HEALTH CARE PLANNING IN SLOVENIA

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I. INTRODUCTION

Two of the most important current dimensions of health planning and administration in the Republic of Slovenia are the regionalization of its health services and the recent amalgamation of its health insurance programs for workers and farmers. Slovenian health services and health insurance programs first were organized in the post-war government on a regional basis in 1951. Separate health insurance programs for workers and farmers existed, however, until the referendum of 1972 which led to the first combined health insurance system in Yugoslavia, initiated in 1973.

Although Slovenia's population of 1.8 million is relatively small in comparison with larger republics such as Croatia and Serbia, Slovenia is the most socio-economically advanced of all the Yugoslav republics. It often plays a pivotal role in the development of new policy approaches elsewhere in Yugoslavia, in health as in other fields. Thus the Slovenian developments considered in this article are important not only in their own right but also in terms of their implications for health policy in other parts of Yugoslavia.

For example, the Autonomous Region of Vojvodina also has adopted a regional approach for its Institute of Health Protection, located in Novi Sad. Regional and local health services are integrated on a regional basis with the activities of the Institute of Health Protection and also with the social insurance program.[1] The Institute of Health Protection for the Banja Luka (northern Bosnia) area operates in much the same way as the Slovenian institutes of health protection, although insurance for workers and farmers is not combined.[2] The Republics of Croatia and Serbia have been interested in the regional approach developed in Slovenia and also in combined health insurance, but neither yet has been able to develop analogous approaches, although Croatia is divided into several large but essentially independent regions for health purposes. Both republics have sent political

and professional representatives to review Slovene practices, but both have farming populations too large to switch easily to a combined insurance system.[3]

The purpose of this article is to examine the implications of regionalization and combined health insurance in Slovenia with reference to likely future developments in Yugoslavia, as well as its applicability to other countries. Particular attention is given to implications for preventive health programming, which is historically important in Yugoslavia because of the revolutionary organizational work of Andrija Štampar. Attention also is given to implications for the functional integration of health, environmental protection and regional development programs, and to the evolution of a more generally federalistic approach to government in Yugoslavia.

II. GENERAL BACKGROUND

Since the major Federal constitutional changes of 1971, each of the six Republics and two Autonomous Regions of Yugoslavia have had their own individualized health services and health insurance programs. Prior to this time, it was possible to speak of Yugoslav health services, as in an article by C. Vukmanović, Director of the Federal Institute of Public Health.[4] During the 1971-1973 period the Republics increasingly became autonomous and individualistic in the organization and administration of all their internal affairs.

It is necessary to understand two fundamental dimensions of all current social organization in Yugoslavia in order to grasp the significance of regionalism in Slovenia. One is that the principle of "workers self-management," first inaugurated in industry in 1951, is operative in all social organization. This means that workers in all types of organizations freely determine organizational objectives, methods of carrying them out, and dimensions of cooperation or competition with other self-managing organizations. Federal and Republic Constitutions set only general standards, even for local government (communes). There is no hierarchical vertical integration among enterprises nor among levels of government. Each unit essentially is autonomous.

The other principle is "self-financing," which means that the level of income for an organization is deter-

mined by the amount and quality of work of individual workers in the organization. This principle also was first applied to production enterprises. As applied to social services organizations, it means that they contract for services on the basis of work to be performed, based usually on prior performance. Direct budgetary allocations from any given level of government to its line agencies thus are reduced substantially in favor of transfers contracted among organizations which buy and sell services to one another.

When establishing prices for services, health institutions act in accordance with general regulations and agreements among all concerned parties at various levels, who determine criteria, guidelines, and the starting points for specific social agreements or contracts.

Historically, the work of the Yugoslav health leader Andrija Štampar had a tremendous impact on the organization of public health services in Yugoslavia, in Europe, and throughout the world. Štampar became head of the Department of Hygiene and Social Medicine at the Yugoslav Ministry of Health in 1919, when the new Kingdom of Serbs, Croats and Slovenes still was suffering the ravages of World War I. The new nation had infectious disease and other health problems of almost unimaginable magnitude.

Štampar's work from 1919 to 1931 in the Ministry of Health was revolutionary in at least six major areas, as follows:

1. *Regionalization.* Public health planning, programming, and administration was organized through nine Banovinal (provincial) Institutes of Hygiene, each with its own regional subunits which included infectious disease control dispensaries, infant and maternity care dispensaries, sanitary engineering services, etc. The Central Institute of Hygiene in Belgrade served as the technical and methodological center.

2. *Federalization.* Although the health system was nationalized and hierarchical to a degree, it was essentially uncentralized. Štampar consciously developed a federalist framework

allowing each unit in the system to adjust its activities to local needs.

3. *Citizen Involvement and Education.* Health centers, wells, waterworks, privies, and other sanitary facilities were provided with public funds at first, but later often were accomplished by voluntary labor, while the government provided only materials. Health became the work of all the people. The main initial purpose of the School of Public Health, established in Zagreb in 1927, was to provide health education to the Yugoslav peasantry.

4. *Program Integration.* Outpatient health care and environmental health functions were administered jointly. In addition, moreover, the health institutions deliberately tended to link their work with the promotion of agriculture, veterinary medicine, education, and the general welfare.

5. *Preventive Care.* Prevention of disease and disability was the hallmark of the Štampar program. This was evident not only in the infectious disease control and sanitary engineering programs, but also in the institutional innovation of the *Zdravstveni Dom* (Slovene) or *Dom Narodnog Zdravlja* (Serbo-Croat). Translated literally as "Home of the Population's Health" or "Health Home," this new institution provided free outpatient medical care, with emphasis on preventive care. Thus a dual medical care system was established, since outpatient and resident patient services continued to be offered privately. The health homes were attached administratively to the Banovinal Institutes of Hygiene.

6. *Integration of Planning and Implementation.* The organizational arrangements mentioned above facilitated the integration of research, analysis, and planning with programs of direct implementation. On the one hand, outpatient care was provided to serve the objective needs of the population; on the other, sanitary facilities were also provided on the basis of community and regional analysis and plans.[5]

Štampar's approach was too advanced for Yugoslavia's medical societies and King Alexander, who dismissed Štampar for alleged incompetence in 1931. Nevertheless, Štampar's basic organization plan continued in effect until World War II. After 1945, the health services were reorganized by the new government but Štampar continued to have influence at the federal level through his affiliation with the School of Public Health at the University of Zagreb and through his seminal role in the World Health Organization, which he helped found in the years immediately after World War II.

In 1973, Štampar's ideas enjoyed their strongest support in Slovenia, Croatia, Vojvodina, and Belgrade. In Slovenia, the Director of the Republic Institute of Health Protection was a strong advocate of Štampar's ideas, especially those concerning "positive health."[6] Regional integration of health services had been established in Slovenia in 1951, the *Zdravstveni Domovi* still existed, and public education played an increasingly important role in the programs of the Institute of Health Protection SRS and its affiliated units. A federalist approach to health organization still was present in health services and health insurance, though probably it was more decentralized than in Štampar's time. Almost all health services were socialized. In citizen involvement (particularly in the rural areas), integration of health care and environmental health programs, and in integration of planning and implementation programs, however, Slovene health practices as of 1973 did not appear to reach the levels advocated by Štampar's original model.

Of course, health conditions had changed markedly in the intervening years. Whereas acute infectious diseases such as tuberculosis, malaria, endemic syphilis, typhus, and trachoma were critical during the early Štampar years, the critical problems in 1973 were respiratory diseases, injuries, gastrointestinal diseases, diseases of the central nervous system and sensory organs, etc. At least the first three reflect environmental conditions. The most frequent causes of death were chronic diseases, among which the most important are cardiovascular diseases, neoplasms, diseases of the central nervous system, and respiratory diseases. Accidents and suicides ranked next in importance. Disability also increasingly was a serious problem.[7]

Standard indicators of health show that substantial improvements have been made in recent years. Infant mortality, 25.3 per 1,000 live born in 1969, is decreasing. It decreased from 80.6 per 1,000 in 1950, for example.[8] Life expectancy for females is increasing slightly and was 67.0 years during the 1960s. Life expectancy for males, in contrast, has begun to show the first signs of decrease, and was approximately 60 years during the corresponding period. Overall, life expectancy did not increase in the 1961-1969 period, and the report from which the above data is obtained concluded that the health situation in Slovenia was not improving and that the need for health protection expenditures was growing.[9]

The fact remains, however, that expenditures for health protection increased faster in Yugoslavia than did gross national product during the period 1956-1969. Health expenditures increased at an average of 23.4 percent, while GNP grew at an 18 percent average per year. Whereas health protection outlays were 6.05 percent of GNP in 1969, they had been only 3.35 percent in 1956.[10]

In 1961, there were approximately 1,500 physicians in Slovenia, or one for every 1,074 persons. In 1972, there were 2,350 physicians, or one for every 735 persons. Numbers of nursing, dental and other medical and paramedical personnel also showed impressive growth during the period.[11]

Hospital beds increased only slightly from 7.4 per 1,000 population in 1961 to 7.42 in 1972 calculated on the basis of actual beds (only 6.46 on the basis of standard beds), just barely keeping up with population increases. A fine new central hospital was constructed in Ljubljana, however, and was designed to serve as a model for all of central Europe. Substantial centralization both of hospitals and health homes occurred during this period, reflecting the efficiencies that could be achieved on a regional basis. While previously there were 32 hospitals, only 24 remained in 1972; the number of health homes decreased from 170 to 19 in the same period. Yet the range of services provided at these facilities grew impressively, just as did the numbers of personnel staffing them.[12]

III. REGIONAL HEALTH SERVICES IN SLOVENIA[13]

Slovenia is unique among all the Republics in that it has adopted a regional administration format for all of its health services. Following the approach developed originally by Štampar, health care and environmental health and preventive health institutions in several designated regions in Slovenia began in 1951 to cooperate with one another through the formation of regional councils whose membership was representative of all health institutions in the region except health insurance organs. The member institutions included hospitals, health homes, and regional hygiene institutes whose functions encompassed a broad range of environmental planning and action programs as well as the other social medicine, health planning, and epidemiological activities which present-day Institutes of Health Protection perform. The regional approach was appropriate especially in Slovenia because of the dispersed distribution of its population, its long-standing experience with social insurance (well over 100 years), and recognition of efficiencies in the use of social insurance which could be realized through consolidation of health services.

A serious problem developed in connection with this original regional council approach, however. Since distribution of regional health insurance monies was being made on the recommendation of the regional council, which had a large preponderance of its representation from hospital and health home personnel (approximately 70 and 25 percent, respectively), most of the available support for regional health activities was captured by the hospitals. The regional health homes and regional hygiene programs got even less than their proportionate share.[14]

Subsequently, in 1962, regional health functions were reorganized in Slovenia. The regional health councils were reestablished on the basis of the new Federal legislation mentioned above, and new budgeting procedures were introduced to assure that allocations from health insurance were based on evaluation of program plans submitted to a given regional health insurance organ by each regional health service institution. Health insurance organs thus became the most powerful members of the regional health councils. The regional hygiene institutes were renamed "Institutes of Health Protection" and

most of their original environmental protection functions were delegated to communal "Sanitary Inspection" organs, evidently because of the general decentralist tendencies of that time and related concerns that too much power was otherwise allocated to one institution.

Currently, each regional health institution operates on the basis of self-management and self-financing principles, with about 75 percent of the budgets of all health care institutions coming from social insurance, and about 90 percent of the budgets of the regional Institutes of Health Protection coming directly from health insurance.[15] Only one and one-half percent of the total Slovene health insurance budget is labelled "preventive," but it is stated by certain authorities in Yugoslavia that 30 to 35 percent of all health expenditures throughout the country are spent for preventive purposes.[16]

The health insurance program is organized on a federalist basis involving a more-or-less "theoretical" Federal government role, with strong basic policy guideline powers exercised by the Union of Health Insurance Associations of SR Slovenia, specific policymaking powers exercised within those guidelines by regional health insurance associations and health working organizations, and administration by local health insurance associations.[17] The Republic and regional level health insurance associations provide coordination of health plans and programs through their financial control.

In 1962 there were nine health regions in use, embracing the entire territory of Slovenia. In 1973 the 60 Slovenian communes, which are units of local government similar to counties in the United States, still were organized into the same nine regional configurations for health purposes. Health was the only social function thus organized.

The region is not a level of government in Slovenia, although there is some current interest in establishing such a level. In Ljubljana there is, however, a quasi-metropolitan "Central Committee" with representative members from each of the five communes which comprise Ljubljana.

Each health region in SR Slovenia has its own regional Institute of Health Protection, although two were as yet unstaffed in 1973. The Institute of Health Pro-

tection SR Slovenia coordinates their work on a Republic-wide basis, although of course each Institute operates under the same self-management and self-financing principles which apply to all working organizations.

The regional Institutes conduct programs in health statistics, health planning, social medicine, hygiene (including community hygiene) and epidemiology, and laboratory analysis that are similar to and related to those of the "parent" body. Some of the regional Institutes are better staffed and carry out more complete programs than the others, depending on local needs, financing capabilities, and urbanization factors.

The preventive health battle against infectious diseases, initiated during the Štampar period and continued after World War II, has been largely won. Currently the public health services are faced with chronic disease problems related to the impact of industrialization and urbanization, together with related problems of environmental health and environmental protection.

As pointed out above, many of the former functions of the Republic and regional level health institutions in the environmental area have been delegated to local government. Partly as a consequence of local inability to cope adequately with these problems, a number of environmentally oriented research and political action groups have sprung up in Slovenia in recent years. Their outlook tends to be Republic-level or regional, and their approach is multidisciplinary. The health professions are not excluded, but all the groups seem to recognize the necessity for a more functionally integrated approach to solving environmental problems than the health professions have yet been able to mount.

One such group is the voluntary *Skupnost za Varstvo Okolja Slovenije* (Community for Protection of the Environment of Slovenia). After two years of existence, it had six chapters in Slovenia. It also has initiated similar organizations in all other Republics, the two Autonomous Regions, and at the Federal level. It is a political action group with evident influence, particularly at the level of the SR Slovenia Assembly. In 1973 it was pressing for a Republic Secretariat for the Environment as well as substantially reorganized local Sanitary Inspection organs.

Partly through its efforts, a 15 member SRS Commission for Protection of the Environment has been established in the SRS Assembly. The legislative review and advisory Commission is heavily burdened by a very large workload of sensitive Republic and regional environmental protection issues ranging from river pollution control to the scenic impact of new highways. Many of the regional issues could be handled more appropriately at the regional level if relevant regional authority existed. The problems simply are too major to be handled well by local communes, yet too minor to be resolved efficiently or effectively by Republic bodies. These factors, plus the inevitable political liabilities incurred by the Assembly members working on these issues, suggest that the Assembly will find a way to delegate some of its authority to the regional level.

Dissatisfaction with the limits of a solely biological approach to solving the problems of the environment led to the formation of a new Commission for Protection of the Environment in the Slovenian Research Council in 1972. This scientific research body now has a strongly multidisciplinary approach to problems of the environment, including some health professionals among its broadly ranging research affiliations.

Slovenia's Institute for Regional Spatial Planning was established in 1968, and was the first such body in Yugoslavia. It is related somewhat indirectly to the SRS Institute for Socio-Economic Planning. It has a mandate to develop Republic-wide urban development plans and has certain environmental protection responsibilities in this connection.

At the Federal level, a potentially far-reaching "white paper" embracing the need for functionally integrated, intergovernmental, long-term urban development policy plans was adopted by the Federal Assembly in 1971.[18]

All of the above-mentioned new organizations maintain ties with existing health organizations and professionals. Yet their very existence is evidence of the institutional and professional lags in existing organizations which make the new organizations necessary, this despite the best intentions and the often close personal relationships that exist between counterpart professionals in, for example, public health and urban planning

organizations.

Of course, it is difficult to switch rapidly to a functionally integrated regional approach to urban-environmental-health problems, especially in the context of governmental decentralization which prevails throughout Yugoslavia. It is clear, however, that the regionalization of preventive health, including environmental protection, is not yet as well developed in Slovenia as it is for health care. Now that environmental problems are perceived to exist in the regional context, it should not be too difficult to federalize planning and implementation of environmental protection programs upwards during the course of the next several years. The health care programs provide a prototype.[19]

IV. UNIFIED REGIONAL HEALTH INSURANCE IN SLOVENIA

Slovenia has a long tradition of experience with health insurance, going back to 1858 when it was introduced both as an inducement to working people to remain in Slovenia and to prolong the working years of those who did remain. At the time there was a large outmigration to the United States and other countries. Because of this long tradition, the idea that health insurance is a basic right belonging to everyone is well established. This undoubtedly contributed in an important way to the outcome of the 1972 referendum in which it was decided by 90 percent of the voters that there should be a single, unitary insurance system for both farmers and workers in Slovenia. Up to that time there were separate systems for both, based largely on the distinction that farmers were self-employed and had relatively lower cash incomes than workers.[20]

Slovenia has a dispersed population settlement pattern, but some 60 percent of the farmers live in villages. Workers and their families also show a strong preference for living in villages and smaller towns. As a consequence, the classic antagonism between rural and urban populations is not as strong in Slovenia as elsewhere in Europe. This also eased the way for the success of the referendum.

In addition, the life style preferences of Slovenes mean that health services, like other public services, are highly dispersed and accordingly more expensive.

Consolidation of health services and supportive insurance programs on a regional basis has been one way of realizing efficiencies and reducing costs inherent in such a system.

As a consequence of the 1972 referendum, workers and farmers now have the same rights, except that farmers do not yet have compensation for income loss due to illness or disability. This deficiency is due to end by 1980.[21] Only 12 percent of all the inhabitants of Slovenia are farmers. However, many are over 50 years of age and are not able to finance their own health insurance. At the present time workers contribute 25 percent of the total resources required for their insurance. In other areas of Yugoslavia, where the proportion of farmers is higher, it is not yet feasible to distribute the additional costs of unified insurance in such a manner.

In fact, probably it would not have been possible to integrate health services and health insurance organizations on a regional basis, as was done in Slovenia in 1962, except for the fact that the regional health insurance organizations of the workers already insured the bulk of the population. If the regional health insurance organizations for the workers and the farmers had had more equal numbers of insurees, it would have been difficult for either of them to arbitrate the budgetary requests of a single set of health care institutions. It was the amalgamation of the two insurance plans which simplified the allocation problem in both political and professional terms, thereby providing more equal protection for all members of society.

The regions utilized for health insurance programs, beginning in 1962, were the same as those already in use by the Institute of Health Protection and the various health care institutions. Their centers are at Celje, Gorica, Koper, Kranj, Ljubljana, Maribor, Murska Sobota, Novo Mesto, and Ravne. These regions continue in being.

In 1966, the *Zveza Skupnosti Zdravstvenega Zavarovanja SRS* (Union of Health Insurance Associations) played a major role in reducing the total number of regional health institutions. Working through an order issued by the Republic Secretary of Health and Welfare, it was able to reduce the number of Health Homes from 80 to 20. One hundred fifty separate ambulatory dispensaries and 50 separate dental care units were also collapsed into the

20 remaining Health Homes. The number of hospitals was reduced from about 30 to 24. These changes had to be accomplished quickly because of the distastefulness of such a move in a nation priding itself on decentralization. But the changes were necessary from the point of view of efficiency.

Generally, the Union of Health Insurance Associations does not operate in such an apparently hierarchical manner. It is comprised of four delegates from each of the nine regional health insurance associations. Each year it prepares, negotiates, and enters into a so-called "Social Agreement" dealing only with the starting points for financing and execution of regional health services for that year. It provides the basis for regional contracts worked out by the regional health insurance associations, regional insured workers associations, and regional health services institutions. In practice, however, the principal negotiators are the regional health insurance and health services organs only.

Thus, basic social agreements are developed at the Republic level while more specific social agreements are negotiated at the regional level. Each regional health insurance association is further subdivided into local health insurance associations, but the latter are administrative rather than decision-making bodies. This pattern stands in sharp contrast to the larger decision-making and implementation powers delegated to local government in almost every other sphere of governmental activity. The reader is reminded, for example, of the contrast with respect to land use control and environmental protection powers described above. It seems likely that the social agreement format may in a few years find similar usage in these functional areas, in order to bridge the intergovernmental gaps between policymaking and actual implementation that exist in those areas.

Health insurance, because of its powerful financial influence, is in a strong theoretical position to affect the distribution of funds between curative and preventive health programs. Although the total amount distributed to preventive care may approach 30 to 35 percent, less than one and one-half percent actually is earmarked for preventive work at the present time. These monies provide nearly all the support for the regional insti-

tutes of health protection.[22] It will be interesting to observe how quickly Slovenia is able to increase allocations to the preventive health sector, since it is a relatively wealthy nation and the Union of Health Insurance Associations is in a good strategic position to research and implement worthwhile tradeoffs vis-à-vis expenditures in the health care area. If this was to occur, there would be a major new force directing the functional integration of health with other environmental protection activities and urban and regional development policy.

V. ANALYSIS AND CONCLUSIONS

Based on the measures of effectiveness mentioned earlier in this article, it appears that there has been considerable progress in health conditions in Slovenia during the last twenty years or so, despite the disclaimer issued by the ZZVSRS in 1966 (fn. 9). While it is true that life expectancy was levelling off at that time, socioeconomic conditions in Yugoslavia have been improving steadily and it is hard to imagine that the general level of life quality has not improved during the last twenty year period. We need more accurate indicators of positive health to make a more definitive statement, however.

It is not possible to judge with certainty whether or how much the regional framework adopted in 1951 has contributed to the effectiveness of the overall health program, based on the material reviewed here. But there seems to be no evidence to suggest that the regional approach has harmed program effectiveness or that it has had negative side effects on other programs. The range of health service available has increased.

As far as efficiency is concerned, we have only presumptive evidence that the regional approach is more efficient in the use of limited resources than an alternative course. Health costs were indicated to be rising more rapidly than GNP. But we do not know that health costs would not have risen even more sharply in the absence of a regional approach. It appears, in fact, that regional management has made possible a number of economies with respect to the distribution of health facilities.

Nevertheless, we need to look elsewhere fully to appreciate the apparent general satisfaction with the regional approach in Slovenia. Its potential to accommodate to future needs is, ultimately, a more critical consideration. It is entirely consistent with future anticipated urban growth patterns, for example. Regional growth will be managed in a polycentric pattern resulting in population dispersion, with urban centers linked in the most efficient time-distance relationships. The regional approach in health provides intergovernmental flexibility to accommodate to the health services needs of such a population distribution. In addition, the regional approach is better adapted to environmental protection requirements than local government, since many of the problem-sheds are regional in scope.

Add to these considerations the fact that the regional approach is the only way to satisfy the needs of workers and farmers simultaneously. It provides at the same time a vehicle for greater equity in provision of services, political workability, and simplicity in administration.

Similar observations can be made concerning the integrated health insurance program recently adopted. It is not possible to be certain that such a program necessarily is more effective or efficient than an alternative, including the possibility of no health insurance at all, since there is no basis for comparison. However, it is clear that more people will have better insurance coverage than under the dual system which existed until 1973. It also stands to reason that there will be administrative efficiencies in operating one rather than two separate insurance systems. Again, considerations of equity, political workability, and simplicity in administration are equally or even more important. In addition, the administrative separation of financial support of health services from actual provision of health services provides an opportunity for an objective evaluation of whether monies are best spent in curative health care or in other categories of expenditure contributing more effectively or efficiently to overall levels of health. In other words, there is the opportunity to consider tradeoffs between curative and preventive expenditures. Ultimately, a higher level of support for environmental protection activities from

health insurance might be expected. This could help finance a more functionally integrated approach to life quality.

For these various reasons, then, it can be anticipated that regional organization of health services in Yugoslavia will spread from Slovenia into other parts of the country, as in Vojvodina and northern Bosnia. Regionalization is a natural solution to the accommodation of both general and specialized health services. It also lends itself to the accommodation of environmental protection and urban development strategies. Perhaps most importantly, it provides a vehicle for resolution of intergovernmental problems in a federalist manner, balancing extreme forms of decentralization without abrogating local self-management principles. For the latter reason, it may be expected that the popularity of the regional approach will also increase as related to social functions in addition to health.

Development of regional planning and administrative mechanisms for health also can be expected to lead to regional health insurance, and initially in the more industrialized areas with relatively small farming populations, to integrated health insurance for farmers and workers. There are too many advantages in terms of equity, political workability, and administrative simplicity for the outcome to be otherwise.

Finally, social agreements developed at Republic and regional levels in Yugoslavia for the planning and budgeting of combined health care and environmental health programs, provide a model potentially useful in other countries for general regional services administration. The social agreement format provides appropriate decision-making and allocation responsibilities to each involved level of government, and obliges intergovernmental cooperation through mutually negotiated terms under the force of law. It is a very useful vehicle for functional integration of services, and for this reason it also points the way towards realization of Štampar's elusive concept of positive health.

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NOTES

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[1]Telephone interview with Prof. Dr. Dušan Savić, Vojvodina Institute of Health Protection, August 28, 1973.

[2]Telephone interview with Dipl. Econ. Sabahudin Osmančević, Banja Luka Institute of Health Protection, August 29, 1973.

[3]Interview with Doc. Dr. Saša Cvahte, Director, Institute of Health Protection SR Slovenia, August 21, 1973.

[4]C. Vukmanović, "Decentralized Socialism: Medical Care in Yugoslavia," *International Journal of Health Services*, 2, No. 1 (1972), pp. 35-44.

[5]Robert G. Dyck, "A Critical Examination of the Slovenian Federalist Model for Joint Administration of Health Care and Environmental Health." Paper for the American Public Health Association, 101st Annual Meeting, San Francisco, November 8, 1973, pp. 4-5. Also see

Robert G. Dyck, "A Futuristic Review of Health Services Innovations Pioneered by Andrija Štampar," unpublished draft of July, 1973.

[6]Defined in the Preamble to the World Health Organization Charter as ". . . a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

[7]Robert G. Dyck, "Overview of Health Conditions in SR Slovenia," unpublished draft of August 1973.

[8]S. Cvahte, I. Kastelic, Z. Odar, *The State of Health of the Population of Slovenia 1956-1964* (Ljubljana: ZZVSRS, Slv., 1966), p. 1 of Summary.

[9]S. Cvahte, I. Kastelic, R. Neubauer, and Z. Odar, *Health Conditions of the Population of SR Slovenia* (Ljubljana: ZZVSRS, Slv., 1971), pp. 11, 27.

[10]Op. cit., pp. 25, 28. No adjustments for inflation.

[11]ZZVSRS (Doc. Dr. Saša Cvahte, Director), *Statistical Report on the Work of the Health Services for the Year 1972* (Ljubljana: ZZVSRS, Slv., 1972), p. 54.

[12]Op. cit., pp. 38, 39, 48, 54.

[13]The initial descriptive material in this section is drawn from Dyck, "A Critical Examination. . .," pp. 9-12.

[14]Interview with Doc. Dr. Saša Cvahte, July 7, 1973.

[15]Interview with Marica Eltrin, Economist, Union of Health Insurance Associations SR Slovenia, Ljubljana, August 17, 1973.

[16]Robert G. Dyck, "A Review of Health Insurance Arrangements in Slovenia —1973," unpublished draft of August, 1973.

[17]Interviews with Jože Piano, General Secretary, Union of Health Insurance Associations SR Slovenia, Ljubljana, July 23, 1973, and with Marica Eltrin and Arne Mavčič of that organization on July 31, 1973.

[18]A more detailed description of the various multidisciplinary approaches cited here may be found in Robert G. Dyck, "A Critical Examination. . .," pp. 16-30.

[19]Op. cit., p. 37.

[20] Robert G. Dyck, "A Review of Health Insurance. . . ."

[21] Interview with Jože Piano, July 20, 1973.

[22] Robert G. Dyck, "A Review of Health Insurance. . . .," p. 11.

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