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INHERITED SYSTEMS, NEW REALITIES: NINETEENTH-CENTURY PUBLIC HEALTH LEGISLATION AND THE FORMATION OF THE PUBLIC HEALTH SYSTEM IN THE KINGDOM OF SERBS, CROATS, AND SLOVENES

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ABSTRACT

With the establishment of the Kingdom of Serbs, Croats, and Slovenes, the unification and organization of the healthcare system began throughout the new state. The regions inherited health, social, and sanitary laws, with some regulations inherited from the Habsburg Monarchy, while others differed from Habsburg legislation or were entirely absent. This article explores the organization of healthcare in the immediate post-World War I period, highlighting foundational aspects and the influence of regional legacies. A comparative, transnational perspective on public health structures across politically and socially diverse territories offers insight into postwar societal transformation, questioning whether systemic changes prevailed or traditional structures persisted.

Keywords: Kingdom of the Serbs, Croats and Slovenes, public health, healthcare laws, Ministry of Public Health, organization of public health

SISTEMI EREDITATI, NUOVE REALTÀ: LEGISLAZIONE SANITARIA DEL XIX SECOLO E FORMAZIONE DEL SISTEMA SANITÀ PUBBLICA NEL REGNO DEI SERBI, CROATI E SLOVENI

SINTESI

Con la nascita del Regno dei Serbi, Croati e Sloveni ebbe inizio il processo di unificazione e organizzazione del sistema sanitario. Le diverse regioni ereditarono normative in materia di salute, assistenza e igiene: alcune provenienti dalla Monarchia asburgica, altre divergenti o del tutto assenti. Questo articolo esamina l'organizzazione della sanità nell'immediato dopoguerra, mettendo in luce gli aspetti fondativi e l'influenza delle eredità regionali. Una prospettiva comparativa e transnazionale sulle strutture di sanità pubblica in territori politicamente e socialmente eterogenei offre spunti di riflessione sulla trasformazione della società nel primo dopoguerra, interrogandosi se a prevalere siano stati i cambiamenti sistemici o la persistenza delle strutture tradizionali.

Parole chiave: Regno dei Serbi, Croati e Sloveni, sanità pubblica, legislazione sanitaria, Ministero della Sanità Pubblica, organizzazione della sanità pubblica

INTRODUCTION[1]

Due to the political, social, economic, ethnic, and religious heritage of its constituent parts, the Kingdom of Serbs, Croats, and Slovenes (KSCS) was, from its foundation, a heterogeneous state and social entity. The distinctive characteristics of the pre-Yugoslav territories resulted in disparate levels of social development across various regions, including in the state of public health and hygiene. Public health has been a subject of scholarly inquiry since the nineteenth century and remains one of the central subjects in the study of state-building processes. Analyzing the structures of a complex system like public health allows for the exploration of numerous issues—not only from a purely medical perspective, but also in the context of daily life, economy, politics, and culture, making it an interdisciplinary subject of study (Toncich, 2022, 523).

Upon its establishment in 1918, the KSCS encompassed the territories of the former Kingdoms of Serbia and Montenegro, as well as regions formerly part of Austria-Hungary. These included Dalmatia, Carniola, parts of Styria, and temporarily parts of Carinthia (pending the 1920 plebiscite, after which only a small part remained in the Kingdom), which had belonged to the Austrian part of the empire. Additionally, Croatia, Slavonia, Srem, Bačka, Baranja, Prekmurje, and parts of Banat, which had previously been under Hungarian administration, became part of the new state, as well as Bosnia-Herzegovina, formerly a condominium of both parts of the Habsburg empire (Dimić, 2001, 35; Milenković, 1992; Griesser-Pečar, 2021; Mitrović, 1969). Across all domains of state governance in the KSCS, various laws, regulations, decrees, and traditions were introduced, depending on the state or regional entity to which they belonged. Health and/or sanitary laws and regulations were no exception, and consequently, six different health laws were in force (Dugac, 2024, 52).[2] Contemporary observers noted that in the early years of unification, the only thing that unified the regions was the budget: “It was understood, of course, that in the first instance, at least relatively, we were unified by the same state budget, while the rest was left to time for the various legislations to be harmonized” (Milovanović, 1933, 1).

The unification and organization of the healthcare system lasted a full decade, until 1929, by which time regulations had been enacted that standardized the laws across the entire territory (Pavlović, 2007, 39–40; Pivec, 2015, 20). Adopted in the second half of the nineteenth century, during a period of significant development in social and health policy, various inherited healthcare laws and regulations were

1 This article is the result of research conducted at the Institute for Recent History of Serbia, funded by the Ministry of Science, Technological Development and Innovation of the Republic of Serbia under the Contract on the implementation and financing of scientific research in 2024 (No. 451-03-66/2024-03/200016, 5 February 2024)

2 Glasnik Ministarstva narodnog zdravlja, 1–2, 1919: Privremena organizacija zdravstva, 26.

similar in nature and shared common objectives (Rafailović, 2022, 535). This can be attributed to the fact that all of them were derived, to varying degrees, from the 1870 Austrian Sanitary Law (*Reichssanitätsgesetz*) (Pivec, 2015, 19; Das, 2020; Gesetz, 1870).

Serbia adopted the Law on the Regulation of the Sanitary Service in 1881 (Zakon, 1881). In Croatia and Slavonia, the Law on the Regulation of the Healthcare Service was enacted in 1894 (Zakon, 1894), followed by the Law on Healthcare in 1906 (Zakon, 1906). In Slovene lands, the 1870 Austrian Sanitary Law was in effect, alongside the 1888 Law on Medical Service in Municipalities in the Crownland of Carniola (Zakon, 1888), as well as the 1892 Ordinance in Styria. In addition to these, other laws were in force in various provinces: the 1874 Law on the Organization of Medical Service in Municipalities in Dalmatia, and the Hungarian Sanitary Law, which was applicable in Međimurje, Bačka, and the Banat (Dugački & Regan, 2019, 51; Milovanović, 1933, 1).

This article examines the key administrative characteristics of the healthcare systems in Croatia-Slavonia, Serbia, and the Slovene lands during the nineteenth century, before moving on to analyze the organization of the healthcare system in the KSCS in the immediate post-World War I years. The paper has two primary objectives: first, to explore the development of modern health laws and the administration of healthcare structures; and second, to analyze, through a transnational perspective, the long-term transformation of society following the war by evaluating the healthcare legislation across various territories. The central question addressed is whether there were significant changes in the healthcare system or if continuity prevailed, with inherited traditions maintaining their influence.

THE ORGANIZATION OF THE HEALTHCARE SYSTEM PRIOR TO WORLD WAR ONE

Organization of Health System in Serbia

Serbia gradually developed its healthcare system throughout the nineteenth century, in parallel with the country's liberation from Ottoman rule (Veljković, 2011; Rajić, 2021). As in other European countries, healthcare institutions fell under the jurisdiction of the Ministry of the Interior. A more substantial reform and the formal organization of the healthcare system were introduced with the appointment of Dr. Vladan Đorđević as head of the Sanitary Department within the Ministry of the Interior in 1879.[3] Thanks to his efforts, two laws that laid the foundations for healthcare organization in the Serbia were enacted. The first was the Law on the National Sanitary Fund (1879), which regulated the functioning of medical services and unified all county-level funds. The second was the Law on the Organization of

3 Vladan Đorđević (1844–1930), was a physician, politician and writer, one of the most important Serbian statesmen and social figure in the nineteenth century (Rajić, Čolović & Ivanić, 2021).

Healthcare and Protection of Public Health (Zakon, 1881),[4] which provided more detailed regulations on the operation of medical services and established a structured healthcare system with an emphasis on medical education and the construction of county and district hospitals (Rajić, 2021). However, these well-conceived laws were not fully implemented due to frequent political conflicts, limited financial resources, and ongoing wars.

The 1881 Law, consisting of thirty-five articles, envisioned a tripartite structure of the healthcare system: the Central Administration, which included the Sanitary Department of the Ministry of the Interior, a chemical laboratory, and the Main Sanitary Council; Counties, along with the City of Belgrade, where the system encompassed physicians, veterinarians, county and municipal physicians, municipal midwives, institutions for disease prevention in humans and livestock, treatment facilities, as well as institutions for the care of the incurably ill, the disabled, the blind, and the deaf-mute; the State, which was responsible for the oversight of quarantines (Zakon, 1881; Mišić, 1921).

The Sanitary Department was responsible for overseeing medical personnel, managing medical schools, facilitating the education of students at foreign universities, studying prevalent diseases, preventing their spread, and ensuring that districts, municipalities, and hospitals were adequately staffed with medical professionals. It was also tasked with drafting legislation related to infectious diseases, among other duties. The Sanitary Council held an advisory role, providing expert opinions on major issues concerning healthcare and public hygiene. It participated in the preparation of the sanitary budget and supervised matters related to forensic medicine and public health enforcement, including police-sanitary affairs (Zakon, 1881, §§ 4, 6, 8).

The county physician served as the principal medical official of a county: "an official of the county administration (or of the town administration of the City of Belgrade) for medical matters." (Zakon, 1881, § 4) His primary responsibility was to "preserve the health of the population" (Zakon, 1881, § 5) within his jurisdiction. To fulfil this role, he was expected to be thoroughly informed about a wide range of public health conditions, including housing standards, water quality, clothing practices, childbirth and postpartum customs, the welfare of youth, the condition of public buildings, prevalent diseases, common hereditary illnesses, marriage customs, and burial practices. In addition to overseeing all other medical personnel, such as physicians, midwives, and apothecaries, the county physician was also responsibl e for public hygiene. He served both as a proponent of applied hygiene and as an epidemiologist, advocating for disease prevention and sanitary improvement. In this capacity, he was obligated to advise county, police, and municipal authorities on measures to eliminate threats to public health at both the household and community levels. Furthermore, he had both the right and the duty to monitor and enforce compliance with regulations enacted to control and eliminate sources of infection (Zakon, 1881, §§ 9–10).

4 Until World War I the law was amended and supplemented by the Law on Organization of Healthcare and Protection of Public Health adopted on March 30, 1881, with amendments and supplements introduced on June 11, 1884, March 4, 1891, January 14, 1900, January 17, 1905, and October 14, 1912 (Mišić, 1921).

A district physician was, according to the law, responsible for providing medical care to the population within a district, including both urban and rural areas, as well as in the district hospital, where he served as both manager and physician. He was also required to assist the county physician and report on relevant health matters. Furthermore, the district physician was empowered to petition higher authorities for the removal of any threats to public health within the district. He was obligated to promptly report the outbreak of acute diseases and to actively participate in efforts to combat contagious illnesses (Zakon, 1881, § 12).

A communal physician was permitted only in municipalities with more than 10,000 inhabitants and was financially supported by the municipality. His responsibilities included providing medical care to the local poor and the general population, administering vaccinations, monitoring marketplaces, fairs, and other public gatherings, supervising communal hygiene, and proposing health-preservation measures (Zakon, 1881, §14). The law also mandated the appointment of communal midwives in all municipalities with more than 5,000 inhabitants, as well as in towns, depending on their population size (Zakon, 1881, § 15).

Hospitals in Serbia were state-run institutions, financed through the Sanitary Budget (the Public Sanitary Fund within the First General State Budget). According to the 1865 Law on the Construction and Organization of Hospitals, an additional hospital tax of 1.60 dinars per taxpayer was introduced. Prior to the establishment of the Public Sanitary Fund in 1881, all hospital revenues were managed by the Administration of Funds. The creation of the Sanitary Fund in 1881 marked the formation of a formalized hospital budget. In cases of financial shortfall, the budget was supplemented with general appropriations from the state budget (Milovanović, 1933, 3).[5] Under the law, physicians in all public hospitals were obligated to provide medical services free of charge in the wards and to examine patients without compensation. The legislation also stipulated that wealthier patients were required to pay for hospital treatment, while the Sanitary Fund covered the expenses of all other patients (Zakon, 1881, § 26).

The Serbian law was considered modern for its time; however, the most significant shortcoming noted in the relevant literature was the lack of medical personnel, as well as the law's failure to address the needs of the agrarian population. As critics pointed out, "it simply forgot that the public healthcare system was intended primarily for the countryside and the peasantry" (Milovanović, 1933, 3). Another major issue was the lack of mechanisms for implementation, as the law did not provide adequate provisions to ensure its practical application. This issue was succinctly summarized in an article published in the *Glasnik Ministarstva zdravlja* in 1927, which stated: "The main thing was missing: enough physicians, enough means, enough understanding and willingness on the part of the authorities to implement the Law, and understanding and conviction in the power of medical science and hygiene on the part of the people."[6]

5 Glasnik Ministarstva narodnog zdravlja, oktobar 1927: Sanitetsko zakonodavstvo u našoj državi, 5.
6 Glasnik Ministarstva narodnog zdravlja, decembar 1927: Sanitetsko zakonodavstvo u našoj državi, 118.

Healthcare System in the Territory of Croatia-Slavonia

Efforts to organize the healthcare system in the territory of Croatia-Slavonia began in the mid-nineteenth century. Following the Croatian-Hungarian Agreement of 1868, which placed healthcare under the jurisdiction of the provincial Croatian government, and in response to outbreaks of cholera and smallpox, the first healthcare law was enacted in 1874 under Ban Ivan Mažuranić. This was the Law on the Organization of Healthcare in the Kingdom of Croatia-Slavonia. In the decades leading up to World War I, the healthcare system underwent significant reforms. It was expanded by the Law on the Associated healthcare communes and the Organization of the Healthcare Service adopted on January 24, 1894 (Zakon, 1894), and later by the 1906 Law on Pharmacy and the Law on Healthcare (Zakon, 1906; Dugački & Regan, 2019, 50–51, 53).

The 1894 Law on the Organization of the Healthcare Service laid the foundation for the medical service in the Kingdom of Croatia-Slavonia. It established healthcare-administrative regions with the aim of enforcing sanitary regulations within the jurisdictions of counties, districts, townships, and medical communes. At the top of the public healthcare system stood the Royal Provincial Government, which initially exercised direct control through healthcare departments and the Provincial Healthcare Council. Over time, the system evolved to follow a territorial-administrative structure. At the county level, there were county physicians and county healthcare commissions. In towns, the system included town physicians, town healthcare commissions, and town midwives. At the district level, district physicians operated, while in village municipalities, communal physicians, communal healthcare commissions, and communal midwives were active (Zakon, 1894, § 2). The Provincial Healthcare Council was responsible for providing expert opinions on all significant healthcare and hygiene-related issues, as well as for proposing appropriate solutions to the provincial government (Zakon, 1894, §§ 8–14).

The County Healthcare Council was the leading body of the county-level healthcare system. It was composed of the county physician, district physicians, the county engineer, a school inspector, a pharmacist, and members of the County Executive Board. The Council offered opinions and suggestions concerning healthcare-related issues and, during epidemics, played the role of an epidemic commission. It had the authority to issue decrees aimed at containing contagious diseases, which were to be implemented by county authorities. However, the grand county prefect retained the right to suspend the execution of such orders, referring the matter to the Provincial Government for a final decision (Zakon, 1894, §§ 16–19).[7]

As in Serbia, the county physician in Croatia-Slavonia oversaw the health of the population and supervised the entire county healthcare system. In the event of an epidemic, the county physician was authorized to order and coordinate measures for combating the outbreak and preventing its spread. He also supervised the

7 Glasnik Ministarstva narodnog zdravlja, oktobar 1927: Sanitetsko zakonodavstvo u našoj državi, 4.

implementation of these measures and was empowered to order the establishment of temporary hospitals as needed to contain and treat the disease (Milovanović, 1933, 4–5). He was permitted to engage in private medical practice, provided that such activity did not compromise the dignity of his official position (Zakon, 1894, §§ 20–23).

The competences of towns, as well as that of the marketplace of Ruma, were equivalent to those of district authorities. The law stipulated that each town must have one physician per 5,000 inhabitants, in addition to a Town Healthcare Commission. The roles and responsibilities of town physicians were identical to those assigned to district physicians (Zakon, 1894, §§ 24–35). The district physicians had duties similar to those of the county physician, but confined to the district level. His responsibilities included monitoring and reporting on the public health situation, overseeing the functioning of hospitals (excluding provincial institutions, i.e., state-funded hospitals), pharmacies, and schools, as well as addressing issues such as quackery, care for the poor, population vaccination, and disease control (Zakon, 1894, §§ 36–41).

The municipality, as the lowest administrative unit, carried out healthcare-related administrative tasks delegated by higher authorities. It was responsible for implementing sanitary and police regulations related to schools, public spaces, marketplaces, drinking water, public baths, providing assistance to the population in cases of disease and child-birth, participating in vaccination efforts, reporting on public health conditions etc. Each municipality was composed of one or more administrative communes, which were organized into either associated healthcare communes or independent healthcare communes, depending on their financial capacity and the availability of medical personnel.[8] Associated healthcare communes consisted of multiple administrative municipalities, with a total of 216 such communes encompassing 516 administrative municipalities. In contrast, independent healthcare communes comprised a single administrative municipality, with only thirty-four established in this form. The organizational structure of a healthcare commune was determined primarily by the availability of financial resources (Dugački & Regan, 2019).

The communal physician, confirmed by the grand county prefect, served as the head of the healthcare commune. His primary responsibilities included providing medical care to the population and serving as an epidemiologist in the event of a contagious disease outbreak. The law also mandated the establishment of communal healthcare services, organized around associated healthcare communes and supported by their respective financial foundations (funds) (Milovanović, 1933, 5–6).

Each county maintained a Fund of Associated Healthcare Communes, administered by the County Executive Board. This fund was financed through a combination of sources, including the already existing County Hospital Fund, hospital revenues,

8 Glasnik Ministarstva narodnog zdravlja, oktobar 1927: Sanitetsko zakonodavstvo u našoj državi, 6–7.

donations, grants, inheritances, fines for violations of police-sanitary regulations, annual direct taxes levied by the County Executive Board, and financial aid from other government sources. In addition, each Healthcare Commune was required to establish a Communal Healthcare Commission. The positions on this commission, held by the municipal physicians, a clerk, a pharmacist, a veterinarian, two aldermen, a priest, and a teacher, were honorary. During epidemics, the commission assumed the role of an advisory epidemic body.[9] When it came to hospitals, the 1906 Law on Healthcare envisioned two categories: provincial (state) hospitals operated by the government, and other hospitals and sanatoria, whether public or private, established with the permission of the Provincial Government. The costs of hospital treatments were borne by the patients themselves.[10]

Healthcare Organization in the Slovene Lands

The healthcare system in the (formerly) Cisleithan Slovene lands prior to World War I and during the subsequent decade was organized according to the principles set forth in the Austrian Sanitary Law adopted on April 30, 1870, which was later amended in 1876 and 1896. This legislation distinguished between the responsibilities of state and local authorities in the field of public health. The state retained authority over all major public health functions, while provincial laws, enacted by the diets of the crownlands, facilitated cooperation among provinces, towns, and municipalities, and at the same time granted municipalities a certain degree of autonomy in managing healthcare affairs (Slavec, 2017, 131; Dobaja, 2012, 122).[11]

Each Austrian crownland had its own legislation regulating medical services at the municipal level, adapted to local conditions. At the head of each crownland stood a prefect, who was supported by an expert Provincial Sanitary Council composed of a provincial healthcare official and five regular members. In every district, there was a healthcare council as well as a designated healthcare official, who was a licensed physician. For instance, Carniola consisted of eleven districts, while the city of Ljubljana (Laibach) had its own dedicated healthcare authorities, including a town physician, a police physician, who also served as coroner, a physician for the poor, two veterinarians, two town midwives, one medical official, and two staff members responsible for disinfection (Slavec, 2005, 59).

In accordance with the 1870 Austrian Sanitary Law, special healthcare regulations were enacted in Carniola in 1888 and 1889 (Zakon, 1888) and in Styria in 1892. In Styria, these provisions did not apply to the towns of Maribor (Marburg), Ptuj (Pettau),

9 Glasnik Ministarstva narodnog zdravlja, oktobar 1927: Sanitetsko zakonodavstvo u našoj državi, 7–8.

10 The law stipulated that in the event that a patient was unable to pay hospital expenses, employers should pay for their servants, parents for their children, the cooperative for its members, children for their parents, spouses or, ultimately, the city municipality for its members, an independent health municipality, or a county foundation of associated health municipalities for citizens (Zakon, 1906, § 72).

11 Glasnik Ministarstva narodnog zdravlja, decembar 1927: Sanitetsko zakonodavstvo u našoj državi, 121–123.

and Celje (Cilli), just as they were not enforced in Ljubljana in Carniola. These urban centers were granted the autonomy to organize their healthcare services according to their own regulations. The provincial laws delineated healthcare communes and districts, regulated their operations, and specified the duties and responsibilities of district and communal physicians (Slavec, 2005, 59; Dobaja, 2012, 123).

According to the law, each municipality was required to provide for its own public medical services, either independently or, in cases of insufficient funding, through cooperation with neighboring municipalities. When multiple municipalities joined together for this purpose, their collective sanitary jurisdiction was designated as a "healthcare district" (Zakon, 1888, §§ 1, 81). Healthcare districts were responsible for all matters related to public health within their jurisdiction. They collaborated with "district physicians," who were assigned to each municipality, with their residences determined by the provincial authorities (Zakon, 1888, §§ 5–7). In addition to overseeing the medical affairs of municipalities, physicians took general care of public health. Among other things, they also monitored the work of mid-wives, oversaw institutions for medical treatment and maternity care, fought quackery, administering vaccines, supervised the situation of vulnerable groups such as the deaf-mute or the blind. They were also responsible for providing medical care to the poor, to the patients in hospitals or in almshouses of "healthcare districts." In cases of epidemics they proposed measures to combat and contain the disease, organized isolation of patients if necessary and issued restrictions on public gatherings (Službeno navodilo okrožnim zdravnikom na Kranjskem, 1889; Slavec, 2005, 59; 2017, 131).[12] District physicians were supervised by heads of the healthcare commune or of the healthcare district (Zakon, 1888, § 14). There were 120 district physicians and approximately ten communal physicians serving in Carniola and Styria. Healthcare districts utilized their financial and organizational resources not only to meet routine medical needs but also to establish and operate their own hospitals (Slavec, 2005, 59).

From the above, it is evident that the laws and various legal regulations prior to World War I focused on public hygiene, applied medicine, and the development of public healthcare services. In all these territories, healthcare fell under the jurisdiction of the police and was primarily aimed at addressing hygienic and epidemiological issues. The organization of the healthcare system itself was based on the administrative-territorial structure.

ORGANIZATION OF THE HEALTHCARE SYSTEM IN THE KSCS

From a post-war perspective, healthcare and medical issues were no less significant than other social and state challenges. The healthcare system was decentralized, the number of hospitals inadequate, and bacteriological laboratories were lacking. In addition to the already high mortality rate, the population had been decimated both on the battlefield and by epidemics. Poor nutrition and inadequate hygienic conditions were widespread in both living and working environments. Infectious diseases such as

12 Glasnik Ministarstva narodnog zdravlja, decembar 1927: Sanitetsko zakonodavstvo u našoj državi, 121–123.

Table 1: Sanitary Organization in the Pre-WWI Territories of the Kingdom of Serbs, Croats, and Slovenes (Source: Milovanović, 1933, 8).

Country or Historical Province	County physicians –physicians	District physicians	Communal physicians	Hospitals	Hygienic service
Serbia	One per district (rarely two)	A significant number, but not present in every county	Only in larger district towns; rarely in rural municipalities	an insufficient number of hospitals	All public service physicians and hygienists involved. Preventive vaccination against smallpox, diphtheria, rabies. Infectious disease control. Insufficient number of physicians.
Montenegro	Not established	Present in most counties	Same	Same	Same, Insufficient number of physicians.
Croatia-Slavonia	One per county	One per district	Present in towns; considerable number in rural areas through associated health municipalities from 1894	Same	Same; greater number of physicians.
Cisleithan Slovene lands	Not established	Same	Present in towns; significant number in villages through associated health municipalities	Same	Same; greater number of physicians.
Bosnia-Herzegovina	One per district	Present in most counties	Present in towns; almost none in rural areas	Same	Same, Insufficient number of physicians.
Vojvodina	One per county	In every district	Present in towns; in villages a large number of physicians (*kerorvoš*)	Same	Same; large and nearly complete medical coverage
Dalmatia	Not established	In every district	Present in towns (that included surrounding villages).	Same	Same; significant number of physicians

tuberculosis, malaria, typhus, dysentery, measles, trachoma, and others were constantly present, while public awareness of hygiene remained low (Konstantinović, 1928).

Despite these challenges, efforts to organize the healthcare system and gradually address the existing problems began immediately after unification. While the scope of this paper does not allow for a detailed analysis, it is important to highlight that the key figures in shaping the healthcare system and policy of the KSCS were Dr. Milan Jovanović Batut,[13] Dr. Andrija Štampar,[14] and Dr. Ivo Pirc.[15] The first step in building the healthcare system was the establishment of a central institution in the aftermath of the World War I—the Ministry of Public Health (Pavlović, 2007, 39; Dugac, 2024). This was followed by the enactment of the Decree on the Organization of Public Health on May 14, 1919 (Uredba, 1919, 2–3), which carried the force of law. For the first time, it separated medical services from administrative control under the Ministry of the Interior.[16] The following year, on December 14, 1920, a new regulation—the Decree on Organization of Public Healthcare—was enacted. It replaced the earlier decree and served as the foundation of the healthcare system in the KSCS for the years to come (Uredba, 1920, 2).

The separation of the healthcare system from the Ministry of the Interior, along with the establishment of the Ministry of Public Health as a central institution, represented a significant advancement. The founding of this new institution signaled a shift in

13 Milan Jovanović Batut Sremska Mitrovica, 1847–Belgrade, 1940 was a physician and founder of hygiene, social medicine, and preventive medicine in Serbia. He obtained his medical degree in Vienna and began his medical practice in Sombor and as head of the Sanitary Department in Montenegro (1880–82). In 1882, with the support of Vladan Đorđević, Jovanović Batut continued his medical specialization in Munich, Berlin, London, and Paris. In 1887, he was appointed professor of public hygiene and forensic medicine at the Grand School in Belgrade, and in 1892 he was named rector of the institution. Following World War I, in 1919, he played a key role in the founding of the Faculty of Medicine in Belgrade, where he was appointed the first full professor of hygiene and served as the faculty's first dean. Public health education and the organization of the healthcare system formed the core of his professional work (Jović, 2002).

14 Andrija Štampar (Brodski Drenovac, 1888–Zagreb, 1958), was a physician and one of the founders of public health in the Kingdom of Yugoslavia. He earned his medical degree in Vienna and began his career as a physician in Nova Gradiška. From 1919 to 1930, he served as the head of the Hygiene Department at the Ministry of Public Health in Belgrade, where he laid the foundations for the national public health service and organized hygiene institutions. Afterward, he worked for the Health Organization of the League of Nations in Europe, the United States and in China. Following World War II, he served as Director of the School of Public Health, Rector of the University of Zagreb (1945–46), President of the Yugoslav Academy of Sciences and Arts (1947–58). In 1946, he became the first Vice-President of the UN Economic and Social Council and Chair of the Interim Commission. He also presided over the First World Health Assembly of the World Health Organization in Geneva in 1948 (Dugac, 2024; Hrvatska enciklopedija, 2025; for further, cf. Dugac, 2022; Salopek Bogavčić, 2022).

15 Ivo Pirc (Ljubljana, 1891–1967) was a physician and a key figure in the development of Slovenian public health between the two world wars. He studied medicine in Graz and Prague, and specialized in hygiene and social medicine in Prague and Berlin. After returning to Slovenia, he worked for the National Government. In 1923, he became director of the Institute of Hygiene in Ljubljana, a post he held until 1945, with a brief interruption (1933–35) due to political circumstances. He was reassigned as advisor to the Hygiene Institute in Skopje. During this period, he also completed studies in dentistry. After World War II, his career shifted to military service, where he was appointed Chief Medical Officer of the 10th Army. In 1950, he became chief epidemiologist at the Military Medical School in Ljubljana (Slavec, 2012).

16 Glasnik Ministarstva narodnog zdravlja, 1–2, 1919: Privremena organizacija zdravstva, 26.

healthcare policy—one that extended beyond purely police measures for combating contagious diseases and the treatment of individual patients or specific patient groups (Batut, 1920, 197; Dugac, 2024).

According to the Decree on the Organization of Public Health, the Ministry's responsibilities included promoting the health of the population, ensuring healthy progeny, protecting public health, preventing diseases, studying public pathology, and advancing health education. In terms of organization, the Ministry was divided into five departments: the Administrative Department, the Hygiene Department, the Department of Medical Services, the Department of Medical Research and Public Enlightenment, and the Pharmaceutical Department. The primary executive officials of the Ministry included the Minister, the Assistant Minister, heads of departments, inspectors, chiefs, clerks, and secretaries. Advisory bodies were also established, such as the Main Sanitary Council, and the Epidemic and Hospital Commissions. The Decree also provided for the creation of specialized medical institutes within certain departments of the Ministry. However, the Decree did not unify healthcare legislation across the Kingdom. Healthcare departments continued to exist in several provinces. These bodies, acting as organs of the Ministry, independently carried out tasks in accordance with the laws and decrees in force within their respective territories.[17] In accordance with this reorganization, former county physicians and district physicians in Dalmatia and Slovenia—as clerks of administrative authorities—were detached from those bodies and reassigned to newly established county or district healthcare administrations (Uredba, 1920, 2).

A new reorganization of the healthcare system was implemented in 1921 following the enactment of the Decree on the Organization of Sanitary Administrations and the Decree on County and District Sanitary Administrations. These decrees were later formalized into law on November 25, 1921. Although the decrees were well conceived, they were not completely implemented because physicians, regional inspectors, heads of county sanitary administrations and district physicians, often chose not to comply with the new regulations in order to retain their private practices. As a result, the reform largely remained "a framework with the title and nice program from the decrees" (Milovanović, 1933, 10). According to the Decree, former county physician and district physicians from Serbia, Montenegro, Bosnia-Herzegovina, Croatia, Slavonia, Međumurje, district physicians from Slovenia and Prekmurje as well as physicians from Banat, Bačka, Baranja, and Dalmatia were reassigned to special county and district administrations, i.e. to district sanitary administrations in Slovenia, Prekmurje, Istria and Dalmatia, whereas in major cities to sanitary administrations of the towns of Belgrade, Zagreb, Ljubljana, Sarajevo, Novi Sad, Split, Skopje, and Subotica (Novo sanitetsko zakonodavstvo, 1924).

In the years that followed, the healthcare system continued to develop in line with modern needs and by 1929, it had undergone a significant transformation. County

17 Health departments were established for Croatia, Slavonia, and Međimurje in Zagreb; for Slovenia in Ljubljana; for Bosnia-Herzegovina in Sarajevo, and for Dalmatia in Split. The responsibilities of these departments included proposing the implementation of existing health laws and regulations, appointing physicians and staff, opening pharmacies, all matters related to the suppression of infectious diseases, and supervising health institutions (Glasnik Ministarstva narodnog zdravlja, 1–2, 1919: Privremena organizacija zdravstva, 32).

physicians and sanitary clerks were abolished as a result of the administrative reorganization of the state, first into regions (1923) and then into *banovinas* (1929). Each district was assigned one physician, and in some cases two. Communal physicians remained, though their distribution varied considerably across different regions. The number of communal and village physicians was significant in the territories of Slovenia and Croatia (217), as well as in Dalmatia (37). In Vojvodina, each municipality had its own village physician. In contrast, communal physicians were few in Serbia, Montenegro, Bosnia-Herzegovina, and Macedonia. According to the *Medical Yearbook*, for example, the Drina Banovina (comprising eastern Bosnia and western Serbia) had no communal or village physicians as late as the end of 1932. The most significant progress was made in the fields of hygiene and epidemiology. According to Andrija Štampar, in the five years between 1920 and 1925, 250 healthcare institutions were founded, for which 170 buildings were either constructed or purchased (Štampar, 1925). The number of bacteriological institutions rose from just three or five before World War I to 304 various social-medical institutions by 1933. These institutions addressed a wide range of public health issues: dealing with hygienic promotion, combating infectious diseases, founding healthcare stations in villages, fighting TB, venereal diseases, trachoma, malaria, doing prevention work among schoolchildren and mothers, etc. (Milovanović, 1933, 23).

Before World War I, the healthcare system relied almost entirely on state authorities and government assistance. After the war, however, in addition to continued state support, numerous organizations played an active role in establishing and operating the new healthcare system. Among the most notable foreign organizations were the Rockefeller Foundation, the Serbian Child Welfare Association of America, and *Goutte de Lait*. Significant domestic initiatives included the Association for the Fight against Venereal Diseases and Alcoholism, the League against Tuberculosis, and others (Batut, 1934; Dugac, 2005; 2024).

CONCLUSIONS

A brief overview of the basic forms of healthcare organization across various territories with differing social and statist systems over the course of just a few decades leads to several conclusions. The organization of healthcare prior to World War I in the region was predominantly influenced by the Austrian model, with part of the territory directly under Austrian jurisdiction and the others enacting legislation inspired by the 1870 Austrian Sanitary Law. This system addressed hygienic and epidemiological challenges, particularly those related to infectious diseases within the framework of an administratively and territorially divided healthcare system.

After World War I, the public health system in the KSCS underwent significant transformation, marked by both innovations and the persistence of older structures. One of the most notable developments was the establishment of the Ministry of Public Health, which for the first time separated health affairs from the Ministry of the Interior, thereby acknowledging public health as an independent and essential state function. This institutional reorganization was accompanied by a series of legislative measures in 1919 and

1920 that sought to redefine the structure and responsibilities of the public health system. In 1921, new sanitary administrations were formed in an effort to unify and reorganize healthcare provision according to the emerging administrative framework of the postwar state. Considerable progress was made in expanding health infrastructure: by 1933, approximately 250 new institutions had been established, and the number of bacteriological laboratories rose dramatically from just a few before the war to over 300. International and non-governmental organizations, as well as local societies for combating infectious diseases, played a significant role in supporting these developments. Furthermore, a new emphasis was placed on public health and preventive care, with increased focus on hygiene, the control of tuberculosis, malaria, venereal diseases, and trachoma, and the improvement of maternal and child health, particularly in schools.

However, not all aspects of the system changed. Many prewar elements persisted into the postwar period. The territorial-administrative organization of healthcare remained closely aligned with political boundaries, such as districts and municipalities. The chronic shortage of medical personnel, including doctors and midwives, continued to hinder service delivery, especially in rural areas. Although the postwar period saw a growing role for non-state actors, the state still bore the primary responsibility for organizing and delivering health services. In addition, remnants of the earlier conception of health as part of a police-sanitary system remained evident, particularly in older legal frameworks that positioned public health within mechanisms of state surveillance and control.

These conditions paint a complex picture of public health in the aftermath of World War I. The overall situation was dire: the war, combined with widespread poverty, epidemics, and poor hygiene, resulted in high mortality rates and the spread of contagious diseases. Health infrastructure was inadequate, particularly in underdeveloped rural regions and the healthcare system in first decade after the war remained fragmented and decentralized despite the presence of a central ministry, with laws and regulations varying significantly across provinces. While there was clear political intent to implement reform, many of the new laws were only partially enforced.

Nevertheless, the period after World War I marked an important shift toward modernization and prevention in public health. This era can be characterized as a transitional phase, during which the foundations for a new, more unified healthcare system were laid. However, the process was neither immediate nor uniform across all regions. While efforts were made to establish new institutions, such as the Ministry of Public Health, and to develop a cohesive administrative framework, the legacy of the pre-war period remained influential. In many cases, pre-existing structures continued to operate in parallel with newly established ones. Certain provinces, particularly those with a stronger Austrian administrative heritage, retained their former healthcare departments and continued to function according to older laws and regulations.

As a result, the interwar period was marked by a complex interplay between continuity and change. It was a time of institutional experimentation, administrative consolidation, and the gradual development of a vision for public health one that sought to integrate the inherited systems while overcoming their limitations in order to meet the new social and political realities of the post-war era.

PODEDOVANI SISTEMI, NOVE REALNOSTI: JAVNOZDRAVSTVENA ZAKONODAJA V 19. STOLETJU IN OBLIKOVANJE JAVNOZDRAVSTVENEGA SISTEMA V KRALJEVINI SRBOV, HRVATOV IN SLOVENCEV

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POVZETEK

V obdobju po prvi svetovni vojni se je Kraljevina Srbov, Hrvatov in Slovencev soočila s kompleksno nalogo poenotenja raznovrstnih zdravstvenih sistemov, podedovanih iz različnih nekdanjih imperialnih držav. Čeprav je bil avstrijski model, s poudarkom na higieni in nadzoru nad epidemijami, pred vojno prevladujoč, je novonastala država začela znatne reforme, med drugim ustanovitev Ministrstva za narodno zdravje po prvi svetovni vojni. Namen teh sprememb je bil centralizirati in modernizirati javno zdravje ter vse bolj poudarjati preventivno zdravstveno varstvo, higieno in nadzor nad infektivnimi boleznimi. Sledil je tudi pomemben razvoj infrastrukture: do leta 1933 je bilo ustanovljenih približno 250 zdravstvenih ustanov, število bakterioloških laboratorijev pa se je znatno povečalo. K tem napredkom so prispevale tudi mednarodne in lokalne organizacije. Vendar so predvojne strukture in izzivi vztrajali. Zdravstveni sistem je ostal teritorialno razdrobljen, zdravstvenega osebja je primanjkovalo, zlasti na podeželju, starejši pravni okviri pa so še naprej vplivali na zdravstveno politiko. Medvojno obdobje je tako predstavljalo prehodno fazo, zaznamovano tako z inovacijami kot s kontinuiteto. Čeprav so nastajale osrednje institucije in so se začele reforme, so številne regije ohranile starejše sisteme, zlasti tiste z močnejšo avstrijsko upravno tradicijo. Rezultat je bil dvojni sistem, v katerem sta staro in novo sobivala, kar je odražalo napetosti med centralizacijo in regionalno raznolikostjo. To obdobje je združilo podedovane prednosti z novimi pristopi k reševanju javnozdravstvenih izzivov povojnega časa ter poudarjalo postopno usklajevanje namesto nenadne preobrazbe.

Ključne besede: Kraljevina Srbov, Hrvatov in Slovencev, javno zdravje, zdravstvena zakonodaja, Ministrstvo za javno zdravje, organizacija javnega zdravstva

SOURCES AND BIBLIOGRAPHY

Das, Flamm H. (2020): Werden Des Österreichischen Sanitätswesens – Vor 250 Jahren Das "Sanitäts-Hauptnormativ", Vor 150 Jahren Das Reichs-Sanitätsgesetz. Wiener klinische Wochenschrift, 132, 4, 115–152.

Dimić, Ljubodrag (2001): Istorija srpske državnosti. Knj. III, Srbija u Jugoslaviji. Novi Sad, SANU.

Dobaja, Dunja (2012): Pregled razvoja zdravstvene zakonodaje v Avstro-Ogrski monarhiji v letih 1867–1918. Zgodovina za vse, 19, 1/2, 121–135.

Dugac, Željko (2005): Protiv bolesti i neznanja: Rockefellerova fondacija u međuratnoj Jugoslaviji. Zagreb, Srednja Europa.

Dugac, Željko (2022): Andrija Štampar i uspostava javnozdravstvenog sustava. Zagreb – Velika Gorica, Hrvatska akademija znanosti i umjetnosti.

Dugac, Željko (2024): Building an Original and Internationally Standardized Public Health System in the Kingdom of Yugoslavia. Acta historiae medicinae, stomatologiae, pharmaciae, medicinae veterinariae, 43, 1, 51–64.

Dugački, Vlatka & Krešimir Regan (2019): Povijest zdravstvene skrbi i razvoja zdravstvenih ustanova na hrvatskom prostoru. Studia lexicographica, 13, 25, 35–74.

Gesetz (1870): Gesetz, betreffend die Organisation des öffentlichen Sanitätsdienstes, Bezeichnung des Kundmachungsorgans, Reichsgesetzblatt für die im Reichsrath vertretenen Königreiche und Länder, 25, 12. 5. 1870.

Glasnik Ministarstva narodnog zdravlja. Belgrade, Ministry of Public Health, 1919–1928.

Griesser Pečar, Tamara (2021): Koroška deželna vlada in koroške politične stranke – poskus doprinosa k razumevanju razmer na Koroškem pred plebiscitom. Acta Histriae, 29, 4, 989–1014.

Hrvatska enciklopedija (2025): Leksikografski zavod Miroslav Krleža, Štampar, Andrija. https://www.enciklopedija.hr/clanak/stampar-andrija (last access: 2025-05-19).

Jovanović-Batut, Milan (1920): Glavni pravci naše zdravstvene politike. Glasnik Ministarstva narodnog zdravlja, 6, 197–202.

Jovanović-Batut, Milan (1934): Radovi oko unapređenja sanitetske struke i narodnog zdravlja u našoj zemlji za poslednih 60 godina. In: Štampar, Andrija (ed.): Deset godina unapređivanja narodnog zdravlja. Zagreb, Narodne novine, 1934, 5–13.

Jović, Milan (2002): Jovanović Batut (1847–1940). In: Sarić, R. Miloje (ed.): Život i delo srpskih naučnika vol. VIII, II. Belgrade, Srpska akademija nauka i umetnosti, 1–28.

Konstantinović, Bogoljub (1928): Narodno zdravlje. In: Jubilarni zbornik života i rada Srba, Hrvata i Slovenaca, vol. 1. Belgrade, Matica živih i mrtvih SHS, 118–140.

Milenković, Toma (1992): Državne granice Kraljevine Srba, Hrvata i Slovenaca. Istorija 20. veka, 10, 1/2, 9–25.

Milovanović, Vojislav (ed.) (1933): Organizacija saniteta u Jugoslaviji (1933). Medicinski godišnjak Kraljevine Jugoslavije. Belgrade, Jugoreklam KD, 1–23.

Mišić, Mioljub (ed.) (1921): Zakon o uređenju sanitetske struke i o čuvanju narodnog zdravlja. Belgrade, Sv. Sava.

Mitrović, Andrej (1969): Jugoslavija na konferenciji mira: 1919–1920. Belgrade, Zavod za izdavanje udžbenika Socijalističke Republike Srbije.

Novo sanitetsko zakonodavstvo (1924): Belgrade, G. Kon.

Pavlović, Momčilo (2007): Zdravstvena služba u Kraljevini SHS/Jugoslaviji 1919–1941. In: Pavlović, Momčilo (ed.): Zbornik radova sa XV naučnog skupa Istorija medicine, farmacije i narodne medicine, održanog 24–25. maja 2006. godine u Zaječaru. Belgrade – Zaječar, Institut za savremenu istoriju – Istorijski arhiv "Timočka Krajina", 39–48.

Pivec, Gregor (2015): Legal Basis for the Development of the Slovenian Health System – from the Enlightenment to the Second World War. Acta Medico–biotechnica, 8, 2, 13–22.

Rafailović, Jelena (2022): Comparison of Social Insurance Legislation of The Austro-Hungarian Monarchy and The Kingdom of Yugoslavia – Legal Inheritance. Annales, Series Historia et Sociologia, 32, 4, 535–546.

Rajić, Suzana (2021): Prvi zakon o zaštiti zdravlja u Kraljevini Srbiji. In: Rajić, Suzana (ed.): Suzbijanje epidemija u novovekovnoj Srbiji: Institucionalni okviri i praktični dometi. Belgrade, Filozofski fakultet, 67–83.

Rajić, Suzana, Čolović, Radoje & Dušan Ivanić (2021): Vladan Đorđević. Srpska enciklopedija, III/2. https://srpskaenciklopedija.rs/books/slovo-dj/page/djordjevic-vladan (last access:2025-05-09).

Salopek Bogavčević, Iva (2022): Prilog proučavanju početaka medicine narodnog zdravlja od 1912. do 1919. s naglaskom na djelovanje Andrije Štampara. Acta medico-historica Adriatica, 20, 1, 51–82.

Slavec, Zvonka Zupanič (2005): Razvoj javnega zdravstva na slovenskem med prvo in drugo svetovno vojno; Dr. Ivo Pirc (1891–1967): Utemeljitelj javnega zdravstva na slovenskem. Ljubljana, Inštitut za varovanje zdravja RS.

Slavec, Zvonka Zupanič (2012): Dr. Ivo Pirc (1891–1967) in razvoj javnega zdravja na Slovenskem (1923–1941). Zdravniški vestnik, 81, 2, 163–171.

Slavec, Zvonka Zupanič (2017): Zgodovina zdravstva in medicine na Slovenskem. Medicina skozi čas, javno zdravstvo, farmacija. Ljubljana, Slovenska matica – Znanstveno društvo za zgodovino zdravstvene kulture Slovenije.

Službeno navodilo okrožnim zdravnikom na Kranjskem (1889): Deželni zakonik za vojvodino Kranjsko, III, 3. april 1889.

Štampar, Andrija (1925): Pet godina socijalno-medicinskoga rada u Kraljevini Srba, Hrvata i Slovenaca. Zagreb, Institut za socijalnu medicinu Ministarstva narodnog zdravlja.

Toncich, Francesco (2022): Inside and Outside the Habsburg Public Health System. Annales, Series historia et sociologia, 32, 4, 523–534.

Uredba (1919): Uredba o ustrojstvu narodnog zdravlja. Službene novine Kraljevstva Srba, Hrvata i Slovenaca, 49, 29. 5. 1919.

Uredba (1920): Uredba o ustrojstvu narodnog zdravlja. Službene novine Kraljevine Srba, Hrvata i Slovenaca, 287, 24. 12. 1920.

Veljković, Snežana (2011): Sanitetsko zakonodavstvo u Srbiji u 19. veku. In: Dimitrijević, Brana (ed.): 800 godina srpske medicine: zbornik radova drugog naučnog 800 godina srpske medicine. Belgrade, Infinitas, Srpsko lekarsko društvo, 11–22.

Zakon (1881): Zakon o uređenju sanitetske struke i o čuvanju narodnoga zdravlja. Srpske novine, 75–80, 4–10.4.1881.

Zakon (1888): Zakon z dne 24. aprila 1888. s katerim se uravnava zdravstvena služba v občinah, veljaven za Vojvodino Krajnsko, brez deželnega stolnega mesta Ljubljane. Deželni zakonik za vojvodino Kranjsko, IX, 30. 5. 1888.

Zakon (1894): Zakon od 24. siečnja 1894. o uredjenju zdravstvene službe u Kraljevinah Hrvatskoj i Slavoniji. Liječnički vjesnik: glasilo Hrvatskoga liječničkog zbora, 16, 3, 14–15. ožujak 1894.

Zakon (1906): Zakon od 25. ožujka 1906. o zdravstvu. Sbornik zakona i naredaba valjanih za Kraljevine Hrvatsku i Slavoniju, VII, 19, 14. 3. 1906.