. This paper is dedicated to Larissa, who should be here today, and to all those who have suffered and died due to the neglect and inequalities perpetuated by capitalist systems.

In this chapter I outline two contrasting approaches to health in Georgia. The socialist Soviet model viewed health care holistically, considering it the state's responsibility to ensure not only a strong health care system but also decent housing, a clean environment, occupational safety, and access to rest and recuperation as part of disease prevention. In contrast, the capitalist model introduced after the Soviet Union's col-

12 As of 2019, the WHO's European Region had the highest prevalence of major oral disease cases (50.1% of the adult population) across all six regions worldwide. https://www.who.int/europe/news/item/20-04-2023-who-europe-calls-for-urgent-action-on-oral-disease-as-highest-rates-globally-are-recorded-in-european-region

lapse dismisses much of the state's responsibility, focusing only on communicable diseases on a case-by-case basis and ignoring the broader social determinants of health, while operating on market principles.

The Soviet Georgian government inherited one of the sickest populations of the Russian empire with virtually no decent housing, infrastructure, or institutional knowledge. It had to build most of the economic and material means which could provide a healthy life for its citizens. Despite intense initial challenges and reduction of funding in the 1970s, the Soviet Georgian government radically improved the longevity and health of the population. In contrast, capitalist Georgia inherited housing, infrastructure, institutional knowledge, and a significantly healthier population, but through market-driven policies and a lack of focus on prevention, the population today is confronted with significant health issues.

The Bolsheviks inherit the sickness of the Russian Empire

The Bolsheviks inherited a population from the Russian Empire that was severely ill. Life expectancy was around 30 years. People were heavily exploited, and their health was detrimentally affected by the terrible working conditions, inadequate housing, poor sanitation, and insufficient health care. On top of this, the First World War had already devastated the population, followed immediately by the Russian Civil War. Georgia had been part of the Russian Empire since the 19th century, was briefly under a Georgian Menshevik government from 1918 to 1921 and Sovietized in 1921 during the Civil War.

Soviet Georgia had to contend with many diseases such as the black plague, cholera, smallpox, malaria, and typhus. Industrialization had exacerbated the plight of workers, who

suffered appalling conditions in the factories. The main river in Tbilisi was polluted from the dumping of toxic waste from manufacturing. Tbilisi was also characterized by overcrowded slums where workers had haphazardly built shacks on their own initiative. In mining towns, workers slept outside during the summer and in the mines during the winter. There were no occupational health and safety regulations in place and labour inspections were ineffective.

The Bolsheviks recognized that these diseases were not only caused by pathogens, but also the social conditions in the country: poverty and class exploitation. If the new society was to effectively treat and prevent disease, it would be necessary to address social and biological ills simultaneously. Society had to be collectively responsible for health outcomes. The revolutionaries recognized how modern industrial capitalism facilitated the spread of illnesses in new ways.

This is why the defining aspect of Soviet medicine was the elimination of the traditional distinction between preventive and curative care. The entire system was founded on the concept of prevention, known as prophylaxis. This principle was articulated in the Communist Party's program:

> *'The Communist Party of the Soviet Union will base its public health policy on a comprehensive series of health and sanitary measures aiming to prevent the development of disease,' and the statute of 1921 regulating the activities of the Russian Commissariat of Health made that body 'responsible for all matters involving the people's health, and for the establishment of all regulations promoting it, with the aim of improving the health standards of the nation, and of abolishing all conditions prejudicial to health.'*[13]

13 As of 2019, the WHO's European Region had the highest prevalence of major oral disease cases (50.1% of the adult population) across all six regions worldwide. https://www.who.int/europe/

Health care was seen as something that could never be a source of profit or revenue, but a necessity for society. The architect of Soviet health care was Nikolai Aleksandrovich Semashko, who was appointed People's Commissar of Public Health in 1918. Semashko – along with Georgia's first People's Commissar of Health Protection, Girgol Kuchaidze – worked tirelessly to first halt the epidemics and then put in place a policy of prophylaxis.

From the early days of Soviet rule, the government focused on transforming health care in Georgia. Health was declared a main concern of the state, and a unified system of health and social security was established. Hospitals and sanatoriums were nationalized, while pharmacies and other medical facilities came under state control in order to create a unitary system and strengthen the material and technical base of health care. The goal was clear: provide free, highly qualified medical assistance to the people, protect their well-being, and extend their lives through preventive measures. This went hand-in-hand with expanding Georgia's economic base, which could help to finance health care.

Prior to Soviet rule, Georgia's health infrastructure consisted of just 45 hospitals, with 1,093 beds and 36 on-site clinics in villages. There was 1 doctor per 27,704 residents in Western Georgia and 1 in 26, 644 in Eastern Georgia. By 1965, 633 hospitals were providing 36,603 beds and 1,356 polyclinics were operating in the rural areas alongside 503 rural ambulatories.[14] The training and further education of publicly employed medical personnel became a primary focus in the Republic. In 1935, Georgia's state medical academy was founded as the Institute for the Advancement of Qualification of Doctors, and in 1941 it was named Tbilisi Institute of Professional Training of Doctors. The Institute played a key role in raising the qualifications of medical professionals.

news/item/20-04-2023-who-europe-calls-for-urgent-action-on-oral-disease-as-highest-rates-globally-are-recorded-in-european-region

14 Health in Georgia. Tbilisi, Georgian SSR Ministry of Health, 1966.

In the early days of Soviet health care, eliminating infectious diseases was the top priority. Significant improvements were made in sanitation, with a systematic approach to tackling unsanitary conditions and expanding hygiene practices, leading to the establishment of institutions like the Tbilisi Sanitary-Hygiene Institute and the State Sanitary Inspection in 1926. Around the same time, a scientific-research institute of vaccinations and serums was set up. The network of ambulatory polyclinics, dispensaries, and hospitals was expanded, and mandatory vaccinations were introduced.

These efforts paid off. Dangerous infectious diseases like the black plague, cholera, and typhus were eliminated. Anti-malaria campaigns were especially vigorous since the disease affected every third person in the country. A provisional malaria station was set up in Tbilisi in 1921 and later evolved into the Scientific Research Institute of Parasitology and Tropical Medicine. By 1955, malaria had been virtually eliminated in Georgia.[15] The advancements in this area were not maintained after 1990: the morbidity rate from infectious and parasitic diseases increased by an average of 2.14 times per year in 2017-2019 compared with 1988-1990.[16] Similarly, the morbidity rate with tuberculosis increased by an average of 1.98 times in 2017-2019 compared to the rate from 1988-1990. During the Soviet era, a Scientific Research Institute of Tuberculosis had operated in Tbilisi to work on the eradication of the disease.

Occupational health care for workers was also made a priority in the new society. In 1927, the scientific-research Institute of Labour Hygiene and Occupational Diseases was founded. Medical service centers were established at individual industrial plants and construction sites to ensure workers received

15 Health in Georgia. Tbilisi, Georgian SSR Ministry of Health, 1966.

16 Natsvlishvili, Beka. Social Consequences of Privatization of Health Care. Tbilisi, Friedrich Ebert Foundation, 2022.

care directly where they worked as well as tracking how occupational diseases developed over time.

Great attention was given to maternal and child health protection. Maternity homes, children's homes, nurseries, and women's counseling centers were opened throughout Soviet Georgia. Creches were built within the workplace to provide on-site care.[17]

During the Second World War, Georgia's health care system adapted to the needs of the conflict. The task was to treat wounded fighters and ensure the population received adequate health care. Evacuation hospitals were created across Georgia, utilizing hospitals, clinics, sanatoriums, and other medical institutions. These hospitals were equipped with treatment laboratories, medical equipment, and personnel. Specialized evacuation hospitals focused on surgery, therapy, physiotherapy, and tuberculosis. A scientific-research Institute of Hematology and Blood Transfusion, with various branches, was established.

Doctors from Soviet Georgia also served alongside Soviet soldiers in the war, contributing greatly to the treatment of wounded soldiers. Soviet medical journals report that evacuation hospitals and other treatment facilities in Georgia returned a high percentage of the wounded to the active army. They also conducted extensive curative and preventive work to combat epidemic diseases caused by the conflict. During this period, Georgian doctors enriched the medical field with new treatment methods and innovations.

After the end of the War, a new phase began for Georgia and the health care of the entire Republic. Efforts were made to improve medical services for the working class. Initially, the

17 Georgian SSR Academy of Sciences, editor. Tbilisi: Economic and Geographical Study. Tbilisi, Soviet Georgia, 1989.

main challenge was to meet the growing city's need for all kinds of medical services and provide highly qualified care for disabled veterans. In 1946, the Institute of Orthopedics and Reconstructive Surgery was opened for them.

Several transformations were carried out to establish a unified health care system that could meet the needs of the entire Republic's population. Significant attention was paid to developing new medical fields. In 1958, a new institute for researching fertility and reproduction was established as the Women's Physiological and Pathological Scientific-Research Institute. After the reimposition of capitalism in the 1990s, the significant role of surrogacy, fertility, and medical tourism in post-Soviet Georgia led to much of the institute's knowledge and resources being preserved and deemed profitable, unlike those of other institutions.

THE INSTITUTE OF BACTERIOPHAGE

The story of bacteriophage research in Soviet Georgia highlights the Soviet Union's pioneering work in alternative treatments, particularly phage therapy, which is now regaining interest due to the pressing issue of antibiotic resistance. This research, largely overlooked in the West, exemplifies how Soviet medicine was ahead of its time in exploring ecological approaches to health and disease. The Soviet ecological view of the interaction between bacterial species and their hosts emerged before the West's interest in disease ecology.[18] In 1938 the Institute of Microbiology, Epidemiology and Bacteriophage was founded. The term bacteriophage (or simply phage) means "bacteria eater."

Félix d'Herelle, a Franco-Canadian microbiologist, discovered bac-

18 Myelnikov D. An Alternative Cure: The Adoption and Survival of Bacteriophage Therapy in the USSR, 1922-1955. J Hist Med Allied Sci. 2018 Oct 1;73(4):385-411. doi: 10.1093/jhmas/jry024. PMID: 30312428; PMCID: PMC6203130.

teriophages at the Pasteur Institute in 1917 and found them to be incredibly potent antimicrobial agents. He developed 'phage therapy,' which uses phages to selectively destroy pathogenic bacteria without harming host cells by introducing it in the bacteria. D'Herelle believed phage-induced bacterial infection was key to understanding the evolution of all bacterial infections, a view that conflicted with modern immunological theories "that had won the Nobel Prize."[19] The debate over immunity and natural recovery involved not just important theories and reputations of scientists, but also the technologies and financial incentives of research and treatment. Downplaying immunity would have reduced the use of serotherapy and vaccines. This partly explains why major research centers like the Pasteur Institute in France actively opposed phage therapy, as it would revolutionize existing medical strategies. D'Herelle was treated as a heretic and his relationship with the scientific community in the West became increasingly hostile. He was heavily marginalized and attacked. The Soviet Union, on the other hand, was interested in bacteriophages because d'Herelle's theories about their role in human immunity aligned with the Soviet focus on symbiosis and an ecological view of infection.

D'Herelle subsequently moved to Soviet Georgia to continue his research. In 1938, the Institute of Microbiology, Epidemiology, and Bacteriophage was established. Just like most other medical and science fields, the Second World War reaffirmed many of these institutions' importance and necessity. During the Cold War, bacteriophage was stigmatized in Western science and smeared as "Stalin's Cure"[20], while penicillin and other antibiotics became hegemonic as treatment. Research in Soviet Georgia nevertheless continued. Although other microbiology institutes in the USSR conducted phage research, only the

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19 Fruciano, Dottore Emiliano, Bourne, Shawna, Phage as an Antimicrobial Agent: D'herelle's Heretical Theories and Their Role in the Decline of Phage Prophylaxis in the West, Canadian Journal of Infectious Diseases and Medical Microbiology, 18, 976850, 8 pages, 2007. https://doi.org/10.1155/2007/976850

20 Fruciano, Dottore Emiliano, Bourne, Shawna, Phage as an Antimicrobial Agent: D'herelle's Heretical Theories and Their Role in the Decline of Phage Prophylaxis in the West, Canadian Journal of Infectious Diseases and Medical Microbiology, 18, 976850, 8 pages, 2007. https://doi.org/10.1155/2007/976850

Tbilisi institute had a dedicated bacteriophage department. By 1953, it had become the center of bacteriophage research in the USSR.

After the Soviet Union was dissolved, the Institute's manufacturing facilities were sold to private companies, leaving the research division, which only barely survived thanks to an international campaign to keep it independent and functioning. With antibiotics becoming less effective against resistant bacteria, interest in bacteriophages has recently revived. Soviet Georgia was ahead of its time in developing these ideas, and now, with their resurgence, the Eliava Institute (named after the communist George Eliava, who had founded the Tbilisi institute and was a student of d'Herelle before later falling victim to Beria's purges in Georgia) is much smaller but continues to attract significant interest from researchers, scientists, doctors, and patients around the world.

Sanatoriums

The Soviet approach to health emphasized the importance of what we now refer to as the "social determinants of health," including housing, decent work, nutrition, and social inclusion. A key component of disease prevention, especially for those working under harsh conditions, is rest and recuperation.

As communicable diseases such as tuberculosis spread across Europe in the late 1800s and early 1900s, health resorts became increasingly popular. These resorts were typically reserved for the wealthy, while public or charitable facilities for the working class resembled poorhouses. The Soviet Union sought to democratize this concept by making high culture, once exclusive to the elite, accessible to the masses.

The organization of retreats for workers began after the establishment of the Kurortology Institute in 1926. Kurortology is a branch of clinical medicine born in the USSR which studies the preventive and restorative benefits of health resorts,

including water therapy, spa climatology, and related physiotherapy disciplines.

In the 1920s, opulent buildings and homes that once belonged to the wealthy were expropriated and repurposed for sanatoria or vacation homes for youth, such as those in Kojori and Manglisi. The first significant step towards establishing "resorts for workers" came in 1931 with Order 31/X of the Georgian Soviet Socialist Republic.[21] This led to the construction of new resorts and vacation facilities, alongside the renovation of nationalized buildings.

Eucalyptus and evergreen trees were planted in resorts throughout Georgia to enhance air quality and provide therapeutic benefits. Protective measures were also taken to preserve the surrounding areas from deforestation. Georgia's rich natural environment and healing properties, combined with the modern science of kurortology, encouraged the establishment of many such resorts. Tbilisi, the capital of Soviet Georgia, was known for its naturally occurring sulfur waters, mild temperatures, and abundant sunshine. Curative mud from Kumisi Lake (located 10 kilometers from Tbilisi) was and is still used in the Tbilisi Balneological Resort, which was established in 1938.

In the 1950s and 1960s, the government launched new initiatives to develop vacation homes and resorts, aiming to provide more people with the opportunity for rest and recuperation. By 1983, Tbilisi alone had 6,500 beds in various recreational facilities, accounting for 8 percent of Georgia's total recreational capacity.[22] Resorts like Borjomi, Abastumani, and Tskaltubo became well known and loved. Specific resorts were established

21 USSR Ministry of Health and the Organ of Tbilisi State Medical Institute, editor. Soviet Medicine. vol. 1-12, Tbilisi, Sakmedgami, 1939. 12 vols.

22 Georgian SSR Academy of Sciences, editor. Tbilisi: Economic and Geographical Study. Tbilisi, Soviet Georgia, 1989.

for professional associations, workers' unions, and organizations for the disabled. Priority was given to workers from the heavy industries, who were in the most need of rest and recuperation. Yet the high general demand led to continuous efforts to expand recreational facilities for all.

In post-Soviet Georgia today, these once-thriving sanatoriums are largely run-down and empty. Only a few have been converted into hotels, but they are often too expensive for most Georgians to visit. Others are used to house refugees from the wars of the early 1990s. The last refugees have now vacated the former Kurortology Institute in Tbilisi. While the Soviet Union once pioneered the science of health resorts and nature therapy, capitalist Georgia has seen this tradition reduced to providing shelter for war-displaced families. The once-grand workers' resorts in Tskaltubo now stand dilapidated and decaying, attracting off-the-beaten-path tourists who explore and photograph these abandoned buildings.

Housing

A central pillar of prophylaxis is the provision of adequate housing for all. Before Sovietization, workers in mining towns or cities either slept outside, inside mines, or rented in Tbilisi. Housing in cities had been a pressing issue for decades.
In urban areas like Tbilisi, the relatively well-equipped apartments in central districts were occupied by the upper class, mainly the bourgeoisie. Meanwhile, 30% of the city's population lived in slums, half-destroyed houses, cramped and humid basements, and shacks, all in extremely unsanitary conditions. Workers attempted to solve the housing problem individually, with newcomers building homes without permits on vacant lands belonging to the city and the railway.

The new Soviet government prioritized housing improvements, recognizing that poor living conditions contributed

significantly to illness. Efforts were made to improve living conditions by renovating old houses and constructing new ones. Large residential buildings were handed over to the state, minimum rent was established, and control was transferred to the City Council. Many of these buildings were converted into multi-unit communal housing. Housing needs were more comprehensively addressed after the Second World War, with the construction of large-scale apartment buildings.

Student housing and stipends were also crucial for universal education, especially for the Tbilisi Medical Institute, where new doctors were being trained. The Soviet's holistic approach to education sought to ensure students enjoyed culture and an active lifestyle. They had opportunities to play sports, attend theaters, and watch films. These programmes grew over time, with the biggest transformations happening after the Second World War.

Today, housing presents a major issue in Georgia. Houses are characterized by overcrowding, dilapidation, and widespread unplanned and unregulated developments. The high cost of housing and significant mortgage debt contribute to the problem. Many people cite buying a home or related debt as the primary reason for migrating and enduring harsh working conditions abroad.

Greening Campaigns in Tbilisi

As part of efforts to improve the environmental factors influencing health, greening played a crucial role in improving sanitary and hygienic conditions and shaping urban appearances.

With the growing urbanization of Tbilisi, pollution became a severe problem. To improve the environment, city planning was rethought, with initiatives to reduce noise, purify water, and enhance recreational areas. Green plants, essential for

creating comfortable living conditions, were integrated into living spaces. Specific plants were chosen for their ability to absorb noise and increase oxygen levels, while trees provided shade for sidewalks and created microclimates. Parks and green zones were constructed or renovated, incorporating flowers and architecture for aesthetic appeal.

These efforts continued annually, with plans to develop and transform green spaces both outside the city and in newly established neighborhoods before the collapse of the USSR. Yet today these green spaces are increasingly encroached upon by unregulated buildings, with almost no effective preventive measures in place. The morbidity rate from respiratory diseases increased by an average of 1.86 times between 2017 and 2019 compared to 1988 and 1990. In 1989, during Soviet Georgia, the rate was 8,733 per 100,000 inhabitants. By 2018, the rate had risen to 15,681 per 100,000.[23]

The Abrupt End

In 1917, Lenin wrote:

> *"It is this communist society, which has just emerged into the light of day out of the womb of capitalism and which is in every respect stamped with the birthmarks of the old society, that Marx terms the "first", or lower, phase of communist society."*[24]

The Semashko model and the Soviet system are not the final word on socialist health care; they are stamped with the period in which they emerged, reflecting both its imaginative

23 Natsvlishvili, Beka. Social Consequences of Privatization of Health Care. Tbilisi, Friedrich Ebert Foundation, 2022.

24 Lenin, Vladimir Ilich. The State and Revolution. Edited by Robert Service, translated by Robert Service, Penguin Publishing Group, 1992. Accessed 4 September 2024.

aspirations and its inherent limitations. By the 1970s, the system was confronted with decreased funding and overall shortcomings in connection with the economic direction of the USSR. These issues, however, were nothing compared to those of post-Soviet Georgia.

There can be no doubt that health policy requires a holistic approach, which accounts for social factors, emphasizes prevention, and fosters collective responsibility. The Semashko model enabled the integration of diverse medical fields. It provided an economically efficient system that was available to everyone for free at the point of use. The results of this approach were a significant increase in life expectancy, a decrease in mortality, a decrease in morbidity, an increase in the number of health care workers per population, an increase in the utilization of health care, the establishment of labour medicine, and the prevention of occupational diseases.

This institutionalized approach – along with all the infrastructure and accrued knowledge – was torn down after the dissolution of the USSR. The material foundation necessary to sustain the system was dismantled, and ideologically, the new capitalist order embraced market-driven principles in health care.

Neoliberals in Power

In the post-Soviet era, Georgia experienced a drop to almost zero financial support for public health infrastructure, limiting its ability to control illness. If in 1990, the equivalent of 130 U.S. dollars a year was spent on health care per person, in 1994 this had fallen to 1 U.S. dollar. Almost 90 percent of health care costs had to be covered by citizens out of pocket. Instead of the Semashko model's integrated view of social determinants, free and universal health care delivery, and collective responsibility, the Georgian government got a revolving door of experts operating under sets of policies known as the

"Washington Consensus" at a time when people in Georgia needed health care the most due to declining social and economic conditions and disease outbreaks. Individual responsibility took the place of collective responsibility, and the social determinants of health were separated from health care.

Many general indicators show the rate of decline. As of 2019, the number of hospital beds in Georgia stood at only 43 percent of 1990 levels. While this number is today again growing, at the current rate it will only return to Soviet-era levels by the year 2045. The average number of qualified health care workers by population — which increased from 26 per 10,000 in 1940 to 82.4 in 1965 and 115 in the early 1980s — fell by half over the course of the 1990s.

This is not just about provision, but the outcomes. The post-Soviet decades have seen a 1.5 percent increase in the average death rate and a 2.3-fold increase in morbidity levels. Not only did the health care system suffer, but many social determinants were made worse by the lack of electricity, hot water, heating, access to food, and the use of dangerous heating substitutes. This led to outbreaks of diseases like tuberculosis, diphtheria, hepatitis, and so on.

In Georgia, the neoliberal state now bore only limited responsibility for communicable diseases, while noncommunicable diseases were left to individuals' responsibility. The assumption that health care should not be profitable was replaced by a total commitment to profit-oriented health care and privatization.

This ideology was neatly summed up by Kakha Bendukidze, an oligarch who made his millions in Russia and a major architect of Georgian neoliberalism during the 2000s in his roles in the finance and economic reforms ministries. For him, "to ask the government for help is like trusting a drunk to do surgery on your brain."

This offloading of government responsibilities has had severe consequences. Hospital care has been replaced with an emphasis on privatized outpatient care, which has only increased the burden on women's unpaid care work; sanatoriums and spas have either been left to rot, earmarked for refugees from separatist Abkhazia as temporary housing, or else sold to corporations and converted into hotels that are completely out of reach for most people. Universal free access was replaced by out-of-pocket expenses for most, with limited subsidies to "targeted" groups. On top of that, the World Bank "reformers" exported the terms "optimization" and "rationalization," which refer to reducing the health care infrastructure to fit better with a free-market system.

Georgia was one of the first countries in the former Soviet Union to receive technical and financial means from Western funders for health sector reforms and other infrastructure and civil-society development programs. The international organizations proposed an immediate transition from a planned economy to a market economy. Yet, due to the nature of public health services, where pandemics are always a possibility, liberalizing mechanisms were moderated in order to maintain the government's role in public health. Diseases like tuberculosis, HIV, and other communicable diseases could put the country, region, and even the wider world at risk if left completely unchecked. Thus, the World Bank and the World Health Organization collaborated to reform the Soviet Georgian health system into a market one with little room for public health.

Disintegrated Health Care

There are many reasons for these undoubtedly negative trends, but one of the main ones is the almost ninefold decrease in the number of preventive examinations, which help to detect diseases at an early stage and find effective treat-

ment. Going to the doctor is now associated with high costs and navigating a complex and predatory web of health care providers. Data from 1970, 1975, and 1980-1983 show that during the Semashko model era, individuals visited outpatient polyclinic institutions an average of 10 times per year. This trend was reversed after 1990. From 2002 to 2019, the average number of visits to outpatient polyclinic institutions increased in frequency, but, by 2019, this frequency was still 2.4 times lower than the 1970 figure and 2.8 times lower than the 1982 rate. While the data does not specify which visits are preventive, the significant decline in overall visit frequency suggests that preventive care has been notably reduced.[25]

Most health workers also lost out from the changes over the past three decades, and real income decreased. Before 1990, there were 2.2 to 2.3 nurses for every doctor, and accordingly, 30 percent of the medical staff were doctors, and 70 percent were nurses and other specialists with secondary qualifications. As of 2019, there are an average of 0.6 nurses per doctor. This would demand that the number of nurses be increased by at least 3.6 times to restore the optimal proportion of medical staff with high- and mid-level qualifications.

The reason for this problem is simple: the education system also operates along market principles. Doctoral diplomas are in demand in society, and the education system supplies the appropriate products to the "market". Despite the fact that training doctors alone does not ensure the full functioning of the health care system, there is no market demand for a nursing degree. On top of the lack of demand, the worsening economic conditions drive many nurses to migrate to the European Union or elsewhere; some are even recruited by foreign agencies, which further destabilizes Georgian health care and puts it at risk.

25 Natsvlishvili, Beka. Social Consequences of Privatization of Health Care. Tbilisi, Friedrich Ebert Foundation, 2022.

In a study entitled "Social Consequences of Privatization of Healthcare", the government approaches are divided into three stages: the first stage is called "Toying with neoliberalism," where the international experts were in the driver's seat since the governments had no knowledge of how markets worked and put their fate in the hands of international financial organizations.

This was followed by a second phase, militant neoliberalism, with the government of Mikheil Saakashvili taking the lead and frequently going above and beyond international recommendations and directives for austerity and liberalization.

The current Georgian government, which the study categorized as "neoliberal without conviction", represents the third stage. It has continued the legacy of total deregulation albeit without having committed ideologues within its ranks. This approach won people's support mostly because it promised single-payer insurance. Many migrants who left in the early 2000s, reported that health care costs of family members were the reason they had to migrate. In 2003-2009, a significant share (40 to 44 percent) of out-of-pocket health care expenditures came from the share of outpatient treatment, which decreased sharply in 2010. In 2010-2020, the share of these expenditures is in the range of 13 to 16 percent though spending on medicine has increased dramatically since 2010. As of 2020, drug costs make up 80 percent of out-of-pocket health care spending.[26]

In 2013, a system of universal insurance was implemented, but it was quickly reformed to targeted insurance, as the costs of financing an unregulated health care market in which virtually all hospitals and clinics are private were deemed too high for the state. Last year, the government also implement-

26 Natsvlishvili, Beka. Social Consequences of Privatization of Health Care. Tbilisi, Friedrich Ebert Foundation, 2022.

ed a minimum wage for health care workers — the only minimum wage that exists in the whole country — and started to discuss the need for public clinics to "compete with private ones." Even if this is a huge step compared to the militant neoliberalism of the early 2000s, it's a drop in the ocean considering the needs of the population. Since the end of the COVID-19 pandemic as a public health issue, even this small rupture in thinking is closing.

The future of Georgia's few remaining public hospitals is uncertain. In the 1990s, as the socialist system was being dismantled, Georgians avoided the neighborhood outpatient centers due to financial constraints, seeking hospital care only in emergencies. With the rise of privatization, preventive health care was deemed unprofitable and has since been neglected. As a result, without the guidance of these centers, individuals now face an overburdened health care system that profits from illness.

During the worst of the 1990s, when hospitals were without power and gas, doctors and nurses continued working, often without pay. Yet, many of these dedicated health workers were later dismissed when their hospitals closed. As Georgia's social structure collapsed, the population faced severe austerity measures imposed by international organizations and domestic reformers, just when they needed help the most.

Without a socialist approach to health care that accounts for the social determinants of health, efforts remain limited and isolated. For example, the struggle to keep a public hospital open can only mitigate the general crisis, for it will remain constrained by the limits of what is currently possible. In this way, public hospitals act more as a holding tank for a better future, as they alone cannot address the broader issues.

Limited Assistance During Critical Times

The decline of Georgia's health care system after the collapse of the Soviet Union starkly contrasts with the robust public health infrastructure and holistic approach established under the Semashko model. What was once a system rooted in the collective responsibility for health and a deep understanding of the social determinants of disease was rapidly dismantled in favor of market-driven principles. This shift not only eroded the material foundations that supported universal health care but also left the Georgian population vulnerable to worsening health outcomes and a sharp increase in preventable diseases. The rapid privatization and reduction in state responsibility for public health were not merely policy changes—they represented a profound ideological shift away from the values that had once prioritized the well-being of every citizen.

Today, as Georgia grapples with the long-term consequences of this neoliberal transformation, the lessons of the Soviet health care system remain painfully relevant. The disintegration of the Semashko model did not just result in the loss of an integrated health care network but also highlighted the broader failure of a system that prioritizes profit over people. As the world faces new public health challenges, the importance of a health care system that addresses both biological and social determinants of health, prioritizes prevention, and upholds collective responsibility cannot be overstated. The experience of Georgia serves as a powerful reminder that the health of people is not merely the sum of individual choices but is deeply intertwined with the social, economic, and political structures that shape everyday life.

Bibliography:

Georgian SSR Academy of Sciences, editor. Tbilisi: Economic and Geographical Study. Tbilisi, Soviet Georgia, 1989.

Georgian SSR Health Ministry. Soviet Medicine. vol. 1-4, Tbilisi, Sakartvelo KB Publisher, 1988. 6 vols.

Health in Georgia. Tbilisi, Georgian SSR Ministry of Health, 1966.

Lenin, Vladimir Ilich. The State and Revolution. Edited by Robert Service, translated by Robert Service, Penguin Publishing Group, 1992. Accessed 4 September 2024.

Natsvlishvili, Beka. Social Consequences of Privatization of Health Care. Tbilisi, Friedrich Ebert Foundation, 2022.

Sigerist, Henry E. "The Essence of the Soviet Health System." Socialized Medicine in the Soviet Union, W.W. Norton and Company, 1937, pp. 86-104. American Journal of Public Health, https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.107111736?journalCode=ajph.

Soviet Medicine. vol. 2, Tbilisi, 1939.

Teles, Alessandra J. "Socio-geographical factors and vulnerability to leptospirosis in South Brazil." BMC Public Health, vol. 23, no. 1311, 2023. BMC Public Health, https://rdcu.be/dSuQs.

USSR Ministry of Health and the Organ of Tbilisi State Medical Institute, editor. Soviet Medicine. vol. 1-12, Tbilisi, Sakmedgami, 1939. 12 vols.

THE GERMAN DEMOCRATIC REPUBLIC: Revolutionizing outpatient care

"Throughout my political life... I have seen the world through the eyes of a doctor, for whom poverty, misery, and disease are the main enemies. That's how I came to communism, and that's how I was lucky enough to experience in the DDR a health and social system that established an impressive framework, a social and health system for the whole population such as I had never seen before. [...] I am not uncritical of the former DDR and do not glorify its past. [...] But one thing I know for sure: it would never have pushed me away from the ideas of socialism, for I arrived at them via unforgettable experiences under capitalism."

– **Ingeborg Rapoport** (1912–2017), professor of pediatrics who emigrated from Nazi Germany to the US in 1938 before resettling in the DDR in 1952 where she held the first chair in the academic field of neonatology in Europe.

Modern German history provides an ideal case study to investigate the contrasts between capitalist and socialist approaches to health care. For more than four decades, the country was divided into two states after WW2: the western two-thirds became the Federal Republic of Germany (FRG, or "West Germany) in May 1949 and the eastern third became the German Democratic Republic (DDR, or "East Germany") in October of the same year. In alliance with the German elites, the Western powers oversaw the restoration of capitalism in the FRG. This included the re-imposition of a health care system oriented around profit and private economic interests. In the East, on the other hand, the anti-fascist political parties working with the Soviet Military Administration sought to definitively break with the past. This entailed not only the removal of Nazi war criminals from public life and the elimination of the socio-economic roots of German fascism, but also a determined effort to construct a fundamentally new health care system freed from the profit motive.[27]

27 The socio-economic roots of fascism were identified as monopoly capital and the concentrated power of the Junker (the landed nobility). In their ambition to expand Germany's sphere of influence, these two social forces fuelled the rise of Hitler and militarism in the 1930s. As such,

A new beginning from amongst the ruins

The anti-fascists that were entrusted with the reconstruction of Eastern Germany after the Second World War emerged from concentration camps or returned from exile to find a dire health situation in the Soviet Occupation Zone (SOZ). The fascist "total war" had left the country's health infrastructure in ruins: hospitals and sanatoriums were destroyed, the supply of medicines had collapsed, and epidemics spread uncontrollably. Deaths from tuberculosis in this period were twice as high as they had been prior to the war. Typhus, cholera, dysentery, venereal infections, and childhood diseases ravaged the population. The number of doctors were half the pre-war levels, and the training of new physicians was interrupted by the closure of universities.

From the defeat of the Nazi regime in 1945 to the founding of the DDR in 1949, the health policies of the SOZ were shaped by orders issued by the Soviet Military Administration, which governed the SOZ together with the legalized anti-fascist political parties.[28] An immediate issue confronting the authorities was how to deal with those health professionals who had supported the fascist system. Roughly 45 percent of physicians had been Nazi Party members, many of them involved in euthanasia and the other atrocities. A significant number of these individuals fled the SOZ, knowing that they would be treated more leniently in the West. The doctors who

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the Allied powers stipulated in the Potsdam Agreement of August 1945 that Germany was not only to be denazified and democratized, but also decentralized so that "the existing excessive concentration of economic power, embodied especially in the form of cartels, syndicates, trusts and other monopoly associations," could be eliminated. While concrete action was taken in the Soviet Occupation Zone (nationalizations of monopolies and a comprehensive land reform), the old economic structures were left largely untouched in the Western occupied zones. The USA and Britain entered into an alliance with German capital to create a separatist West German state that would act as a bulwark against socialism in Europe.

28 Initially, these parties included the Communist Party of Germany (KPD), the Social Democratic Party of Germany (SPD), the Christian Democratic Union (CDU), and the Liberal Democratic Party of Germany (LDPD). They were joined in 1948 by the Democratic Farmers' Party (DBD) and the National Democratic Party (NDPD).

stayed posed a politically and morally difficult dilemma: enacting a blanket dismissal of health professionals – as had been carried out amongst judges and teachers – was out of the question, if only because of the health crisis facing the country. As a result, doctors who had not been found guilty of any crimes were allowed to continue their work, and many of them later committed themselves to the new health system.

Many of the doctors and health workers assigned to administrative positions in the SOZ's general administration had been active in the resistance or imprisoned under the Nazi regime. Their immediate tasks were dictated by the decisions of the Allied powers in the Potsdam Agreement of 1945 and the newly legalised political parties. The Socialist Unity Party of Germany (SED) – formed in 1946 through a merger of the two working class parties, the Communist Party of Germany (KPD) and the Social Democratic Party of Germany (SPD) – set out to establish a functioning health care system. This required nationalising health care institutions and guaranteeing the right to health care. Free medical treatment was provided through a universal health care system, and the protection of health was understood as a task for all sectors of society.

When drafting social and health policy programmes for a new, democratic Germany, SOZ authorities drew on the progressive traditions from the German Empire (1871–1918) and the Weimar era (1918–33). Revolutionary social democracy had, for example, successfully fought for the introduction of social health insurance in 1883, which became the first of its kind in the world. The workers' movement had also set up self-run health care organisations to compensate for the gaps in the state's insurance system. Initiatives like the Proletarische Gesundheitsdienst (Proletarian Health Service) took up the tradition of social medicine, which was developed by the German physician Rudolf Virchow (1821–1902) to investigate the interaction between people's health and their social conditions. It was recognized that factors such as working conditions, housing, nutrition, education, social relationships, etc.

form the basis upon which our physical and mental health develop; if these social determinants of health can be investigated and addressed, many diseases can be prevented rather than relying solely on treatment after they manifest. Social medicine thus became a guiding principle of health policy in East Germany, and, in this regard, the Soviet "Semashko model" also influenced German policymakers. As the People's Commissar of Public Health in the USSR from 1918 to 1930, Nikolai Semashko had created a centrally managed, multilevel system of single-payer health care oriented around social medicine and prevention. While the DDR adopted some aspects from Semashko's model – such as its unitary structure – it was not simply replicated in East Germany and differed, for example, in the degree of central organisation and state funding.[29]

The DDR's comprehensive approach to health care

Health officials in East Germany recognised that it would be necessary to separate people's medical needs from private economic interests. In the capitalist health system, for example, outpatient care[30] is often provided by self-employed doctors in individual private practices that are scattered throughout cities and towns. Medical experts had long pointed out that the entrepreneurship associated with this model objectively ran counter to the progressive development of medicine: freelance doctors are economically dependent on sick patients seeking out prescriptions and treatment. That is, they are financially incentivised not to prevent disease but to treat symptoms after they manifest. This was by no means a novel or specifically socialist observation; it had already been put

29 While the Soviet health care system was funded directly from the national budget, individuals in the DDR paid up to 10 percent of their monthly wages toward a social security system that covered health, accident, and pension insurance. Contributions were, however, capped at 60 Marks per month for workers. Enterprises then matched the contributions of their employees, and additional state subsidies covered any shortfalls.

30 Outpatient care (sometimes referred ambulatory care) relates to the care of patients outside the hospital system and without an overnight stay in a health facility.

forth by the League of Nations, a forerunner of the United Nations founded after the First World War. Yet it was socialist states like the DDR that set out to transcend this outdated model of care.

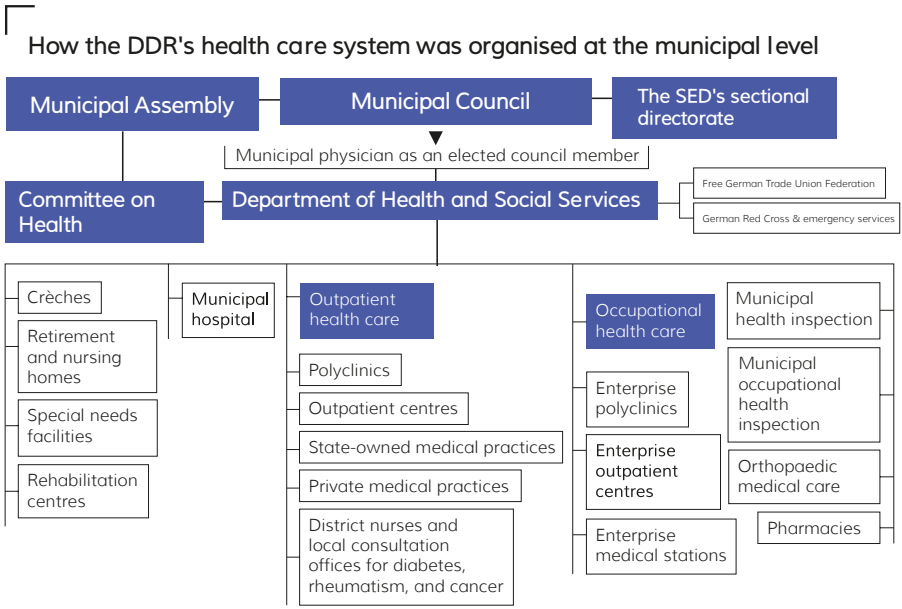

Figure 1: The unitary, centrally led structure of the DDR's system meant that all health facilities cooperated with one another to provide comprehensive care to patients' throughout their lives.

By nationalizing health care institutions and tying them into a unitary system, the DDR was able to overcome the separation found in many capitalist countries between publicly funded health services and the large, privately organised sector of outpatient and hospital care. The gradual elimination of private forms of ownership facilitated the integration of preventive, therapeutic, and aftercare measures so that patients could receive more holistic care. The country's numerous and diverse medical institutions – from hospitals and clinics to pharmacies and research centres – could

now cooperate with one another as part of a consolidated network led by the Ministry of Health. This offered a significant advantage over the fragmented model of health care in which there is little to no contact between general practitioners, specialists, aftercare professionals, and the pharmacists providing medication.

Socialist property relations in other sectors of society also played a crucial role in facilitating a preventive approach to health care. The social determinants of health – working conditions, housing, nutrition, education, etc. – could now be directly managed by the state and other societal structures such as the trade unions and mass organisations.[31] This was particularly important in the post-war situation. A number of factors – such as the necessity to construct a heavy industrial base from scratch, the burden of sanctions and reparation payments, and internal investment deficits – meant that workers and residents of the DDR were exposed to significant health risks at times, particularly in the early years.[32] In this context, socialist property relations facilitated a socio-political approach to health care: everyday risks in the workplace, neighbourhood, and school could be investigated and tackled by the various levels of society in a coordinated manner. Health protection came to be seen as a social, not just an individual responsibility.

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31 For example, the Free German Trade Union Federation (FDGB) stringently supervised occupational health and safety in the DDR. Alongside specialist occupational health inspectorates, the unions monitored the enforcement of health provisions and reported on their effects to ensure that enterprise management was minimizing threats to workers' health. This was enshrined in the Labour Code.

32 For more background: Prior to 1945, Germany's heavy industrial base was located in the Ruhrgebiet in Western Germany. Eastern Germany was traditionally home to light industries (e.g., chemicals and synthetics). The reparations due to the USSR were originally agreed to by the Allied powers in the Potsdam Agreement (1945), but less than a year after the Agreement was signed the Western powers stopped paying the share due from their occupation zones. This meant that Eastern Germany was footing the reparation bill alone, originally in the form of entire industrial plants that were dismantled and transported to the Soviet Union. Later, reparations were paid in the form of goods. In addition, after being cut off from coal deposits in the West, the DDR was forced to rely on lignite (brown coal), which was its only native fuel source but a horrible air pollutant. Finally, internal investments deficits that arose in the wake of consumer-oriented policies in the 1970s led to outdated machinery in some enterprises and suboptimal structural conditions in many health care facilities.

Outpatient care proved decisive in this regard because it is aimed at caring for patients in their own residential area or social environment more generally. It ensures that people receive the medical help directly where they live and work, ranging from preventive measures and therapy to aftercare and rehabilitation. An effective outpatient system guides people throughout the course of their lives, providing fast and direct care, avoiding hospitalization, and, in the best case, preventing illness in the first place. The restructuring and reorganization of the outpatient sector in East Germany arguably represents the most revolutionary aspect of the DDR's health system.

The polyclinic: a modern approach to outpatient care

It was understood in the DDR that modern, democratically organized outpatient care would have to overcome the restrictions to which self-employed physicians are subject in their private practices. If doctors could be publicly employed and guaranteed a reasonable income, they would be able to make medical decisions independently of economic considerations. At the same time, advances in medical science require access to laboratories and new technology. In the private system, individual practices are often unable to house the diverse equipment and staff demanded by modern medicine, so patients are referred to separate specialists or diagnostic centres, often creating inefficiencies or even discrepancies in diagnoses.

The polyclinic was developed as an alternative to the outdated private practice model. As the name implies, polyclinics were facilities in which multiple medical specialties collaborated under one roof to prevent and treat a wide variety of diseases. More specifically, polyclinics were defined as publicly owned outpatient facilities containing at least the following six specialist departments: internal medicine, oral medicine, gynaecology, surgery, paediatrics, and general medicine. Many polyclinics also housed clinical diag-

nostic laboratories, physiotherapy departments, and medical imaging facilities. The clustering of medical departments, technology, and laboratories under one roof helped to overcome bureaucratic and financial obstacles that plagued private practices and helped to facilitated more effective collaboration between individual specialties.

Under capitalist health care systems, self-employed outpatient physicians have generally been (and often still are) solely responsible for medical decisions. The collaborative structures in polyclinics made it easier for specialists across different disciplines to discuss complicated cases or, for instance, the prescription of new medications and recommendations for new types of therapy. This interdisciplinary collaboration also provided a framework in which the relationship and communication between preventive, therapeutic, and aftercare measures could be strengthened and brought closer together. Laboratory and medical imaging services could be requested immediately and were usually available within a short time or even during the consultation itself. Polyclinics were also able to house superior medical equipment, mainly because common usage was more cost-effective than individual use in private practices. A uniform filing system for patient records was likewise maintained to reduce inefficiency and miscommunication between specialists.

On average, polyclinics staffed 18 to 19 physicians, which allowed them to extend hours of operation and continue to provide care even when individual doctors were sick or on holiday, unlike in private practices. In addition, this allowed physicians to provide more extensive care to their patients, as they could couple their normal consultation hours with on-site visits. Paediatricians, for instance, were able to conduct regular check-ups in childcare centres while other doctors took charge of walk-in consultations in polyclinics.

The physicians and staff working in polyclinics were publicly employed and thus freed from their traditional economic depen-

dencies on the sick. This approach differs from the UK's National Health Service (NHS), where general practitioners remain self-employed and provide services to the NHS on contract as well as non-NHS services. In the DDR, all financial motives had been removed from both the doctor-patient relationship and the medical decision-making process. With a secured position and income, doctors could focus first and foremost on preventive care. This new model of employment also greatly improved the collegial atmosphere in the outpatient sector. Staff were guaranteed fixed working hours, in-house health care, communally organised meals, and joint holiday facilities for themselves and their families. Importantly, physicians, assistants, and nurses were now all employed as staff members; they were treated equally in accordance with labour laws and were organised within the same trade union. These measures gradually helped to erode professional hierarchies.

"Does not [...] the real freedom of the physician consist in the fact that they are given the means to secure the health of each individual citizen without limitation? By building up the state health system, physicians are no longer economically interested in people falling ill; they can instead genuinely act as the guardians and preservers of health".

– Speech at the National Health Conference in Weimar, 1960

In a similar vein, the DDR introduced comprehensive reforms in the educational system to break down traditional barriers in the medical field. This included, for example, providing tuition-free education and fixed stipends to cover students' living costs so that those from working-class and peasant background had the chance to enter the medical profession. Childcare and distance education programmes also helped open medicine up to women, who, from the late 1970s onwards, often made up more than 50 percent of medical students in the country. Intensive academic training programmes helped to turn nursing and caretaking into highly qualified and respected professions. The old relations between physicians and nurses gradually gave way to new socialist relations.

Such a drastic transformation of the outpatient sector did not unfold without challenges. There was, for instance, considerable scepticism and even resistance to the idea of polyclinics among physicians in the early years. The radical idea of publicly employing medical specialists to work together under one roof sharply contrasted with the deeply rooted self-perception of the 'freelance' doctor who works for him or herself. Conservative physicians' associations had already begun systematically opposing calls to establish polyclinics during the Weimar era, and they resumed this offensive after the end of the Second World War in 1945. With the inner German border open until 1961, disgruntled doctors could simply migrate westward to retain their privileges in the medical field and society. What is more, as a way of bleeding DDR dry, West Germany actively poached doctors that had been trained tuition-free in East Germany. This dynamic impacted the DDR from the outset: the exodus of physicians following the war was so massive that it would have required at least five additional graduating classes of all DDR medical schools to compensate for the loss.

Health officials in East Germany thus faced the same difficulty that confronted the Bolsheviks after the October Revolution: how could the specialised professionals and intelligentsia, who had been privileged under capitalism, be won over to the construction of socialism? Given the high levels of emigration, the SED decided to both illustrate the benefits of the new model (by, for instance, expanding the technical capabilities and laboratories in polyclinics and offering freelance doctors the chance to hold additional consultation hours in state-run institutions) and make concessions to the medical intelligentsia. These compromises included the assurance that no freelance doctor or dentist would have to give up their practice in favor of the polyclinic and their children could inherit their practice if they became a doctor or dentist. The transition from private to public outpatient care was thus a gradual process; for many years, self-employed doctors continued to provide a large portion of outpatient care (see Figure 2). Yet it ultimately proved possible to win over medical professionals to the

concept of the polyclinic: by 1970, only 18 per cent of outpatient physicians were in private practice, compared to well over 50 per cent in 1955. Particularly the younger medical students from working-class or peasant backgrounds appreciated the benefits of fixed employment and socialist health care in general.

Public versus private employment of doctors in the DDR's outpatient sector

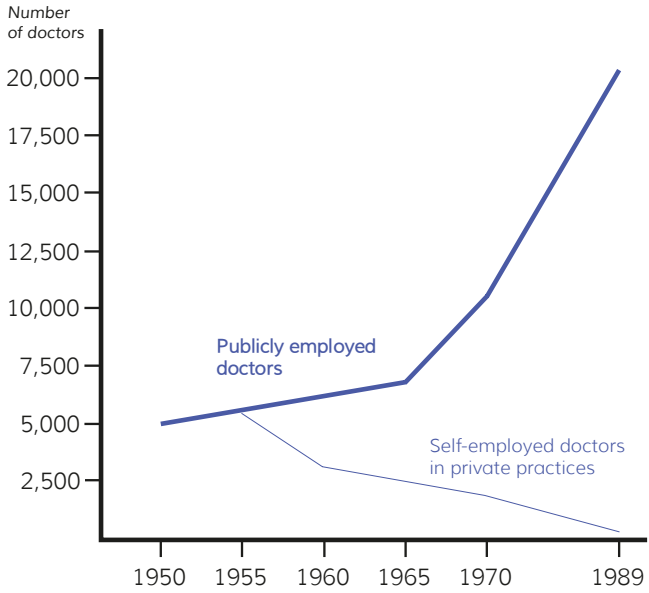

Figure 2

The acute shortage of doctors was also gradually overcome. By 1989, the DDR was on par with other leading industrialized states in terms of the physician-to-patient ratio (see Figure 3). The contrast between outpatient health care in East and West Germany gradually widened over the four decades following the founding of the DDR: by 1989, the vast majority of West German outpatient doctors were still operating in private practices, while almost all of their East German counterparts were publicly employed by that time.

Physicians per 10,000 residents

	DDR	FRG	France	Sweden	UK	US
1950	7.2	12.5	-	-	-	-
1960	8.7	14.2	-	10.0	8.0	11.0
1970	16.0	16.3	12.0	13.0	9.0	13.0
1989	24.0	30.0	30.0	28.0	16.2*	18.0

* for the year of 1990

Figure 3

Coverage of areas outside urban centres was also given special attention in East Germany. Smaller institutions embodying the same principles as the polyclinic were called Ambulatorien and typically housed at least three different departments: general medicine, internal medicine, and paediatrics. In even more remote locations, individual public practices and field offices were set up and organisationally linked to polyclinics for operational support. The DDR also developed several mobile outpatient services such as dental clinics that visited villages to provide children with preventive care and community nurses, who travelled between towns performing important medical services during house visits. While the profession of the community nurse was developed in the early 1950s to alleviate the initial shortage of doctors in the countryside, their efficacy proved so great that number of nurses was increased from 3,571 in 1953 to 5,585 by 1989. By linking these various outpatient services and facilities together and by establishing affiliations with hospitals and universities, the DDR sought to foster comprehensive medical collaboration between all outpatient professionals. This was the advantage of a unitary, centrally led system.

After 1990, the FRG's private practice model was rigorously reimposed on East Germany, undoing the DDR's achievements in the outpatient sector. Innovative professions such as the community nurse were abandoned. The polyclinic system was liquidated. This represented, as social health specialist Dr. Heinrich Niemann argued before the Health Committee of the German Parliament in 1991, "the greatest blunder in health policy" after unification – an assessment corroborated by the precarious state of the health system in Germany today. While the FRG made it possible in the late 1990s for outpatient doctors to work as employees rather than freelancers, these clinics are almost exclusively under private ownership and lack a unified structure. Their commercial orientation marks a significant regression from the integrated and publicly funded outpatient facilities of the DDR.

Protecting health in the workplace

In East Germany, workers' health was given great importance from the very beginning. In 1947, during the period in which Germany was still occupied by the four Allied powers, the Soviet Military Administration issued Order No. 234, which stipulated that workplaces with more than 200 employees were to set up medical stations, while those with more than 5,000 employees were to establish enterprise polyclinics. Within three years, 36 enterprise polyclinics had been set up, and by 1989, they numbered more than 150.

The enterprises themselves were responsible for maintaining the rooms, furnishings, and operating costs of these health facilities while the state health system provided and oversaw the medical staff and equipment. This point represents a decisive contrast to the occupational health care that is offered in some private companies today: in the DDR, the medical professionals overseeing occupational health and safety were employed by the public health system, not the enterprise within which they worked. As such, it was the interests of the workers, not the employers, that guided their medical decisions.

In the DDR's first constitution in 1949, legal protections for workers' health were laid out alongside the extensive social insurance system. In the subsequent constitutions in 1968 and 1974, these protections were expanded, and their implementation was overseen by the workers themselves: the Free German Trade Union Federation, present in all enterprises and institutions of the DDR, was tasked with monitoring the enforcement of legal provisions and reporting on their effects.

By law, the workplace represented much more than merely a source of income. Enterprises provided the framework in which employees could pursue cultural and intellectual interests alongside recreational activities. Workers' brigades were encouraged to attend cultural and sporting events, discuss political developments, and visit holiday camps maintained by the enterprises. The DDR's Labour Code of 1977, for instance, contained clauses to protect and promote both the physical and mental health of employees. This legislation further demonstrates that the interests of working people determined the direction of the economy.

EXCERPTS FROM THE DDR'S LABOUR CODE OF 1977:

§2 (4) Labour law is aimed at improving, in a planned manner, the working and living conditions of employees in the enterprises: specifically, to expand health protection; to enhance labour power; to improve social, health, intellectual and cultural programmes; and to increase the workers' opportunities for meaningful leisure time and recreation. It guarantees working people material security in the case of illness, disability, and old age.

§ 17 (1) Enterprises as defined by this law are all state-owned establishments and combines as well as socialist cooperatives.

§74 (3) The enterprise shall systematically reduce hazardous working conditions and limit the amount of physically difficult and monotonous work.

§201 (1) It shall be the duty of the enterprise to ensure the protection of the health and labour power of working people primarily by organising

and maintaining safe working conditions that are free from hardship and conducive to health and efficiency.

§207 Workers who are to undertake work which is physically demanding or hazardous to health shall be medically examined free of charge before employment and at regular intervals in accordance with legislation.

§293 (1) The supervision of occupational health in enterprises shall be conducted by the Free German Trade Union Federation (FDGB) through health and safety inspections.

As with the outpatient sector, the system of occupational health was gradually expanded. By 1989, it covered 7.5 million workers from 21,550 enterprises, or 87.4 per cent of all working people in the DDR. Institutions specifically dedicated to this field – such as polyclinics, outpatient centres, and medical stations operating within enterprises – employed some 19,000 health care professionals. Occupational medicine was also established as a major field of study, with approximately one out of seven outpatient doctors specialising in this field. The Central Institute for Occupational Medicine employed physicians and scientists to research work-related illnesses and develop preventive measures, and the importance that this sector carried in the DDR is evidenced by the fact that West Germany had only half as many occupational health specialists, despite the West German labour force being three times larger than its equivalent in the East.

In certain professions, workers were exposed to hazardous substances and/or particularly arduous physical conditions. Health officials campaigned to reduce the number of such jobs, and enterprises were obliged to report on the measures they were taking to combat harmful conditions. Yet, in certain sectors of the East German economy, such as heavy industry, production processes posed unavoidable threats to workers' health. By 1989, roughly 1.69 million workers remained exposed to harmful pollutants and stresses such as excessive heat, noise, or vibrations. To minimize

the injuries that often resulted from such jobs, the DDR provided targeted care to exposed workers. Of the 7.5 million workers monitored under the occupational health system in 1989, roughly 3.34 million received care that was tailored to the specific conditions in which they worked. For example, regular hearing tests were conducted for those working in construction, while regular lung examinations were conducted for those employed in chemical plants. Alongside these measures, specialist occupational health inspectorates monitored enterprises' compliance with safety standards and specified limits for harmful substances or work stresses.

The field of occupational health was particularly important in the context of West Germany's trade embargo, which caused the DDR to rely heavily on the only energy source readily available in East Germany: brown coal, a lignite-based substance that emits considerable pollution when burned. This economic necessity, alongside shortfalls in technical modernisation in some enterprises, led to special exemptions being permitted regarding harmful exposures in some workplaces. Occupational health and safety became a contentious field as officials debated which priorities should be set. Ludwig Mecklinger, the DDR's minister of health from 1971 to 1989, recognised this dilemma, stating that health policies were inevitably restricted by economic necessities and external factors.

Today, the weakening of trade union power and the rise of precarious employment has led to a deterioration in working conditions in most capitalist states. While there have been advances in the production processes themselves, new health burdens are constantly emerging, particularly in connection with digital workplaces, along with agriculture and food industries. As such, the importance of occupational health has only increased, and the experiences of the DDR in this field remain relevant not only from a medical point of view, but also by demonstrating that a fundamentally different approach to health protection in the workplace is possible.

Health Care for Mothers and Children

In East Germany, women enjoyed access to first-rate health care, comprehensive childcare, and guaranteed employment. These social achievements meant that by 1989, the employment rate among women had reached 92 per cent. At the same time, from the 1970s, East Germany also had a higher birth rate than the West largely due the continuous expansion of the country's social and health infrastructure, which enabled women to both pursue employment and raise a healthy family.

The development of this infrastructure was established in the DDR's legislation, which proved to be consistently more progressive than in the FRG, where patriarchal laws reflected bourgeois familial concepts such as the stay-at-home mother. The DDR's 1950 Law on Mother and Child Protection and the Rights of Women, for instance, prescribed an extensive expansion of day care and health care facilities for children, explicitly supporting single and working mothers. While in 1956 only 10 per cent of children attended childcare facilities, by 1990 nearly 80 per cent of eligible children attended a crèche (from the age of 0 to 3) and 94 per cent attended kindergartens (from ages of 3 to 6). At the time, these were some of the highest rates of childcare coverage in the world.

Women's committees within trade unions were instrumental in introducing and overseeing new laws to address the need to balance family and work responsibilities. One result, for example, was the establishment of enterprise kindergartens directly connected to the workplace. Through the socialisation of childcare responsibilities, mothers were able to work while also raising children and thus develop economic independence from their partners. This was reflected in East Germany's divorce rate, which remained significantly higher than in the FRG throughout the DDR's 40-year existence. This trend was dramatically reversed after 1990, when women's employment levels fell sharply in the former DDR.

Childcare facilities also played a central role in the health policies of the DDR. These institutions were actively monitored by the Ministry of Health and, in the case of crèches, even placed directly under its responsibility rather than that of the Ministry of Education. This made it possible to create integrated social and health standards to further children's wellbeing, such as regular paediatric visits to crèches to carry out vaccinations and periodic medical check-ups conducted directly in kindergartens and schools, making health care an integral part of children's everyday lives. In this way, maintaining good health and detecting potential health issues became a social responsibility that was no longer left to parents alone.

In addition to providing free childcare to all families, the DDR strove to break down cultural taboos and promote the health of women and children, regardless of their circumstances. The 1965 Family Code, for instance, eliminated the discriminatory legal category of 'children born out of wedlock' while emphasising the role of both parents in raising a child. The 1972 Law on the Termination of Pregnancy also contributed to women's self-determination and family planning by introducing free and legal access to contraceptives and abortions within the first 12 weeks of pregnancy. In contrast, the constitution of the Federal Republic of Germany contains a clause criminalising abortion to this day, and, since 1976, women have been required to attend a compulsory counselling session in order to receive an exemption.

Pregnant women in the DDR were guaranteed comprehensive pre- and post-natal consultations to aid and monitor mothers and their children. By 1989, there were more than 850 pregnancy consultation centres throughout the country to guide expectant mothers in medical and social questions. After birth, some 9,700 maternity consultation centres regularly examined infants and assisted the parents in their new roles. Periodic medical examinations then accompanied children all the way to adulthood. Importantly, dental care was also integrated into preventive screenings in kindergartens and schools, again in contrast to most health systems today

in which dental health is not publicly guaranteed and is instead left to the financial resources and discretion of parents. Taken together, these structures and policies helped to ensure that family planning and childhood development could unfold independently of economic considerations.

Vaccination strategies

As in many other socialist states, the DDR was able to achieve particularly high vaccination rates during its four decades of existence. A clear example of this was the campaign against the polio virus. In 1961, while West Germany was still registering over 4,600 cases of polio, East Germany had reduced its number of cases to less than five. The DDR made use of an oral vaccine produced in the Soviet Union and subsequently offered 3 million doses to the FRG, but the latter declined. While East Germany recorded its last polio case in 1962, cases continued to be recorded in West Germany until the end of the 1980s.

The differences in the speed and effectiveness with which the two German states tackled polio stem from two fundamentally different approaches to immunisation. In the DDR, as in most other socialist states and some Western countries, childhood vaccinations had been mandatory since the early 1950s, and all children received a series of standard vaccinations set by the Ministry of Health. These vaccines were administered to children directly in crèches and schools, while adults were vaccinated in the workplace. Individuals who did not want to be vaccinated or have their children vaccinated (which primarily occurred for religious reasons) could obtain an exemption after consultations with a physician and regional health officials. Vaccinations and health care more broadly were thus treated as a social task in the DDR, and a wide range of societal actors, whether doctors, teachers, or parents, ensured that all children received preventive medicine and care.

In the FRG, in contrast, vaccinations were recommended but not mandatory, and it was the responsibility of the families to arrange appointments with their paediatricians for vaccinations. The Standing Committee on Vaccination (STIKO), an honorary commission of medical experts, made vaccination recommendations which doctors were then asked and paid to administer, but public vaccination programmes were not implemented in schools or at the workplace. Hence, for doctors in the FRG, the incentive to vaccinate is primarily financial rather than medical.

Mandatory vaccinations in the DDR were ultimately met by a public that was highly willing to be vaccinated. The use of coercion to increase vaccination rates – a hotly debated issue today – was thus not an issue in East Germany. Similar circumstances are evident in Cuba today, where the COVID-19 vaccination rate (roughly 90 per cent of the population) is one of the highest in the world, and yet no coercive measures have been employed.

Mandatory vaccination was understood in socialist East Germany not as a one-sided legal obligation for the citizen, but as the duty of the state and its medical institutions. Monitoring and achieving vaccination coverage to the greatest extent possible was a central priority for health care professionals, especially for physicians and authorities at the municipal level. Alongside the immunisation services that were integrated into workplaces, kindergartens, crèches, and schools, permanent vaccination centres were established where citizens could obtain information and schedule appointments for additional voluntary vaccinations, such as against influenza viruses. To this day, the willingness to be vaccinated against influenza remains significantly higher in East Germany than in the West.

Despite temporary difficulties in the production or import of vaccines, the DDR guaranteed universal child immunisation up to its dissolution in 1990. Furthermore, the number of diphtheria cases was drastically reduced, the fight against measles was advanced through booster jabs despite temporary setbacks, and the intro-

duction of a vaccination against tuberculosis for all new-borns helped to significantly reduce the number of cases (see Figure 4). The FRG, which had always been in a stronger financial position than the DDR, was also able to eradicate many childhood diseases, but its campaigns often progressed far more slowly than in East Germany, as is evident with the poliovirus.

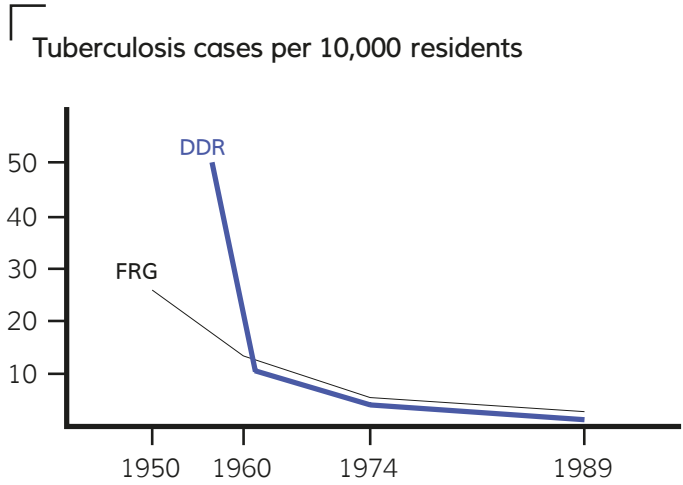

Figure 4

The dismantling of the DDR's health care system after 1990 was accompanied by a decline in the willingness to be vaccinated and a rising prevalence of diseases that had previously been in decline. With the transition to a health care system oriented around the private sector, immunisation has once again become an individual responsibility left to the discretion of patients and their general practitioners rather than centrally organised state institutions. Though various factors contribute to the emergence of epidemics, the reappearance of tuberculosis and measles cases in the East of unified Germany after 1990 is tragic proof of the efficacy of the DDR's vaccination strategy.

Medical solidarity for national liberation struggles

Western countries have a long tradition of poaching medical personnel from less-developed states in order to compensate for their own shortages. For decades, the vast majority of the world's migrating doctors have settled in just a handful of Western states. Countries like Germany are very open about their intention to spur on a "brain drain" from the Global South, ignoring all protest from organisations in countries such as Ghana or Kenya. The socialist states, on the other hand, set out to reverse this brain drain by organising extensive education programmes for young students from the former colonies. Medical schools were established throughout the socialist bloc with the explicit aim of teaching international students the skills required to construct health systems back home. In the DDR, the Dorothea Christiane Erxleben Medical School was set up for this purpose and drew roughly 2,000 students from more than 60 states and national liberation movements during its 30-year existence. Thousands of other doctors received specialist training in the DDR's other medical institutions.

The spectrum of the DDR's medical internationalism also included supplying medicines and equipment, deploying doctors and nurses overseas, treating wounded national liberation militants in the DDR, and building and operating hospitals in the former colonies. There were contractual agreements with over 40 countries and liberation movements, such as the South West African People's Organisation (SWAPO) and the African National Congress (ANC). The DDR's solidarity was characterised by both immediate aid and a commitment to supporting the long-term development of self-sustaining medical services in the emerging nation states.

For more: "Reconstruction, sovereignty, and education: An East German medical school dedicated to internationalism", published by the Internationale Forschungsstelle DDR, available under ifddr.org

The DDR's health care system in retrospect

With the incorporation of East Germany into the FRG in 1990, the DDR's 40-year endeavour to construct a fundamentally different health care system was brought to an end. The medical infrastructure and staff of the former DDR were engulfed by the West German system, which had itself been caught up in a wave of neoliberal commercialisation since the mid-1980s. The profit motive came to dominate the medical profession once again.

"By 1993, physicians had begun to set up their private practices. After my chief doctor had attended a class on self-employment, she said to us, 'I learned today that there are three principles of self-employment in the new system. First, we must always be kind to the patients so that they like to come to us. Second, we must discover what we can earn from the patient. How much revenue will they generate for us? And the third principle: We cannot allow them to get healthy.' That was my experience of the system change after 1990, and it has been my overall feeling in the health sector ever since."

– Irene, a former nurse employed in one of the DDR's polyclinics

The commercialisation of health care in East Germany after 1990 made the contrast between capitalist and socialist health care all the clearer. While the market turns diseases into commodities and patients into customers, socialist medicine seeks to prevent the disease and illness to begin with, making human well-being its guiding principle. In the DDR, political emphasis was placed on social medicine – that is, the systematic recognition and combating of the socio-economic determinants of health and illness rather than an approach that merely focuses on how these manifest at the individual level. While both social and individual medicine provide crucial perspectives for preventing and treating illness, policies aimed at improving the population's health will inevitably be restricted if the general social context and root causes of disease are disregarded.

The outpatient sector was pivotal in this regard. Health facilities and professionals were integrated into all areas of DDR society, from workplaces and schools to urban neighbourhoods and rural villages. The country's various medical institutions were connected through a unitary network that promoted cooperation rather than competition. This extensive infrastructure functioned as an early warning system that could identify and counteract harmful developments wherever and whenever they emerged. The field of occupational health care was particularly important in this respect since it allowed the links between work and illness to be scrutinised and addressed. As stipulated in the DDR's labour code, the workers themselves were able to supervise health protection in the workplace through the Free German Trade Union Federation.

What stands out in the East German context are the achievements in health care policy despite the difficulties facing DDR society. Situated on the frontlines of the Cold War, the country was heavily sanctioned and struggled to import modern technology and equipment. At the same time, working conditions were strained by the necessities of reindustrialisation after 1945, which entailed arduous labour and exposure to harmful substances. In the health care sector itself, there were several major issues. The DDR's early years were marked by a labour shortage, as medical professionals were lured westward. In the 1970s, the government also began prioritizing the production of consumer goods at the expense of investment into the industrial sector, which created certain imbalances in the planned economy that were felt in the health sector, too. This was apparent, for instance, in the wear and tear on hospitals and the scarcity of certain medical supplies and equipment, which made health workers' day to day tasks more difficult.

Yet, despite these challenges and its much weaker starting position, the socialist DDR was able to make use of its limited resources to progressively improve the social situation and health of the population. The well-being of its 16 million inhabitants was reflected by favourable, even leading values according to World Health Organi-

sation measures such as the physician-to-population ratio, infant mortality, and the reduction of tuberculosis. Over the course of four decades, the DDR was also able to revolutionise the medical profession and break down traditional hierarchies. The field of medicine was opened up to the working class, peasantry, and women, while the transition from private practices to polyclinics helped to erode the privileges of physicians over nurses and assistants.

These successes were made possible by two major political developments. First, health was made into a societal priority in East Germany after the Second World War. While in the Weimar era health rights had to be fought for and constantly defended by the trade unions, the DDR was a workers' and peasants' state; health, social, and cultural rights were enshrined in the country's constitution, and the enforcement of these rights was largely overseen by workers themselves. The second factor was the socialisation of property relations in East Germany, which created the framework through which health objectives could be discussed and implemented in relation to other social, economic, and political objectives. In other words, the state's organisation of industry, housing, medicine, and education meant that health policy could be linked to all areas of society, creating for the first time a practical basis for genuine – and often contentious – policy debates.

An in-depth study on the DDR's health care system entitled "Socialism is the Best Prophylaxis" can be found along with an extensive list of references online at: ifddr.org

YUGOSLAVIA:
The self-managed health care approach

Introduction

The building of the health system in socialist Yugoslavia was much more than just a question of policy—it was an expression of the belief that health is a basic human right, and that health care belongs to the people, not private interests. Unlike in many Western states after the Second World War, where reforms may have aimed to expand access to health care services yet relied on models prioritizing technological progress and the dominance of health experts, particularly physicians, the Yugoslav model attempted to transfer health governance into the hands of (health) workers and communities.

The vision of health that underpinned Yugoslavia's health care system closely aligned with the Alma-Ata Declaration of 1978, whose influence can still be seen in the guiding documents and practices of grassroots networks like the People's Health Movement (PHM). Key elements that defined Yugoslavia's health system included the recognition of social determinants of health, particularly among the working class, a strong foundation in community work and initiatives, and universal access to health care.

It was a system built on participation and solidarity through the work of "self-managed interest communities"[33] (samoupravne

33 The model of self-management was central in socialist Yugoslavia. It was not limited to health care but extended across various sectors, in an attempt to introduce mechanisms through which workers could collectively plan and fund activities or services. SIZs were meant to decentralize governance and embed decision-making within the self-management framework, aligning the operations of socially owned enterprises and community needs. All this was part of a broader institutional architecture following the 1974 Constitution, which expanded decentralization

interesne zajednice, SIZ), which, in the context of health care, oversaw the coordination and financing of care at municipal levels. This model was integrated in the 1974 Constitution[34] and upheld in a 1980 Health Care Act.[35] It also recognized the potential of workers, patients, and health providers in becoming co-managers of the system, leading to a weakening of market-driven models in health care and a better understanding of what the health system should encompass. Under the framework of self-management (samoupravljanje), health workers and patients were invited to deliberate on health priorities, funding allocations, and strategies—decades before the concept of decentralization in health became fashionable in the West.

While the development of self-management models in health care sometimes fell behind the trends in industry, by the late 1970s the Yugoslav health system counted hundreds of self-managed units.[36]

The roots of self-managed health care

Some of the key principles that lay at the base of the Yugoslav health care model were:

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and enshrined the self-management principle at different levels of governance – a peculiarity of Yugoslavia's vision of socialism in comparison to other socialist countries of the time. However, by the 1980s, the SIZs became symptomatic of a fragmented and increasingly contradictory system, struggling under the weight of economic crisis, and disappeared during the early stages of transition into capitalism.

34 Krešimir Zovak, Niz nezgodnih pitanja: završna faza radničkog samoupravljanja u Jugoslaviji [A Series of Uncomfortable Questions: The Final Phase of Workers' Self-Management in Yugoslavia] (Zagreb: Baza za radničku inicijativu i demokratizaciju, 2023). See also: Gal Kirn, "A Few Notes on the History of Social Ownership in the Spheres of Culture and Film in Socialist Yugoslavia from the 1960s to the 1970s," Etnološka tribina 44, no. 37 (2014): 109–123.

35 Nikolina Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas — (dis)kontinuiteti u decentralizacijskim praksama" ["Health care in Croatia from Self-Management to the Present — (Dis)Continuities in Decentralisation Practices"], in Upravljati zajedno: Prilozi istraživanju (dis)kontinuiteta samoupravljanja [Managing Together: Contributions to Research on the (Dis) Continuity of Self-Management] (Sarajevo/Zagreb/Beograd: Crvena, Institut za političku ekologiju, Zajedničko, 2023), 62–81.

36 Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas" in Upravljati zajedno.

1. Solidarity

This principle was implemented in all aspects of health care, from financing to the administration of health services. Unlike centralized health insurance models where workers were simply contributors to health care funds, self-management sought to ensure that those who financed care (the workers from whose income the funds were pooled[37]) and those who provided it were also involved in shaping policies. This principle was associated to the concept of reciprocity and rooted in the idea that those insured should not be just passive funders of health care services but also active participants in determining the type of services provided, the organization of the system, and so on.

The decentralization of health care was another mechanism that accompanied these two values, especially for making sure that solidarity was not just an abstract term but a lived practice. By shifting decision-making closer to workplaces and communities, the system sought to create a direct link between those who provided health care services and those who used them. The belief behind that was that a closer connection between different groups involved in the system would lead to more effective resource allocation. This principle was applied for other sectors beyond health care as well.[38]

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37 The financing of health care in Yugoslavia was decentralized, in line with the broader structure of the system: the bulk of funds was collected at the local and municipal levels through payroll contributions, in amounts set at the republic level or lower. While the federal level could provide material support for specific elements of health care, most autonomy and responsibility for organizing and delivering health care services lay with the republics and municipalities themselves. A significant portion of this lower-level funding was directed toward primary health care, which was a central priority of the system, as discussed later in the text.

38 Despite these intentions, until the 1990s the reality was that many communities lacked the right financial capacity to sustain health care services as envisioned by self-managing units, leading to disparities and struggling services. To mitigate this, a unified and mandatory insurance model was introduced as part of the 1980 Health Care Act, ensuring that all citizens had access to a minimum standard of care, regardless of the wealth of their municipality. Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas" in Upravljati zajedno.

2. Decentralization and participation

The SIZs operated at the municipal level, involving different workplaces and ensuring different parts of the community had a say over health planning. Professor Silvije Vuletić, a physician who worked in primary and public health care, described this as a decentralization that allowed communities to plan and manage health services independently.[39]

Crucially, this decentralization did not entail privatization or outsourcing – it was seen as a form of democratic control over public resources, rather than an opportunity to transfer responsibility to the private sector. This meant that unlike in market-based systems that invoke decentralization, the Yugoslav model envisioned democratic participation as a key element of good health governance.

3. A preventive, social medicine approach

Health was not perceived as merely the absence of disease but a collective social good. Unlike today's fragmented systems, where health care is reactive, and intervention begins only after illness manifests, the Yugoslav model valued prevention and health promotion. Inspired by the field of social medicine, infrastructure was established to address the social issues that influenced the population's health, as Vuletić explained.[40]

In this system, community health centers (sing. dom zdravlja) represented the backbone of primary health care. They were designed to resolve 80 percent of medical issues at the first point of contact. The centers carried out immunization drives, maternal and child health services, and health education,

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39 Interview with Silvije Vuletić, "Socijalna medicina kroz rad u društveno-političkoj zajednici" ["Social Medicine through Work in the Socio-Political Community"], Radnička prava, July 12, 2016, https://radnickaprava.org/tekstovi/intervjui/silvije-vuletic-socijalna-medicina-kroz-rad-u-drustveno-politickoj-zajednici.

40 Vuletić, "Socijalna medicina kroz rad u društveno-političkoj zajednici," Radnička prava, 2016.

while also collecting data to help develop public health campaigns. Diseases linked to poverty, housing, and nutrition were monitored and tackled by publicly employed nurses, midwives, and doctors in the community health centers. In this way, health care was freed from private economic interests and embedded into daily life.[41]

A health system for the people

Long before the Second World War, the necessity of a public health system was self-evident in Yugoslavia. The interwar period was marked by high rates of infectious diseases, widespread poverty, and a population with little access to medical care. Andrija Štampar, a pioneering physician in social medicine, recognized that addressing these structural determinants of health was crucial for improving the health status of the population.[42] During this time, Štampar essentially rejected the elitist, curative model of Western medicine in favor of a preventive, community-based approach. His work emphasized public health education, vaccination programs, social determinants of health, and the importance of health workers' presence in their community. These values were

41 The work of community health centers was not limited to primary health care, although this did make up the bulk of their activities. In addition to basic services necessary to provide high quality primary health care, like laboratory services, some centers incorporated specialist departments as well, such as basic cardiology, eye care, etc.

42 Under Štampar's leadership, dozens of rural health stations were established across Yugoslavia between the First and Second World Wars, which helped to provide basic medical services, hygiene education, and disease prevention programmes. These health stations were staffed by doctors, nurses, and sanitarians, who worked directly with local populations to combat endemic diseases such as malaria and tuberculosis that were widespread due to poor sanitation, lack of clean drinking water, and malnutrition. In urban areas, a similar approach based on health workers' field work was introduced to address problems in poor and working-class communities. Despite political resistance from conservative medical circles and the ruling elite, Štampar's model gained international recognition, influencing the founding principles of the World Health Organization (WHO) in 1948.

embedded in the socialist health care system that was later constructed.

In the aftermath of the Second World War, socialist Yugoslavia faced a number of public health crises, like outbreaks of malaria, tuberculosis, and trachoma. In response, the federal government first implemented a Soviet-style centralized health care model, which, according to Vuletić, was the right choice given the epidemiological challenges of the time.[43] In the years that followed, Yugoslavia had successfully tackled infectious diseases, reduced infant mortality, and expanded access to health care through newly built community health centers.[44] This health infrastructure was built not only through the non-material support of health workers and patients but also, in many cases, through their financial self-contributions (samodoprinos). These funds were pooled from workers' income, democratically allocated at the workplace or community level, and earmarked for specific projects. Many community health centers and hospitals were financed through such contributions, ensuring that health infrastructure was developed in areas where its construction might have otherwise been delayed.

In the decades that followed, however, the structure of the health system changed along with the introduction of self-management in other areas of the economy. As Vuletić and other health workers active in the era argue, this shift was, among other things, a recognition that health was not simply an administrative function, but something that should be collectively shaped by those who use and provide medical services.

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43 Vuletić, "Socijalna medicina kroz rad u društveno-političkoj zajednici ," Radnička prava, 2016.

44 Snježana Ivčić, Ana Vračar, and Lada Weygand, "Primarna zdravstvena zaštita u Hrvatskoj od samoupravljanja do tranzicije: korijeni ideja privatizacije" ["Primary Health Care in Croatia from Self-Management to Transition: Roots of Privatization Ideas"], in Socijalizam: izgradnja i razgradnja [Socialism: Construction and Deconstruction], ed. Chiara Bonfiglioli and Boris Koroman (Pula-Zagreb: Srednja Europa, 2017), 99–128.

However, while SIZs were intended to facilitate working from the bottom-up, they also introduced bureaucratic layers that, in some cases, made it difficult for local initiatives to function smoothly, as Vuletić concludes. Other recollections from this period describe how the development of self-management in social services received significantly less attention than in the industrial sector, resulting in weaker and less clearly defined mechanisms. Nevertheless, when they worked, the SIZs allowed health care planning to address real concrete needs rather than abstract directives. They introduced several novelties that expanded the role health services play in society – starting with their operational model.

THE ANATOMY OF THE "SELF-MANAGED INTEREST COMMUNITIES" (SIZ)

To advance the principle of self-management, each SIZ consisted of:

1. A **User Assembly**, responsible for shaping health care policy from the perspective of the community, including the patients. In this space, workers and patients were able to speak about their specific health care needs and advocate for the introduction or expansion of certain services. In addition to representatives from industrial workers and farmers, this body included delegates from the Confederation of Trade Unions of Yugoslavia (SSJ), war veterans' associations, the Socialist Alliance of Working People of Croatia, as well as the Red Cross.
2. A **Health Workers' Assembly**, which was a space for doctors, nurses, and other medical professionals to engage in decision-making regarding the functioning of health care services. It allowed for the assessment of staffing needs, professional standards, and so on. The introduction of health workers' assemblies meant that front-line workers were not just executing policies but actively shaping them based on their own experiences.

3. In a **Joint Assembly**, health workers and users played a key role in shaping the plans and programmes of health care services, setting standards to uphold, and evaluating the health status of the population they represented. However, industrial and health objectives were discussed in parallel, rather than interconnectedly: there was no formal mechanism to ensure the two were aligned.

Additionally, SIZs formulated long-term development plans for local health care infrastructure, ensuring that the system was responsive to the needs of the community. While Yugoslavia had a federal health secretariat, its role was primarily to provide guidance on inter-republic matters, e.g. nationwide outbreaks. Most health policies were devolved at the level of the republics and the municipal SIZs.

Based on: **Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas"; Ivčić, Vračar, and Weygand**, "Primarna zdravstvena zaštita u Hrvatskoj od samoupravljanja do tranzicije."

By the late 1970s, Yugoslavia's health system had made significant progress compared to the immediate post-war period: health coverage expanded, and the primary health care network was strengthened through investment in community health centers and their workers. Improved living conditions, combined with health education and prevention programs, reduced the burden of diseases of poverty, significantly improving quality of life.

Still, contradictions remained. Rural areas struggled with inadequate coverage, and regional disparities persisted between wealthier republics and poorer regions.[45] The

45 Regional disparities took shape long before the establishment of socialist Yugoslavia, mirroring pre-existing differences in, e.g., industrial development. Areas in the north and west, such as Slovenia and Croatia, had a more developed industrial base dating back to the Austro-Hungarian Empire. Bosnia and Herzegovina and Macedonia were less developed. Despite efforts to equalize

participatory structures of the SIZs also began to suffer from bureaucratization: medical professionals and policymakers frequently dominated assemblies, limiting broader worker and patient engagement.[46] This was the result of overlapping factors, including the fact that medical workers entered the process with more knowledge about the functioning of (standard) health systems and processes compared to patients and other community members. Such a knowledge asymmetry, combined with the influence that certain groups of health workers (primarily physicians) continued to enjoy in society, meant that it was relatively easy to dismiss inputs from non-medical participants without giving sufficient attention to their education on the matter – an issue that could be considered a problem of health literacy. However, it is important to note that these asymmetries were not the result of ill intent, but rather of a failure to identify and address these issues in due time. Despite these shortcomings, self-management in the health system proved that health care could be both universal and participatory.

Public health – a priority, not an afterthought

A core aims of Yugoslavia's health system was to address and prioritize the social determinants of health, rather than just reacting to illness. This required the development and strengthening of, among other things:

- **Workplace/occupational health services**, which were of particular importance in the wider self-managed world. Many enterprises had dedicated medical units staffed with health workers who conducted checkups, provided first-

regional development under socialism, disparities persisted. For instance, Slovenia's GDP per capita was significantly higher than that of Macedonia throughout the socialist period.

46 Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas" in Upravljati zajedno.

aid and primary care, and monitored workplace conditions to address the occurrence of chronic conditions related to industrial labour.

- **School medicine services**, integrated into the educational system to enable early detection of health issues amongst children and adolescents. Health workers in this field also conducted regular check-ups and administered vaccinations, as well as providing advice in areas such as nutrition. School medicine structures played an essential role in the promotion of dental care – and their dismantling since the 1990s had a clear impact on children's dental health.
- **Community health initiatives**, including tuberculosis screenings, anti-smoking campaigns, and alcohol abstinence groups, were implemented in direct response to local health needs. Community nurses played a crucial role in this work, caring for a defined cohort within the allocated communities. Their close engagement allowed them to identify not only potential drivers of infectious diseases but also social and family factors affecting health. By maintaining continuous patient relationships, community nurses helped primary health care services view individuals holistically rather than merely as service users.

DENTAL HEALTH IN SOCIALIST YUGOSLAVIA: "A mouth without teeth is like a mill without a stone"

In the republics of socialist Yugoslavia, dental health was a significant component of the public health care system. The state emphasized preventive care, promoting regular dental check-ups and oral hygiene. Popular educational materials and public health campaigns, published by leading public health institutes, featured slogans like "A mouth without teeth is like a mill without a stone."

The School of Public Health in Zagreb played an important role in disseminating educational content that linked oral health to overall well-being. These efforts aimed to instill good dental hygiene habits from a young age.

Following the transition to capitalism, the whole region faced a downturn in public dental health standards. Health care system reforms led to reduced emphasis on preventive care, and oral health in Croatia, for instance, has seen a notable decline in indicators since 1999.

Based on: **Snježana Ivčić, Ana Vračar, and Lada Weygand**, "Usta bez zuba, mlin bez kamena" ["A Mouth Without Teeth, a Mill Without a Stone"], Mreža antifašistkinja Zagreba, December 6, 2016, https://www.maz.hr/2016/12/06/usta-bez-zuba-mlin-bez-kamena/.

The importance attributed to public health did not come at the expense of other elements of the health system. The system also recognized the importance of the accessibility to medicines and other medical supplies, and directed efforts into building production and distribution capacities that would decrease dependence on Western states or corporations.

A NEW PHARMACEUTICAL PRODUCTION MODEL: The Institute of Immunology in Zagreb

As it built a strong public health system, socialist Yugoslavia also directed efforts into strengthening pharmaceutical production capacities. One of the best-known institutions in this context is the Institute of Immunology in Zagreb (IMZ), which traces its roots back to 1893 and was later restructured into a key institution of socialist public health policy. Unlike many other states that remained completely dependent on pharmaceutical imports from

the West, Yugoslavia managed to ensure domestic vaccine and serum production, ensuring access to life-saving medicines.

In the socialist period, the IMZ operated as a public institution with commercial capacities, securing funding through state allocations, international partnerships, and the revenues generated from its high-quality vaccines. It was able to provide vaccines for diphtheria, tetanus, pertussis, tuberculosis, polio, and measles, among others. The Edmonston-Zagreb measles vaccine strain, produced by the IMZ, was widely recognized in WHO immunization programs around the world.

The institute also took pride in its exports: it provided products to seven states in Asia, six in Africa, two in the Americas, and 14 in Europe. The IMZ thus held symbolic significance in the context of international solidarity, supplying affordable vaccines and immunological products to the newly liberated states. As a member of the Non-Aligned Movement (NAM), Yugoslavia thereby offered at least some respite from the Western monopoly over drug production.

However, as structural adjustments were imposed by international financial institutions in the 1980s, Yugoslavia's public pharmaceutical production largely collapsed. By the 1990s, the IMZ's capacities had significantly deteriorated, and privatization efforts disrupted its important role. The loss of state support and declining international status ultimately led to the institution's virtual disappearance from the global pharmaceutical landscape.

Based on Vedran Duančić, Snježana Ivčić, and Ana Vračar, "The Failed Promise of a Brighter Future: The Institute of Immunology in Zagreb From a Public Asset to a Privatized Burden," in Immunization and States: The Politics of Making Vaccines, ed. Stuart Blume and Baptiste Baylac-Paouly (Abingdon: Routledge, 2022), 89–109.

Up until the 1980s, the Yugoslav health system represented a valid attempt to structure health care in a way different to the capitalist model seen in the Western states. Rooted in the principles of social medicine, the system attempted to bring together health care planning with community needs by integrating patients and health workers into the decision-making process. At its peak, the system lived up to the idea that health was not an individual responsibility, but a right to be guaranteed and protected collectively.

Yet, by the 1980s, these mechanisms had already begun to weaken under the encroachment of market logic. The broader economic crisis and the pressures of structural adjustment policies ensured a shift away from public health care and towards cost-cutting and efficiency-driven management. As the new model took hold, self-management and public health were no longer seen as assets, but obstacles to economic rationalization.

The path to privatization

The 1980s: market-oriented language enters the scene

Starting in the late 1980s, economic restructuring, international financial pressures, and a changing political climate resulted in significant changes in Yugoslavia's health care governance. The language of self-management was gradually replaced with references to efficiency, competition, and cost-cutting. By the time of socialist Yugoslavia's demise, the health care system that had been built on community participation and social medicine had already been primed to transition to a market logic driven by commodification and privatization.

While the full-blown process of privatization of health care did not start until the 1990s, the shift away from self-management began earlier, under the economic restructuring policies imposed in the previous decade. The International Monetary Fund (IMF) and the

World Bank hoisted market-based reforms upon Yugoslavia by conditioning loans on public sector austerity, including significant cuts to health care funding. In Croatia, this resulted in:

- A decrease in health care expenditure, falling from 6.8 percent of GDP in 1978 to 5 percent by 1982.
- Limits on access to care: the SIZs were forced to reduce the services they provided.
- Changes in policy language: market-oriented terminology entered the scene, with increasing calls for "efficiency" and "competitiveness" in health care.

While the change in language might seem the least important, it soon had very concrete repercussions on the functioning of health services. By talking about concepts like "cost-sharing" and "privatization of non-essential services", policymakers were preparing the ideological terrain for even deeper market reforms in the 1990s.

As Mladen Radković, a senior health official, remarked at the beginning of that decade:

> *"It's always good to have a pike in the pond. We will have to get used to competition, to the idea that the best, fastest, and cheapest will survive. The public sector is entering this with too many employees, excessive administration, outdated equipment, and enormous debt. However, since amendments to the health care law are already in progress, which would allow the private sector to participate in the SIZs and the health care fund, this is our near-future scenario."*[47]

47 Lada Weygand, Ana Vračar, and Snježana Ivčić, "Korijeni privatizacije zdravstvene zaštite u Hrvatskoj" ["Roots of the Privatization of Health Care in Croatia"], Radnička prava, December 27,

The 1990s: Full-blown privatization kicks in

With the breakup of Yugoslavia, the no-longer socialist Republic of Croatia moved to dismantle the self-managed health care system. Led by Minister of Health Andrija Hebrang, the government launched a series of reforms that ushered in privatization. "People need to understand that health care has a cost," Hebrang stated in 1990, saying that "the previous system" spread the illusion that health care was free.[48]

Health care reforms of this time were implemented on multiple fronts, including through:

1. **The abolition of self-management and the centralization of health care:** In the early 1990s, the Croatian government dissolved the SIZ system, replacing it with a centralized insurance-based model managed by the Croatian Institute for Health Insurance (HZZO). This move was framed as an efficiency measure, while in practice, it eliminated direct community and worker participation in health governance.
2. **The introduction of private practice:** In contrast to the socialist era, doctors were now allowed to open private practices and enter self-employment. Concession-based practices were introduced in primary health care, pushing physicians back towards profit-driven logic. This not only fundamentally altered the way primary health care was conceived but also reversed decades of efforts to reduce inter-professional hierarchies in the medical field. Nurses and midwives in primary care

2016, https://radnickaprava.org/tekstovi/clanci/lada-weygand-ana-vracar-i-snjezana-ivcic-korijeni-privatizacije-zdravstvene-zastite-u-hrvatskoj.

48 Weygand, Vračar, and Ivčić, "Korijeni privatizacije zdravstvene zaštite u Hrvatskoj."

were relegated to the role of physicians' assistants and became directly employed by private practices, instead of being regarded as equal colleagues.

3. **The commercialization of medical services:** The reformed system introduced co-payments and fees for services that had previously been free at the point of use. Private insurance schemes were established to promote the idea of individual choice and responsibility, while hospitals were told to adopt a corporate style of management, an approach they continue to struggle with to this day.

One of the most devastating effects of the privatization process was the dismantling of Yugoslavia's emphasis on preventive medicine. As health care services shifted their focus (and budget) away from disease prevention and health education, these programs were severely weakened. For example:

- **Workplace and occupational health services were drastically downscaled**, leaving many workers without access to regular health screenings. Today, whatever preventive check-ups are provided are largely bought from private health providers.
- **School-based health infrastructure and programmes were slashed**, shifting responsibility for children's health to primary care pediatricians and general practitioners, further straining the primary health care system.
- **Community health initiatives were almost eliminated entirely.** While community health nurses are still employed by community health centers and continue

to use a field-based approach, they receive far less support from the primary health care network. Their role has also changed—from proactively identifying and addressing social determinants of health in the community to primarily providing basic maternal health education and essential home care.

COMMUNITY NURSING AFTER PRIVATIZATION

Community nurses (patronažne sestre) were an essential part of socialist Yugoslavia's public health system. They were trusted figures embedded in local communities, providing preventive health services, maternal and infant care, and education on hygiene and nutrition. After privatization was imposed, their role has been drastically altered.

Before the 1990s, community nurses worked closely within the primary health care network, collaborating with general practitioners, social workers, and public health services. Privatization fragmented this system, introducing individualized choice of general practitioners instead of a collectively decided allocation that was based on residence or workplace. This shift weakened support among health care workers and disrupted coordination between services.

In capitalist Croatia, each community nurse is responsible for approximately 5,000 patients, regardless of the geographic area. Some are based in a single neighborhood in a large city, others cover multiple villages in rural areas. These differences are rarely acknowledged, and community health centers often lack sufficient funds to support their work adequately.

Despite these disadvantages, the community nurse system remains a relic from a different health care system, and it continues to play an important role in addressing many social determinants of health.

Based on: **Ana Vračar**, "Patronažne sestre, svjedokinje socijalnih i zdravstvenih posljedica krize" ["Community Nurses as Witnesses to the Social and Health Consequences of the Crisis"], RAD. and Radnička prava, June 3, 2016, https://radnickaprava.org/tekstovi/clanci/ana-vracar-patronazne-sestre-svjedokinje-socijalnih-i-zdravstvenih-posljedica-krize.

The 2000s and beyond: the true face of privatization in Croatia

More than three decades after the introduction of market-based health care in Yugoslavia's former republics, the promised benefits of competition, efficiency, and individualization have completely failed to materialize. In Croatia, for example, the health system faces soaring costs, with underfunded public hospitals struggling in the face of persistent deficits and uncertainty. A medical elite, which is in part connected to the ruling right-wing Croatian Democratic Union (HDZ), dominates the health sector. In primary care, community health centers have been reduced to administrative hubs focused mainly on curative services. The centers have been stripped of the broader functions they once held, as Silvije Vuletić describes.[49] Unlike in the socialist period, when most aimed to expand and offer specialized procedures, today only a handful of community health centers provide anything beyond basic care in capitalist Croatia.

Over time, the marketization of health care severely eroded working conditions and this in turn fueled a mass exodus of physicians, nurses, and other health workers to Western Europe. Once engaged in participatory planning, health care workers are today overworked and underpaid, making it increasingly difficult for public health

49 Vuletić, "Socijalna medicina kroz rad u društveno-političkoj zajednici," Radnička prava, 2016.

services to retain staff. This shortage is particularly evident in primary health care, where finding pediatricians and gynecologists has become increasingly difficult, leaving many children[50] and women[51] without access to care that is legally guaranteed to them. Those who can afford it are turning to the private sector.

The effects of these shortages and the weakening of primary health care are especially pronounced in rural areas, which have also been impacted by depopulation. Many elderly residents are left without local health care services, significantly affecting their quality of life. This is particularly striking given that one of the main criticisms of self-managed socialist health care was its inadequate coverage of rural populations. Proponents of privatization claimed the transition to capitalism would improve access for everyone, yet the situation has arguably worsened.

In cities, the same process has led to a proliferation of private health facilities, from individual practices to clinics, which claim to fill the gaps left by an underfunded public system. In many cases, these facilities are owned or operated by physicians who are simultaneously employed in public institutions, contributing to the widespread problem of dual practice.

Today, as Croatia still deals with the ramifications of privatization, the lessons of self-management in the health care system serve as a powerful reminder that things can be structured differently.

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50 Snježana Ivčić and Lada Weygand, "Privatizacija hrvatskog zdravstva na primjerima pedijatrije i zdravstvene njege u kući" ["Privatization of the Croatian Health System: The Examples of Home Health Care and Paediatrics"], in Društvena pravda u postkomunističkim društvima [Social Justice in Post-Communist Societies], ed. Bojan Vranić and Nemanja Anđelković (Belgrade: Udruženje za političke nauke Srbije; Univerzitet u Beogradu – Fakultet političkih nauka, 2022), 67–86.

51 Ana Vračar and Lada Weygand, "Ginekologija između 'slobodnog izbora' i manjkavosti sustava" ["Gynecology Between 'Free Choice' and Systemic Deficiencies"], Bilten, September 24, 2015, https://www.bilten.org/?p=9165.

Revisiting the lessons from self-managed health care

The dismantling of self-management and the commodification of health care in Yugoslavia's former republics had devastating effects. These include the mass migration of health workers, the quiet takeover of key health services by the private sector—such as gynecology in primary care—and a corresponding reduction in access for those unable to afford private fees. Health policies introduced since the late 1980s facilitated this transition from a system rooted in the belief that health is a human right to one resembling those of Western European countries.

Yet, the memory of Yugoslavia's participatory and preventive health care model remains alive. Public health professionals who began their careers under self-management still recall[52] the emphasis on solidarity and reciprocity, as well as the practices that upheld these values. The question remains, both for these experts and beyond, whether the core principles of Yugoslavia's self-managed health care system—universal access, community participation, and socialized medicine—can be reclaimed and adapted to today's world.

Recent efforts have sought to revive participatory models in health care, notably through regional health councils (savjeti za zdravlje) in Croatia, intended to foster dialogue among different stakeholders and improve public health policy.[53] However, their implementation varies widely depending on local authorities' priorities, and they primarily function as technical bodies rather than the politically engaged institutions that SIZs once aspired to be.

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52 Rajković, "Zdravstvo u Hrvatskoj od samoupravljanja do danas."

53 Aleksandar Džakula, Dražen Jurković, and Selma Šogorić, "Nove zakonske obaveze županija u zdravstvenoj zaštiti – Savjet za zdravlje i Županijski planovi zdravstvene zaštite" ["New Legal Obligations for Counties: Health Council and County Health Care Plans"], in Knjiga sažetaka 2. Hrvatski kongres preventivne medicine i unapređenja zdravlja (Zagreb: 2nd Croatian Congress on Preventive Medicine and Health Promotion, 2010), 256.

The lessons of self-managed health care extend far beyond the region, offering insights such as:

- Forms of worker and community participation in health care governance that genuinely incorporate health workers' practical experience and community needs
- A vision of decentralization that is not aimed at facilitating privatization or shifting costs from the central budget but at addressing the specific health needs of different localities
- Alternative models for developing public and community health interventions, relying not only on institutions that have faced decades of defunding but also on bottom-up initiatives
- New approaches to health financing that move beyond market-driven solutions

Yet, incorporating these lessons into contemporary health systems is unlikely without a broader political struggle for social justice and a commitment to health as a fundamental right. Just as the building – and then dismantling – of Yugoslavia's health care system was a political project, so too must be any effort to break the entrenched link between health and the market.

Bibliography:

Duančić, Vedran, Snježana Ivčić, and Ana Vračar. "The Failed Promise of a Brighter Future: The Institute of Immunology in Zagreb From a Public Asset to a Privatized Burden." In Immunization and States: The Politics of Making Vaccines, edited by Stuart Blume and Baptiste Baylac-Paouly, 89–109. Abingdon: Routledge, 2022.

Džakula, Aleksandar, Dražen Jurković, and Selma Šogorić. "Nove zakonske obaveze županija u zdravstvenoj zaštiti – Savjet za zdravlje i Županijski planovi zdravstvene zaštite" ["New Legal Obligations for Counties: Health Council and County Health Care Plans"]. In Knjiga sažetaka 2. Hrvatski kongres preventivne medicine i unapređenja zdravlja, 256. Zagreb: 2nd Croatian Congress on Preventive Medicine and Health Promotion, 2010.

Ivčić, Snježana, Ana Vračar, and Lada Weygand. "Usta bez zuba, mlin bez kamena" ["A Mouth Without Teeth, a Mill Without a Stone"], Mreža antifašistkinja Zagreba, December 6, 2016, https://www.maz.hr/2016/12/06/usta-bez-zuba-mlin-bez-kamena/.

Ivčić, Snježana, Ana Vračar, and Lada Weygand. "Primarna zdravstvena zaštita u Hrvatskoj od samoupravljanja do tranzicije: korijeni ideja privatizacije" ["Primary Health Care in Croatia from Self-Management to Transition: Roots of Privatization Ideas"]. In Socijalizam: izgradnja i razgradnja [Socialism: Construction and Deconstruction], ed. Chiara Bonfiglioli and Boris Koroman, 99–128. Pula-Zagreb: Srednja Europa, 2017.

Ivčić, Snježana and Lada Weygand. "Privatizacija hrvatskog zdravstva na primjerima pedijatrije i zdravstvene njege u kući" ["Privatization of the Croatian Health System: The Examples of Home Health Care and Paediatrics"]. In Društvena pravda u postkomunističkim društvima [Social Justice in Post-Communist Societies], edited by Bojan Vranić and Nemanja Anđelković, 67–86. Belgrade: Udruženje za političke nauke Srbije; Univerzitet u Beogradu – Fakultet političkih nauka, 2022.

Kirn, Gal, "A Few Notes on the History of Social Ownership in the Spheres of Culture and Film in Socialist Yugoslavia from the 1960s to the 1970s," Etnološka tribina 44, no. 37 (2014): 109–123

Rajković, Nikolina. "Zdravstvo u Hrvatskoj od samoupravljanja do danas — (dis) kontinuiteti u decentralizacijskim praksama" ["Health care in Croatia from Self-Management to the Present — (Dis)Continuities in Decentralisation Practices"]. In Upravljati zajedno: Prilozi istraživanju (dis)kontinuiteta samoupravljanja [Managing Together: Contributions to Research on the (Dis)Continuity of Self-Management], 62–81. Sarajevo/Zagreb/Beograd: Institut za političku ekologiju, Crvena, Zajedničko, 2023.

Vračar, Ana. "Patronažne sestre, svjedokinje socijalnih i zdravstvenih posljedica krize" ["Public Health Nurses as Witnesses to the Social and Health Consequences of the Crisis"]. Radnička prava, 3 June 2016. https://radnickaprava.org/tekstovi/clanci/ana-vracar-patronazne-sestre-svjedokinje-socijalnih-i-zdravstvenih-posljedica-krize.

Vračar, Ana and Lada Weygand. "Ginekologija između 'slobodnog izbora' i manjkavosti sustava" ["Gynecology Between 'Free Choice' and Systemic Deficiencies"]. Bilten, 24 September 2015. https://www.bilten.org/?p=9165.

Vuletić, Silvije. "Socijalna medicina kroz rad u društveno-političkoj zajednici" ["Social Medicine through Work in the Socio-Political Community"]. Radnička prava, 12 July 2016. https://radnickaprava.org/tekstovi/intervjui/silvije-vuletic-socijalna-medicina-kroz-rad-u-drustveno-politickoj-zajednici.

Weygand, Lada, Ana Vračar, and Snježana Ivčić. "Korijeni privatizacije zdravstvene zaštite u Hrvatskoj" ["Roots of the Privatization of Health Care in Croatia"]. Radnička prava, 27 December 2016. https://radnickaprava.org/tekstovi/clanci/lada-weygand-ana-vracar-i-snjezana-ivcic-korijeni-privatizacije-zdravstvene-zastite-u-hrvatskoj.

Zovak, Krešimir. Niz nezgodnih pitanja: završna faza radničkog samoupravljanja u Jugoslaviji [A Series of Uncomfortable Questions: The Final Phase of Workers' Self-Management in Yugoslavia]. Zagreb: Baza za radničku inicijativu i demokratizaciju, 2023.