Rebuilding the Healthcare System in Mostar: Challenge and Opportunity

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A basic premise of this article is that the political and ethnic division of the city of Mostar imperils community health planning efforts beyond those normally encountered in the aftermath of war. Bosnia and Herzegovina is divided among ethnic groups, and the city of Mostar is further subdivided between the Croatian and Muslim interest groups. In that respect, Mostar presents a very special challenge to those planning the reconstruction of the health care delivery infrastructure. A new healthcare delivery plan was organized by the Federation of Bosnia and Herzegovina in 1996. This paper examines obstacles involved in implementing that plan in light of some epidemiological indicators of current health conditions.

Key words: Bosnia-Herzegovina; community health services; epidemics; epidemiological monitoring; health care providers; health facilities

The city of Mostar is located in the very center of a region that is ethnically divided. Prior to 1991, when fighting began following the succession from Yugoslavia, the ethnic composition of Mostar included several different population groups. About a third of the city was Croatian and another third Muslim; 20% of the population was Serbian, and the remainder was classified as “others”, including a Jewish minority and individuals who simply considered themselves Yugoslavian. Mostar had long been regarded as the economic and cultural center of southern Bosnia and Herzegovina for diverse ethnic groups (1). In 1998, the metropolitan area of 150,000 is about half Croatian and half Muslim. Muslims control the eastern part of the city that was heavily damaged during the war. Separated by the River of Neretva, the western part of the city is controlled by the Croats with damage localized to areas of front-line fighting.

Ethnic Aspects of Mostar’s Dilemma

Croats and Muslims were initially allied against largely Serb Yugoslav forces in fighting that followed the Bosnian declaration of independence in 1992. However, when the Yugoslavian army departed in 1993, Croats and Muslims began to fight among themselves. A 1994 cease fire determined the present lines dividing Mostar. The US-sponsored Dayton Accords of 1995 led to the reluctant incorporation of Croats and Muslims into the state of Bosnia and Herzegovina (BH). The partition of Mostar is a microcosm of the division that characterizes the federation. The European Union (EU) assumed administrative control of Mostar in 1994 with the expectation that early municipal elections would produce a Croatian-Muslim leadership coalition. However, successive elections (1996 and 1997) confirmed the ethnic bifurcation of the city. The 1997 election results (Table 1) reflected current divisions of the city with the Croats in control of the western part and the Muslims of the eastern part of the metropolitan area.

Table 1: Election results (municipal seats) for the Mostar metropolitan area, 1997. [view this table]

The EU continues to support a twelve-point plan, developed by Swedish mediator Karl Bildt, to integrate Mostar, in which a key element is the political re-unification of the city. Success in Mostar is expected to reinforce tolerance and reconciliation for all Bosnia and Herzegovina. Rebuilding the healthcare delivery system is an important factor in the settlement process. However, political deadlock has impeded progress toward restoration and, as a result, the population is on the brink of unfavorable health status circumstances. Early indications of troublesome epidemiological shifts
include increases in the reporting of a number of infectious diseases, a slight decrease in life expectancy, declining vaccination rates, and healthcare manpower deficiencies.

**Epidemiological Trends**

Comparisons of several important health indicators verify concerns. As demonstrated by Table 2, while natality and the natural mortality rate changed little from 1991 to 1996 (i.e., before and after independence), average life expectancies in Bosnia and Herzegovina declined by about one year for both males and females. Paradoxically, infectious morbidity rates substantially declined over the same time period while vaccination rates dropped. This condition is probably due to the higher vaccination rates prior to 1991. In spite of declines in vaccination rates since 1991, immunity levels in the population appear to be high enough to forestall outbreaks of major diseases. The problem of decreasing vaccination rates for BCG, polio, and measles still poses a risk for younger children. If persons born since 1991 are not inoculated at an increased rate, disease outbreaks can be expected in the near future. The situation is further complicated by changing healthcare manpower ratios. The population per doctor ratio in Bosnia and Herzegovina increased from 592 in 1991 to 978 in 1996, while the total number of healthcare employees dropped from 19,300 to 11,857. Most of these changes are not drastic and offer time to correct problems such as declining vaccination rates. However, so long as the political impasse continues, the future appears to be troublesome for an already suffering population.

Table 2: Health status indicators in the Federation of Bosnia and Herzegovina. [view this table]

Table 3: Epidemic diseases on the increase in Bosnia and Herzegovina: 1991 and 1996 rates. [view this table]

Reports of the leading epidemic diseases in Bosnia and Herzegovina further attest to the declivity in health conditions. While problematic ailments such as hepatitis A, bacterial dysentery, mononucleosis, mumps, salmonellosis, and scarlet fever show promising declines in reports from 1991 to 1996, there are almost a dozen infectious diseases that appear to be on the increase. According to information supplied by the Institute for Epidemiology in Sarajevo (4) and contained within Table 3, the list is more expansive than would be expected in nearly every country in the Western Europe. Shown in rank order, the most completely reported of these diseases include varicella (chickenpox), scabies, and enterocolitis. Additional higher-ranking infectious diseases on the increase include pharyngitis (strep), tuberculosis, and alimentaria. Whereas the tuberculosis problem could be related to the worldwide resurgence of the disease, war and the ensuing unrest have clearly contributed to the problem. Sufficient health-related resources are required, as soon as possible, to determine if the tuberculosis increases are being caused by multiple drug resistant strains so that appropriate treatment procedure can be introduced. Other infectious diseases that can be brought under control through vaccination and topical treatment include measles and mycosis, whereas forms of meningitis can ultimately be better contained through housing reconstruction. Such vector-borne diseases as tularemia and hemorrhagic fever are a product of regional disease ecologies. These statistics provide a pragmatic argument for the immediate redevelopment of the healthcare delivery system of Bosnia and Herzegovina, and Mostar can take the lead in these efforts.

**Adopting a New Delivery Model**

One observer has recently described Mostar as a “divided city living in an armed truce” (5). There are by some definitions actually three interest groups involved in the municipal governance in Mostar: Bosnian Muslims allied with the central federation in Sarajevo, Croats with ties to Zagreb, and the EU. Divisive elements, such as separate telephone systems and incompatible currencies, contribute to the political stalemate (6). The goal of rebuilding the healthcare system is often greatly overshadowed by hostile obstructionism on the part of all parties concerned. Meanwhile, the health status of the population appears to be declining, and many infectious diseases that can be prevented and controlled have begun to approach Third World reporting conditions.

In prewar Bosnia and Herzegovina, spending for healthcare accounted for 6.5% of the GDP; this proportion compared favorably with other countries in the region (7). The Yugoslavian healthcare system provided universal coverage through a centralized system, with the emphasis on primary prevention programs and technology-based hospitals. The 1996 health plan proposed by the Ministry of Health for the Federation of Bosnia and Herzegovina encourages privatization and local autonomy...
in the delivery of healthcare. The proposed plan is a mixture of decentralized delivery and centralized coordination, with the expectation that cumbersome aspects of the previous centralized system can be streamlined. A system of mixed responsibility is expected to minimize fragmentation and duplication of services while improving access and quality of care in poorer districts (8). Public health services are to be the responsibility of the local authorities, thus removing the “national sanitary police” archetype. Primary care, which has historically been the responsibility of the Neretva-Herzegovina Canton Health Office in Mostar, is expected to devolve to private practitioners, with capitated funding for family practice.

The Federation government will retain authority for the definition and coordination of local hospitals and three regional tertiary care centers, one each in Tuzla, Sarajevo, and Mostar. Other entities administered at the national level include institutes for research and treatment of substance abuse, public health, and blood transfusions.

The funding stream for the proposed system is a combination of insurance payments, general tax revenues and specialized financing. Following the logic of related emergent programs in Central and Eastern Europe, individual compulsory health insurance premiums collected through the canton insurance fund will be the major source of reserves. Five percent of these funds are to be redirected to federal programs for the medically indigent and high-risk patients. Other planned sources of revenues include private supplemental insurance policies, supplemental healthcare fee contracting, and direct payment from employers for work site health promotion and occupation-specific healthcare programs. Canton health insurance institutes will handle reimbursements for local hospitals and primary healthcare centers. The Ministry of Health will finance regional centers and federal institutes. This planning model, based on experiences of the countries with decentralized local health services, is supported by Croats while Bosnian Muslims endorse a more centralized delivery system. The current plan seems to reflect the political relationship between Bosnia and Herzegovina and Republic Srpska as a loose “confederation” with both Serbs and Croats sustaining close ties with ethnic “mother republics”. To some extent, many Muslims perceive a sense of marginalization that permeates from the federal level, including healthcare delivery. These circumstances have led to friction and outright conflict driven by cultural differences that eclipse historical multiethnic aspects of Mostar. In healthcare, as well as other areas, modifications will be necessary to account for the cultural identity and political integrity of both parties.

However, containment of cultural differences is not the only dilemma. With an initial start-up cost of approximately US$434 million, the Federation of Bosnia and Herzegovina does not have the funding to rebuild the healthcare system at the present time. As with many other countries, expensive specialty care hospitals and high technology can drive the system. It may be necessary to restructure some of these operations so that funds can be redirected to more cost-effective primary care and prevention. Additionally, an infusion of external capital is required to both counteract the current deterioration of community health and to establish local financing. Locally based funding is supported by the World Bank and the EC as the best means of decentralization. However, state involvement in local finance mechanisms exacerbate confusion about lines of authority and accountability.

**Addressing the Stalemate**

The legislation enacted by the Federation of Bosnia and Herzegovina offers a framework for a new healthcare delivery system. However, intense competition among political factions and infrastructure shortcomings in Mostar have impeded the re-establishment of healthcare delivery. Additional issues affecting healthcare restructure include work force development, improved reporting of epidemic and endemic diseases, and war victim rehabilitation. Political exigencies complicate these and other aspects of progress toward a democratic model of healthcare delivery. Moreover, healthcare is only one of several competing priorities for the region, e.g., education, physical infrastructure, and economy. Each of these needs has legitimate demands and supportive constituencies.

Reconstruction of the healthcare system is incumbent upon cooperation that will produce equivalent benefits to all of Mostar’s inhabitants, and not upon differential access and quality based upon ethnicity. Additionally, a system which supports healthcare for all its citizens offers an opportunity to build consensus that can be applied to other spheres of community life and governance. Currently a bifurcated budget process, allocating separate healthcare funding for Muslims and Croats, perpetuates the development of parallel delivery systems. Healthcare delivery split between two ethnic groups will not effectively address the needs of the region. A division of services exacerbates duplication and fragmentation and cannot be justified under current resource constraints. Additionally, it eliminates opportunity for the cooperative planning envisioned within the Federation plan. Cooperation is imperative to even begin the task of rebuilding the healthcare infrastructure in Mostar. Hospitals and primary care facilities were among the first targets of the violence with over 20,000
square meters of healthcare facilities destroyed or damaged beyond use. Those facilities which survived are overcrowded, with obsolete equipment and insufficient staffing. Hundreds of medical personnel sought refuge in other parts of the country or in Europe, with a resultant medical “brain drain” in Mostar.

Prior to the development of ethnic disharmony, universal access to healthcare enabled Mostar to enjoy health status indicators equal to other European nations (9). Public health is now a primary concern. Damage to water supply, sanitation, and solid waste disposal has resulted in deteriorated services. Epidemics of diseases previously under control and endemic diseases are on the increase. Rebuilding the public works infrastructure, estimated at US$70 million, is a community wide endeavor that is critical to a healthy population.

Mostar survived some of the most widespread damage of any city in the country, leaving large numbers of injured and disabled persons. These victims of both physical and psychological trauma, on both sides of the conflict, offer competing needs and expectations for scarce healthcare funds.

Discussion

Mostar is one of numerous areas throughout the globe where ethnic divisions have resulted in increased hostility and diminished quality of life. Once a city known for ethnic tolerance and cultural diversity, it now struggles to rebuild both its buildings and its lifestyle. Additionally, Mostar has been seen as a barometer for a return to normalcy in other areas of Bosnia and Herzegovina. There are numerous international and domestic efforts to rejuvenate the physical structure and the social fabric of the community. Rebuilding the healthcare system responds to the immediate need of the population and contributes to the long-term political stability.

Addressing the global and individual health care needs of the Mostar’s citizens requires cooperative effort in creating a funding mechanism, in planning and in rebuilding the healthcare system. It is dependent to a great extent on initiatives at the community level based upon a strong foundation in municipal administration. While there is an obvious need for external funding, a local system for collecting health insurance funds and reimbursing care givers needs to be developed. Rebuilding the healthcare infrastructure requires detailed understanding of current capacity and unmet needs, which can only be done at the local level. The World Bank, a major external funding source, has identified governance as a critical issue in rebuilding healthcare systems. Establishment of a local structure, with representatives from both ethnic groups, would allow the development of a comprehensive plan for healthcare delivery designed to meet the needs of all the citizens of Mostar.

It is difficult to achieve a comprehensive political solution for peace without incremental successes (10). Continuing divisiveness impedes progress and inhibits social interaction. Individual successes provide a foundation for greater trust and prepare a path for compromise. Healthcare is a commodity with mutual appreciation by both sides in this conflict. It offers an opportunity to begin a dialogue which can lead to well-being through improved healthcare and enhanced civility.

References

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