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CURING AND BUILDING TRUST: STATES, DOCTORS AND PATIENTS IN POST-HABSBURG PUBLIC HEALTH SYSTEMS. A BORDER HISTORY OF PUBLIC HEALTH

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ABSTRACT

This paper transnationally examines the crucial role of public health after the collapse of the Habsburg Empire, focusing on the new borderlands around the Slovenian part of the Kingdom of Serbs, Croats, and Slovenes: the "Rapallo Border" with the Italian Kingdom and the border with the Republic of German Austria, which cut through the former Duchies of Styria and Carinthia. Health and disease played central roles in redefining identities, legal affiliations, and trust-based relationships between civilians, physicians, and the new "successor states". This text offers a broader view of public health, moving beyond state-centred perspectives to include the "patient's viewpoint" and the intimate doctor-patient relationship.

Keywords: public health, post-WWI, trust, borderlands, KSCS Slovenia, Italian Julian March, Austrian Styria, Austrian Carinthia

CURARE E COSTRUIRE FIDUCIA: STATI, MEDICI E PAZIENTI NEI SISTEMI SANITARI PUBBLICI POST-ASBURGICI. UNA STORIA DI CONFINE DELLA SANITÀ PUBBLICA

SINTESI

Questo contributo analizza, in prospettiva transnazionale, il ruolo cruciale della sanità pubblica dopo il crollo dell'Impero asburgico, con particolare attenzione alle nuove zone di confine della regione slovena all'interno del Regno dei Serbi, Croati e Sloveni: il cosiddetto "confine di Rapallo" con il Regno d'Italia e il confine con la Repubblica austro-tedesca, che attraversava la Stiria e la Carinzia. La salute e la malattia ebbero un ruolo centrale nella ridefinizione delle identità, delle appartenenze giuridiche e dei rapporti di fiducia tra civili, medici e i nuovi "stati successori". Il testo propone una visione più ampia della sanità pubblica, andando oltre le prospettive incentrate sullo Stato per includere il "punto di vista del paziente" e la dimensione intima del rapporto medico-paziente.

Parole chiave: Sanità pubblica, primo dopoguerra, fiducia, terre di confine, Slovenia nel Regno dei Serbi, Croati e Sloveni, Venezia Giulia italiana, Stiria e Carinzia austriaca

INTRODUCTION – PUBLIC HEALTH IN TRANSITION: JUST A MATTER OF STATES' GOVERNANCE?[1]

In recent years, particularly in the context of the First World War centenary, there has been a resurgence in historical scholarship that has re-evaluated and deconstructed linear narratives of state- and nation-building in Central Europe following the dissolution of the Habsburg Empire. This renewed focus has reconsidered classical historical interpretations of the post-war transition in Central and Southern Europe, which have traditionally concentrated on the actions of states, political parties, and diplomatic conflicts, typically framed from a national perspective (Wörsdörfer, 2004; Cattaruzza, 2017; Rahten, 2020; Pupo, 2021). In addition, it has expanded to address the so-called "Habsburg legacy", shedding light on the complex and often contradictory continuities of cultural, economic, and administrative structures from the former empire, as well as the resilience of civil societies within the successor states (Timms & Robertson, 1994; Becker & Wheatley, 2020; Becker et al., 2020; Pudłocki & Ruszała, 2021). Within this broader historiographical shift, the North Adriatic region has received increasing scholarly attention through interdisciplinary and transnational approaches, drawing on methods from microhistory, social and cultural anthropology, and postcolonial and gender studies (Verginella, 2016; Klabjan, 2018; Kirchner Reill, 2020). Nationalist narratives have been critically re-examined through the lens of non-normative experiences, including those of "stateless" or "alien" individuals and the emergence of new "national minorities" within the post-imperial nation-states (Promitzer, Hermanik & Staudinger, 2009; Hametz, 2019; Marelja, Pilipović & Athik, 2021).

Despite this shift in perspective, the severe humanitarian and sanitary crises that followed the war – malnutrition, epidemic diseases such as the "Spanish flu", typhus, and tuberculosis, along with psychological disorders like "shell shock" – have remained marginal in broader historiographical debates. Issues such as disease, public health, and social welfare have often been interpreted narrowly, primarily as tools of state control and repression, dismissing topics connected with "health" and "disease" as minor "epiphenomena" (Peckham, 2016, 9–10). However, recent scholarship offers a more nuanced view, framing public health as a contested arena where diverse social actors express and negotiate sociopolitical and cultural claims (Berridge, Gorsky & Mold, 2011). The transformative impact of the late nineteenth-century "bacteriological revolution" and the urgent sanitary needs during the First World War significantly shaped both civil society and state structures in the twentieth century (Eckart, 1996; Sarasin et al., 2007; Hofer, Prüll & Eckart, 2011; Reid, 2017). Growing demands for improved sanitary services became closely linked to civil rights, civic identity, and

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[1] This article is a result of the research project *Public Health in Transition (1918–1924)*, which the author conducted at the Department of History of the Faculty of Arts, University of Ljubljana between 2022 and 2024, with funding from the Marie Skłodowska-Curie Actions (HORIZON-MSCA-2021-PF-01, No. 101068435).

political participation – issues that modern states increasingly addressed from the late nineteenth century onwards, paving the way for early welfare state models (Obinger, Petersen & Starke, 2018).

Anti-epidemic and hygiene measures during the First World War had lasting effects throughout the twentieth century, becoming tools for excluding “aliens” and eliminating perceived “enemies” (Weindling, 2000; Trubeda, Promitzer & Weindling, 2021). Alongside physicians and bureaucrats in constructing a new “world of walls” (Slobodian, 2018), former Habsburg scientists and Central European experts played key roles in shaping new forms of international public health cooperation. They constituted a notable “international civil society”, active within a hybrid “grey zone” between science, diplomacy, and local governance (Herren, 2014, 8). This scholarship highlights the interdependence of local, national, and international spheres, challenging notions of absolute state sovereignty. Sanitary zones, cordons sanitaires, and epidemic border controls became testing grounds for emerging state practices and institutions such as the League of Nations’ Health Organisation (Silverstein, 2020).

From this more dialogical perspective, the post-war transition emerges not as a straightforward state-to-state process, but as a far more complex interplay of continuities and innovations, involving a range of actors – including non-state ones – from both former and emerging systems (Planert & Retallack, 2017; Egry, 2019). Records of public health management in border areas reveal a less monolithic image of the new states and highlight the significant role played by professional and non-state actors. They underscore the centrality of health in everyday life and its influence in reshaping legal and socio-cultural affiliations – aspects that historiography has often attributed solely to political and legal processes. A border history of public health offers fresh insights into the complex reconfiguration of spaces, identities, and affiliations after the First World War, with long-term consequences throughout the twentieth century. It reveals how post-war mechanisms of inclusion and exclusion were shaped not only by legal or national criteria (Caglioti, 2021), but also by broader social, economic, cultural, medical, and even emotional factors. It further shows how the new borders often marked merely an ideal line of separation, where, in theory only, “one nation’s space ends and that of the ‘other’ begins” (Grandits, 2025, 6). Accordingly, this article adopts a transnational approach based on a broader scope of research, drawing on sources in multiple languages produced by various state authorities and preserved in archives located in three present-day countries: Slovenia, Italy, and Austria. This approach not only seeks to compare different states, public health systems, and societies, but also challenges the prevailing state- and doctor-centred narratives, which assume that healthcare lies exclusively within the domain of state and professional control.

Studies on healthcare and citizenship have largely focused on the role of the state or socio-political actors, often subsuming public health within a broader history of welfare or of rights, while overlooking the contributions of medical and psychiatric sciences. Framing healthcare solely through the lens of legal citizenship oversimplifies the issue, reducing medical systems to national political traditions bound by rigid legal frameworks (Oosterhuis & Huisman, 2014). By adopting the patient's viewpoint and advancing a bottom-up history of public health and medicine (Porter, 1985), a more dynamic and nuanced understanding emerges. This approach offers a richer framework for rethinking the complex developments following the collapse of the Habsburg Empire in the Alps-Adriatic borderlands. Public health is best understood as a multi-layered and hybrid space situated at the intersection of public and private life (Karge, Kind-Kovács & Bernasconi, 2017). It extends beyond biopolitical and biomedical domains, encompassing intimate, emotional, psychological, and fiduciary dimensions. The personal dynamics between patients, professionals, and institutions challenge conventional biopolitical models, which often portray patients as passive recipients within a top-down system (Foucault, 1997). Biopolitics is only one dimension of a more intricate reality, in which public health also functions as a space for social, medical, and emotional interaction. A research perspective grounded in praxeology (Reckwitz, 2003) and the history of emotions (Frevert, 2011; Scheer, 2012) is therefore vital for capturing the multifaceted nature of public health. Moreover, the patient's viewpoint reveals more than individual suffering, as it draws attention to relationships with medical staff, family, and social networks. Finally, by examining how bodies, minds, and health shaped new territories, boundaries, and identities, the patient's viewpoint supports a transnational perspective grounded in the analytical framework of medical anthropology, highlighting the agency of local societies in shaping post-war borders, where boundaries often became zones of passage rather than rigid divisions (Verginella, 2008, 3).

HEALTHCARE, GOVERNANCE, TRUST

"[The] Military Medical Corps fulfilled its challenging task brilliantly, earning the trust of hostile populations by delivering substantial humanitarian benefits and excelling in its propaganda efforts" (ASTs, RCGC AG, V: b. 224/2, f. report on 22 February 1919)[2]. In February 1919, the Italian Military Governorate of the Julian March reported on the dire health conditions in the newly conquered "new provinces". Health facilities were poorly managed due to the region's proximity to the Isonzo/Soča Front, with significant shortages of medical staff in the vast Karst region. Italian military doctors, instructed by the governorate, carried out civilian physician roles during severe outbreaks of infectious and epidemic diseases among the local Slovenian-speaking population. The post-war influx of migrants, particularly via the (former) Austrian Southern Railway and the reactivation of the port of Trieste/Trst, heightened the fragility of the still-contested border, which remained under negotiation at Saint-Germain-en-Laye. Facing these challenges, the governorate recognised the essential role of military doctors in asserting governance among the hostile yet needy population (Kacin-Wohinz & Pirjevec, 2000; Vinci, 2012; Svoljšak & Godeša, 2013). In doing so, it emphasised the importance of building "trust".

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[2] Translations of cited non-English sources and secondary literature are provided by the author.

By March 1920, the Kingdom of Serbs, Croats, and Slovenes (KSCS) was focused on consolidating its northern border with the German-Austrian Republic, having occupied Southern Carinthia in November 1918 (Rahten, 2020, 118–130). While the Saint-Germain treaty of September 1919 divided the former Duchy of Styria along the Mur/Mura River, Southern Carinthia's fate, tied to its bilingual German- and Slovenian-speaking population, remained fiercely contested, pending a referendum in October 1920 (Weimann, 2008). As military and political violence escalated (Wernitznig, 2021), the Slovenian health chief of the KSCS Drava Military Division in Carinthia highlighted the crucial role of public health in shaping political and military outcomes:

> *In view of the future plebiscite,* [...] *the people here could lose trust in our administration if their interests are not adequately addressed. Prompt medical assistance and the availability of hospital treatment are of great importance and must not be underestimated in any way.* (ARS, ZOzSiI: b. 13, f. 2199)

In the geopolitically contested and culturally mixed new border regions, the post-Habsburg successor states faced strikingly similar challenges and used public health as a tool to implement their political agendas to assert control and governance over ethnically non-homogeneous societies. Even though they secured legitimacy through the international peace treaty in Paris, successor states struggled – and sometimes failed – for years after the war to stabilise factual control over border regions – such as the Karst, Styria, and Carinthia – amidst widespread trauma, mental health issues and the spread of infectious diseases. Amid rising demand for social care and protection in the aftermath of a total war (Obinger, Petersen & Starke, 2018), this fostered disillusionment and mistrust towards new "uncertain states" (Hametz, 2013).

The emphasis placed by military authorities on rebuilding "trust" – rather than "loyalty" – through healthcare in borderlands reflects an acknowledgment of the limitations of absolute governance (Hametz, 2022). Sociologically, "trust" serves as an efficient means of reducing complexity and mitigating growing anomie within a social (dis)order. However, trust inherently disrupts absolute hierarchical, vertical dynamics – such as top-down state-society relations – and promotes a more horizontal relationship among counterparts, fostering mutual relationships through negotiations and interdependencies (Luhmann, 1973, 6–7).

Post-Habsburg societies generally faced a widespread erosion of trust and a "loss of meaning", driven by several factors, some of which stemmed directly from the wartime period. Already during the final years of the First World War, the catastrophic management of civilian life by the Austrian imperial authorities and the "military dictatorship" imposed by army and state institutions during the conflict led to growing disaffection among local communities and Austro-Hungarian citizens towards the Habsburg crown (Judson, 2016, 391–407). This disaffection ultimately contributed to the final collapse of the imperial state structure and disrupted traditional loyalty and trust relationships within local populations and towards state institutions (Boyer, 2018, 19). Material, financial, and human resource shortages, infrastructure disruptions, political, social, and economic instability, and increasing postwar violence further deepened societal disillusionment in the immediate postwar situation (Konrád & Jučera, 2022).

Particularly for local communities in the new border areas between the successor states, the end of the war did not mark the end of violence and trauma, as warfare seamlessly transitioned into a postwar environment characterised by ongoing violence. This was driven by militarisation aimed at enforcing strict control over newly acquired border regions, as well as by the emergence of paramilitary forces. The sense of instability and daily threat in regions such as Styria, Carinthia, and the Julian March was further intensified by rising ethnic tensions, stemming from the presence of "national minorities" within the borders of the successor states (Kacin & Verginella, 2008; Pahor, 2009; Svoljšak & Godeša, 2013; Klabjan, 2018; Vreča, Zangger & Močnik, 2018; Wernitznig, 2021).

The two sources quoted above reveal both elements of novelty and continuity in the management of wartime public health in the postwar period. Primarily, the enlistment of doctors into the armies during the war not only led to a prolonged state of emergency and need due to the shortage of physicians, but also had enduring consequences over the medical class and individual professionals. This initial lack of medical personnel left local communities exposed to health crises with little support. In addition to this, another form of brain drain developed, as many doctors left their positions due to the exhaustion caused by the war – more precisely, by the "militarisation of medicine" and exposure to industrialised warfare and violence (Harrison, 1996) – as well as the new political context that emerged after its end (Hofer, Prüll & Eckart, 2011, 17–19). As a result, the majority of public doctor positions remained vacant for years after the war – particularly in rural areas, such as Slovenian Styria or the Karst region – posing a significant challenge to state public health policies in the newly acquired territories.

Persistent sanitary emergencies inherited from the war were significantly exacerbated by escalating socio-medical challenges, most notably the widespread presence of war invalids – both physically and psychologically wounded – whose visibility and mobilisation in seeking state protection became a major source of political, social, and identitarian polarisation in postwar societies (Cornwall & Newman, 2016; Reid, 2017). Alongside these war-related pressures, more long-standing and deeply rooted structural factors also shaped the relationship between the successor states and local populations in the territories of the former empire.

From the 1870s onwards, the Habsburg Monarchy progressively introduced a systemic and advanced legislative framework to regulate public health and social insurance: the Austrian parliament passed the Imperial Sanitary Act in 1870, reorganising the public health system, and in 1888 enacted the first comprehensive and systematic workers' insurance law, in parallel with similar reforms in the German Empire (Köhler & Zachler, 1980). This system of health and social protection – absent in other European states, such as the neighbouring Kingdom of Italy – fostered a growing sense of state responsibility for social welfare while simultaneously raising public expectations of state support among local communities, which endured well after the First World War (Wedrac, 2013; Giorgi & Pavan, 2021, 81–82; Mezzoli, 2022; Rafailović, 2022). Well before the postwar demands for social and medical care for war invalids, the expansion of social rights in the Habsburg Empire – closely tied to the extension of political rights and the representation of the working classes in the late nineteenth century – had already established a robust legal relationship between the state, local authorities and institutions, and the civilian population. This Habsburg legacy clashed with the fragmented and uncertain postwar reality, presenting the successor states – which lacked similarly advanced welfare systems – with the considerable challenge of upholding a tradition of public health and social protection, while also meeting the expectations of thousands of new citizens and former imperial subjects (Balińska, 1995; Hametz, 2022).

In this challenging context, the military authorities of the postwar successor states initiated repeated and coordinated efforts to rebuild networks of "trust".

"BY KIND CONCESSION": PUBLIC HEALTH IN THE SERVICE OF STATES' BIOPOLITICAL AGENDA

Three successor states, each with their own political and administrative structures and specific characteristics – the centralised Kingdom of Italy, the federalist multinational KSCS, and the federalist Republic of (German) Austria – sought to impose their distinct public health models. In Slovenian territory, the Yugoslav kingdom established the Health Department for Slovenia and Istria (*Zdravstveni odsek za Slovenijo in Istro*) in November 1918. Based in Ljubljana up until 1925, it mostly aimed to tackle critical health issues in border regions like Styria and Carinthia, still governed by Habsburg laws. Across the "Rapallo border", the Italian-occupied territories endured "armed pacification" under the Royal Military Governorate of the Julian March (first *Regio Governatorato Militare della Venezia Giulia*, from July 1919 *Commissariato Generale Civile per la Venezia Giulia*). Meanwhile, the Republic of German Austria faced severe economic, political, and social crises as well as border disputes, including fighting the KSCS army over the division of Carinthia and Styria. Regional governments and local authorities, inheritors of the former monarchy's crownlands, led the transition in the public health system.

Although these three statehood models differed significantly, they shared weaknesses in central authority and a reliance on regional and local institutions, which became the primary decision-makers during the transition. Local military and civil institutions asserted their power through self-legitimising declarations and practices, propagandistically leveraging direct relationships with medical personnel to reinforce state-society hierarchies. This was exemplified by the Italian military governorship in Trieste which, upon opening outpatient clinics for endemic, chronic, or epidemic diseases in Gorizia/Gorica and its province, repeatedly declared that public health facilities were available to civilians "by kind concession of the health directorate of the Army Corps" (ASGo, ASCGo: b. 1079, f. 109). However, this authoritarian, paternalistic narrative showed cracks, as their respective agendas often failed in practice.

From the state perspective, public health was seen as an effective tool for governing culturally diverse populations, serving both as a means of building trust through soft power and as a biopolitical instrument of control, coercion, and exclusion. As early as November and December 1918, states began using public health facilities to address the complexities of ethnolinguistic diversity and the unclear legal status of individuals within the new post-war borders (Dalle Mulle, Rodogno & Bieling, 2023). Hospitals became key mechanisms for determining legal status and deciding who to include or exclude. These selection practices were part of a broader trend of state intervention in social welfare and "social medicine" during and after the First World War in Europe (Hubenstorf, 1981; Obinger, Petersen & Starke, 2018). Anti-epidemic and hygiene measures, linked to eugenic theories and racial politics, had long-term consequences, becoming political and social tools for controlling and eliminating internal "aliens" or "enemies" (Weindling, 2000).

The most pragmatic approach was to implement control over the new borders. The "medicalisation of borders" became essential to making new borders visible, through medical control facilities at checkpoints, during a critical time marked by massive post-war migration flows (Trubeda, Promitzer & Weindling, 2021). At the Italian-Yugoslav border, both states collaborated in establishing a cordon sanitaire during epidemics such as typhus, cholera, tuberculosis, and flu. Bilateral agreements between successor states governed medical border control following the Saint-Germain treaty. Between 17 and 29 November 1919, a conference in Ljubljana resulted in a bilingual agreement to establish a cordon sanitaire along the new border, particularly at the Italian-Yugoslav train stations of Logatec, Podbrdo-Bistrica Bohinjsko Jezero, and Rateče-Kranjska Gora (ASTs, RCGC AG, V: b. 225, f. 2203). This was one of the few conferences held by the post-Habsburg successor states to address common issues, together with those in Portorož/Portorose (1921) and Graz (1922) regarding passports (Becker, 2020). The Ljubljana conference also created categories for "medically dangerous patients", including "refugees", "prisoners of war", and "gypsies". Interestingly, this agreement predated the formal Italian-Yugoslav border agreement in the Rapallo Treaty signed on 12 November 1920, highlighting strong pragmatism in developing contextual governance strategies to manage complex cross-border emergencies among successor states.

Consequently, for instance, the military and civil authorities in the Italian Julian March sent the municipalities weekly lists of individuals, private citizens, who had entered Italy from the KSCS with their personal data and addresses. State intrusion into the private lives and free movements of individuals was justified by the outbreak of tuberculosis, flu or typhus epidemics in some Yugoslav regions, and resulted in these individuals being placed under strict medical surveillance (ASGo, ASCGo: b. 1168, f. 1195).

Post-war transborder epidemiological surveillance was not entirely new in the former Habsburg lands. From the early nineteenth century, the Austrian Empire had adopted varied quarantine measures and medicalised border controls during epidemics, notably cholera (Jesner, 2021). Following international trends in pandemic governance (Promitzer, 2021), the Habsburgs revised traditional sanitary systems after the mid-nineteenth century, contributing to the global spread of "Neo-Quarantinism" (Baldwin, 1999, 141). These reforms, while rooted in older practices, created new dynamics between centres and peripheries, as local authorities often managed border control during health crises (Watzka, 2021). This federalised structure sometimes hindered efficiency but also shaped the skills and outlooks of local officials. In the Upper Adriatic, such practices developed in the late nineteenth century, especially during cholera outbreaks (Bratož, 2017). After the 1866 war, when the Austrian Littoral's border became the Austrian-Italian state frontier, the Trieste Lieutenancy and municipal authorities managed cordons sanitaires and coordinated with Italian officials in Udine and Friuli. During the 1885–86 cholera wave, the two sides jointly operated quarantine controls at railway stations in Cervignano and Cormons (Toncich, 2021, 251–252). It is plausible that, after the end of the First World War, this body of know-how held by local, regional, and municipal authorities and bureaux was reactivated and employed by the successor states in order to establish a cordon sanitaire along the new border.

CREATING BORDERS IN THE HOSPITAL WARD

Hospitalisation after November 1918 became a particularly challenging experience for a large number of indigent individuals. Entering a hospital could mark the beginning of a nightmare. Upon admission, two parallel procedures were initiated: a strictly medical one aimed to cure the person, and a bureaucratic one aimed to determine their legal status. This dual system, inherited from the Habsburg era, focused primarily on verifying and establishing both the old and new legal status of the patient (Toncich, 2022). The investigation sought to determine who would be responsible for paying for their treatment.

Issues of legal belonging and hospital fees mostly affected the poorest and frailest individuals, those who were socio-economically or ethnically vulnerable to poverty and stigma, and members of "national minorities". Many patients who had been ordinary citizens of a multinational empire automatically became "aliens" in their own homes. After the Habsburg Monarchy's disintegration, individuals with a *Heimatrecht* (pertinency) linked to a municipality now outside the borders of the successor state where they lived, automatically acquired a new, "foreign" citizenship (Kirchner Reill, Jeličić & Rolandi, 2022). To address the complex transition from the old to the new concept of legal belonging, the Paris Peace Treaty introduced a simplified understanding of pertinency based on birthplace (Weitz, 2008). However, this approach proved far from seamless. While the successor states permitted inhabitants of the newly acquired territories to opt for citizenship, many delayed doing so, thereby, in numerous ambiguous cases, becoming "stateless" (Hametz, 2019).[3]

For the many unable to afford private care, health became a pivotal factor in redefining their sense of belonging. Hospitals emerged as spaces where new affiliations were forged or altered, often requiring extensive and repetitive paperwork. In cases of chronic or incurable illnesses, this process could last for years, even decades. Medical records reveal a strong correlation between legal and social factors – social class, profession, gender – and clinical diagnoses, which influenced treatment decisions, hospitalisation duration, and costs. These intertwined processes underscore the significant role of medical procedures and the responsibility of medical professionals in shaping the legal and social fabric of local communities after the collapse of the Habsburg Monarchy. Consequently, both medical and psychiatric diagnoses should not be regarded as "objective" but as acts imbued with profound political and social implications (Berg & Bowker, 1997; Karge, 2020).

In major urban centres such as Trieste, Ljubljana, and Graz, the significant presence of non-pertinent residents – immigrants or stable workers from the former Habsburg labour market – placed considerable strain on public health structures. In addition to providing care, hospitals strove to manage this explosive situation and mitigate its complexities amidst severe resource shortages. In the months and years following the war, strategies were pragmatically implemented, relying on existing imperial and regional laws and pre-war practices, even before the establishment of the final international agreements and peace treaties:

1) "Repatriation" of "foreign" patients: A non-pertinent poor patient diagnosed as "incurable" or "chronic" was often deemed a burden due to costly, prolonged treatment. The primary solution was "repatriation", a practice rooted in the Habsburg Monarchy, by which non-pertinent indigent incurable patients were sent to their legal "homeland", crownland, or city (Wendelin, 2000). After November 1918, "homeland" became a legal construct which was largely unrelated to an individual's professional and personal ties. This practice spread and was reinforced paradoxically after the empire's collapse, evolving into a transnational system coordinated by the successor states, and often organised in groups for cost-effectiveness. Public health networks expelled many individuals labelled as "aliens", including nearly 100,000 war refugees from the Republic of German Austria (Mentzel, 2017, 149–152), by means of negotiations involving provincial authorities and diplomatic networks. Hospitals facilitated this process, sometimes in collaboration with international organisations. In early December 1918, the Red Cross organised the transportation of many former Austro-Hungarian soldiers from territories now within the KSCS, along with Italian prisoners of war, moving them from Vienna and Graz to Trieste via the Southern Railway (StLA, FH, admission books, 1918).

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[3] Cf. ASTs, PTs AG: b. 63 "cittadini jugoslavi, ricovero ospedale - rimpatrio".

2) Mutual payment among successor states: The high cost of transport and complex bureaucratic procedures for repatriation sometimes led to two countries agreeing on the reciprocal retention of "their" pertinent citizens hospitalised in "foreign" hospitals. This allowed patients to remain while provincial governments negotiated cost-effective fees, benefiting state and regional budgets by avoiding the need for new facilities or staff to house and care for hundreds of new patients. However, these fees were based on the lowest hospital category, reducing treatment quality for the "alien" patients (register books from: StLA, LKH; StLA, FH; ARS, ODBvLj). At the same time, these arrangements were often unreliable due to inflation, currency devaluation, and disrupted post-war international transactions (ARS, ZOzSiI, b. 10, f. 1038). Consequently, authorities often reverted to repatriation or barter agreements. For example, Austrian Styrian hospitals relied on food and coal supplies from Slovenian Lower Styria, particularly coal from the Trbovlje mines. After the division of Styria, these supplies were disrupted (StLA, Laa. A., R. VI: b. 1708, f. 3602). From 1919, the Austrian Styrian government demanded monthly deliveries to Graz, leveraging Slovenian Styrian patients hospitalised in Austrian Styria by threatening to transfer them to KSCS hospitals, which would have become overwhelmed (StLA, Laa. A., R. VI: b. 1668, f. 34212).

3) Entrustment of patients to family or social networks: An alternative approach was to entrust "alien" patients to relatives or trusted individuals. Upon discharge – whether cured or not – they were often handed over to caregivers within networks of "country(wo)men". Hospital records from post-imperial border regions highlight the existence of vibrant communities of "foreign" labour migrants who shared sociocultural, linguistic, or geographical ties. These communities operated as informal, non-institutional (health)care systems based on "self-help" and "self-organisation" (Badura et al., 1981). Public health records from the Austrian Styrian government, for example, reveal that many migrants had settled there before the war, while others arrived later for work, such as Slovenian-speaking workers in Graz and other Styrian industrial and mining centres, such as Knittelfeld, Voitsberg, and Bruck an der Mur (ARS, ZOzSiI: b. 5, f. 2102; f. 3919; f. 4840). Upon discharge from Styrian hospitals, many patients originating from KSCS Slovenia were entrusted to compatriots — possibly relatives, friends, or colleagues — who shared the same cultural and geographical background and were KSCS citizens residing and working in the Austrian republic (StLA, LKH, Register books K3–K6, years 1919 and 1920).

THE STATE-DOCTOR-PATIENT INTERPLAY

These cases reflect a typical top-down perspective, portraying patients as passive subjects under state control, dependent on its decisions, with limited autonomy. However, behind the state- and doctor-centred façade, documents reveal a more vibrant interplay and negotiation between the authorities, the medical profession, and the sufferers. Patients exercised their agency, voicing personal or collective concerns, needs, feelings, and desires, employing survival strategies, and seeking personal or familiar benefits. Public health also became a space where individuals reconsidered and manipulated their legal status, in some cases for the first time since the empire's collapse. Paradoxically, many civilians initially displayed indifference or ignorance regarding the procedures for opting for a new citizenship and failed to pursue naturalisation in due time, until they fell ill and required free medical care.[4] The emergence of new borders, economic concerns, and the need for healthcare collectively shaped how sufferers approached intervention and protection on the part of the new states, influencing their health mobility.

The creation of cordons sanitaires along the new borders did not fully disrupt pre-war transregional medical movements. In the region around the Mur/Mura River, which became the border between Slovenian and Austrian Styria after the Treaty of Saint Germain, the border hospital of (Bad) Radkersburg/Radgona remained the primary healthcare facility for both river sides. In July 1921, after a year and a half of armed dispute due to the KSCS occupation, the town came under Austrian rule (Vreča, Zangger & Močnik, 2018; Rahten, 2020, 118–130). However, by August 1921, over eighty percent of the patients at Radkersburg were still KSCS citizens, mostly from the Apače (Abstall) basin. This distinction was legal and economic, not ethnic: despite the area's mixed linguistic population of Slovenian- and German-speakers, all patients from this area were considered "aliens" and a financial burden on the Austrian-Styrian treasury. The reliance on the Radkersburg hospital continued, facilitated by regional passports. However, Austrian physicians in Radkersburg recognized that reliance on the hospital was conditional, depending on whether or not patients required specialized treatment. Local rural communities demonstrated ability to identify symptoms and ailments by themselves, and were aware of the services and costs offered by the cross-border health market. As a result, KSCS sufferers preferred Radkersburg for certain ailments, even as private-paying patients, as travelling to Slovenian hospitals in Maribor (Marburg an der Drau) or Celje (Cilli) was costlier under post-war conditions. However, for surgery or long-term care, they opted for Slovenian hospitals, where costs were covered by the KSCS state. In response to high inflation and resource shortages in 1921, this cross-border health strategy required pragmatic management by the Austrian Styrian government and Radkersburg's medical class. The everyday practices of this border society challenged the state's enforcement of borders, leading to the introduction of new hospital fees, charging non-Austrian patients three to four times more than Austrian patients, thus avoiding the need to expel or transfer foreigners (StLA, Laa. A., R. VI, b. 1706, f. 21953).

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[4] On 2 September 1922, the President of the Provincial Government of Gorizia wrote a letter of concern to the General Civil Governorate for the Julian March, highlighting the escalating situation caused by the rising costs of care for poor patients who were not pertinent to the Province: *Since pertinency still forms the basis upon which the right to public relief for the poor is founded, which also includes free medical care in case of illness, and since citizenship is an essential prerequisite for pertinency to such an extent that the loss of the former also entails the loss of the latter,* […] *the undersigned Provincial Council, in order to be able to advance on behalf of the municipalities the sums owed to public hospitals for expenses incurred by indigent patients belonging to this Province, turns to your Office with the request that you express an opinion regarding the citizenship status of those individuals who, either unaware of the deadline established for inspecting the lists or uninterested in consulting them, were not entered into the lists of full-right citizens despite fulfilling all the conditions set out in the aforementioned decrees* (ASTs, PTs AG, b. 63, f. 11290/22).

Raising the fees for “non-pertinent” inmates often left patients and their families unable to pay, creating a form of exclusion and exposing them to the risk of repatriation. In response, many adapted to the situation by exploiting the citizenship system. Opting for new citizenship during – or in preparation for – a long and costly hospitalisation became a pragmatic strategy to navigate the new barriers in public health. Decisions by “foreign” sufferers to apply for new citizenship were often driven by health needs, material concerns, and the request for protection, rather than by loyalty or national identity. For instance, Marie, a Graz resident but legally tied to Ljubljana, became mentally ill and was hospitalised in the Feldhof asylum. In December 1920, the Styrian government quadrupled the fees for non-pertinent patients (Landes- und Verordnungsblatt für das Land Steiermark, 1920). Unable to afford them, her brother, residing in the Slovenian town of Kamnik, sought her Austrian naturalisation from the Ministry of the Interior:

> *After the daily hospital tax was quadrupled (280 K. per day) for those not belonging to a municipality of the German-Austrian Republic, I am unable to afford such a high amount and have appealed to the Ministry of the Interior on behalf of my sister, Marie* […], *for her option as an Austrian citizen.* (StLA, Laa. A., R. VI, b. 1708, f. 3051)

DO NOT TOUCH MY BODY! MISTRUSTFUL AND CHALLENGING SUFFERERS

Looking beyond national narratives portraying the nation-state’s actions as absolute and monolithic, various non-state actors – such as doctors, single sufferers or entire communities – acted independently in managing health issues, accepting or rejecting medical assistance during acute health crises. Local societies allowed state intervention in the private and intimate sphere of health only contextually, depending on the state’s ability to establish networks of trust.

The Slovenian Karst under Italian administration offers a striking example. After the war, military doctors managed severe health crises and migrant influxes in this region. Initially, certain Slovenian-speaking communities appeared willing to accept military physicians, provided they demonstrated medical competence and a sense of humanitarian trustworthiness. In September 1919, the mayor of Trnovo (Bisterza Ternova) near Ilirska Bistrica, petitioned the Italian military governorate in Trieste to retain Captain Dr Giuseppe Rosato in civil service, citing his professional and personal merits. Despite the linguistic barrier and the fact that he represented the new state in a Slovenian-speaking district, Rosato gained the community’s trust through his expertise and humanitarianism. The mayor, on behalf of the population of the municipality, requested “to urge the command to prevent this transfer and honour the heartfelt request of the community” (ASTs, RCGC AG, V: b. 224/1, f. Condotte mediche: Bisterza).

However, in much of the Karst region, Italian governance in public health failed. An initial positive inclination on the part of the Slovenian-speaking Triestine and Karst communities largely disappeared due to the escalating political violence and nationalistic pressure, particularly after the burning of the Slovenian National Hall (*Narodni*

Dom) in Trieste in July 1920 (Klabjan & Bajc, 2021). Consequently, the Italian state struggled for years to establish public health governance, with many Slovenian-speaking practitioners fleeing to the KSCS overnight, fearing violence and repression, often taking medical and surgical equipment with them. This loss was devastating for the Italian authorities, who were already facing severe material and human shortages (ASTs, RCGC AG, V: b. 226/1, f. 1462). Paradoxically, the increasingly urgent state agenda of nationalising homogenisation, together with the escalation of anti-Slavic violence by Fascist paramilitary squads in the Julian March, undermined attempts to build trust with non-Italian-speaking populations, as reflected in the military government's document of February 1919 quoted above. Instead of solving problems, these state-driven actions created them (Klabjan, 2018, 998).

One such practitioner was Dr Anton Brecelj from Žapuže in the Gorizia/Gorica province. Despite attempts to remain, he was forced to leave and moved to Ljubljana in 1920, where he worked with the Provincial Government of Slovenia, served in hospitals, and actively engaged in interwar Slovenian-Yugoslav politics (Brecelj, 1928; Kalc, 1996). By 1921, the dramatic consequences were clear: during an epidemic crisis, skilled medical practitioners had left, and the local populations shunned Italian doctors. Instead, communities organised an "illegal" medical self-governance system led by unlicensed "empirical practitioners", as exemplified in the Sežana district in August 1921:

> *It has come to the knowledge of this office that in several municipalities there are often cases of deaths in the population without the slightest medical assistance from a doctor, that there are empirical practitioners who, against the law, take the place of doctors for human illnesses and veterinary surgeons for animal illnesses, and that pharmacies also dispense medicines that cannot be dispensed without a doctor's or veterinary prescription.* (ASTs, RCGC AG, V: b. 226/1, f. Sesana Distretto, provvedimenti di assistenza sanitaria)

After the district and town doctor fled to Ljubljana, the population of Sežana avoided the Italian-speaking doctor sent by the governorate as replacement. For intimate health matters, locals refused treatment from a representative of a distrusted state, with language proving to be an insurmountable barrier. In response, the communities either relied on an "alternative-medicine" system based on "folk-medicine" practices with unlicensed practitioners (Jütte, 1996) or followed the Slovenian-speaking doctors who had fled. Ljubljana's public hospital admission records show numerous individuals and families from the Karst region seeking treatment there instead of relying on Italian doctors or facilities in Trieste, even as private patients (ARS, ODBvLj, Splošne evidence). This group of people hospitalised in Ljubljana was notably diverse and reflected the composite nature of the broader post-war migration of Slovenian- and Croatian-speaking inhabitants of the Italian Julian March into the KSCS (Kalc, 1996, 24–25). One segment comprised individuals or families recognised as "refugees", with their hospital expenses covered by the KSCS state. Another group included migrant workers, particularly from the Southern Railway, who had moved to KSCS Slovenia for work or fled the oppressive conditions of the Julian March, thereby highlighting the railway company's role in facilitating emigration. Eventually, numerous individuals from the Karst appear in hospital records as private patients. When faced with health emergencies, they avoided relying on Italian healthcare in nearby Trieste or Gorizia and preferred to travel by train to Ljubljana, seeking treatment at the public hospital or KSCS clinics.

This cross-border mobility of practitioners and sufferers underscores the significance of the exclusive relationship between patients and doctors, which transcends state control and is grounded in personal networks and mutual trust.

THE INTIMATE PHYSICIAN-PATIENT RELATIONSHIP

"The problem of dissatisfaction with the delivery of medical care […] is not solely a matter of inadequate financing or insufficient facilities and personnel. […] The quality of medical care depends in the last analysis on the interaction of the patient and the doctor" (Korsch & Negrete, 1972, 66). Consequently, any analysis of public health that focuses only on its medical, political, legal, material, or economic aspects is incomplete. Public health also relies on shared cultural values, interpersonal trust, and emotional factors, especially during periods of upheaval (Singh, 2024, 210–211).

Besides the aforementioned cases, which illustrate a clear, straightforward top-down dynamic and the role of physicians aligned with the policies of the new successor states, public health documents also reveal evidence of alternative logics that undermined state-centred approaches. In many instances, physicians and state officials questioned their own socio-professional role and responsibility within post-war society, as well as their professional ethical code. Thus, in certain cases, when the safety and even the lives of patients were endangered by political or bureaucratic decisions, some physicians and bureaucrats raised their personal and professional voices in opposition to those policies. A Radkersburg case study provides vivid examples of humanitarianism prevailing over political agendas.

In March 1921, a bilingual – German- and Slovenian-speaking – fifty-six-year-old woman was admitted to Radkersburg Hospital suffering from severe and protracted bronchitis. She could prove no clear legal affiliation, having neither pertinency nor nationality. As her condition failed to improve and was deemed "incurable", a lengthy negotiation between Graz and Ljubljana ensued, but without resolution. As a result, the woman was to be transferred to her last verified place of residence, Zgornja Ročica (Tischen) in Slovenian Styria. In this case, however, the cold bureaucratic procedure did not proceed as usual, since a moral issue arose concerning this stateless patient. Physicians in Radkersburg and officials in Graz stated that "this would constitute a grave act of inhumanity. Nor could such a burden reasonably be placed upon an Austrian Styrian municipality. It is therefore recommended that her transfer to a poorhouse be carried out without delay, irrespective of the unresolved question of responsibility" (StLA, Laa. A., R. VI, b. 1731, f. 6858).

Moreover, in August of the same year, a report written and signed by several physicians of the Radkersburg Civil Hospital, and sent to the provincial government in Graz, described the alarming situation in the facility caused by a constant and unstoppable influx of non-Austrian patients from Slovenia and Hungary. They clearly explained the need for negotiation, as the policy of refusing non-pertinent patients conflicted with the physicians' professional mission and ethical standards:

> *The closure of the hospital by the state government for all patients who are not in immediate danger of death is a serious blow to the entire population of the lower Mur Valley, but is also unfeasible from a sanitary and general humanitarian point of view.* […] *From a medical and humanitarian point of view it is impossible for us to turn away such patients, even if there is no immediate danger to their lives.* (StLA, Laa. A., R. VI, b. 1706, f. 94903)

Public health documents, alongside legal, economic, and medical data, capture patients' and physicians' emotions – pain, fear, concern, loyalty and affection – which played a central role in decision-making during the dramatic post-First World War and post-Habsburg transition in the new borderlands. They also reflect the struggles of the professionals, who faced exhaustion and a personal and professional crisis due to the violent impact of the war (Hofer, Prüll &Eckart, 2011).

The examination of this emotional and praxeological dimension unveils dynamics that go beyond state-centred and ethnocentric narratives, since the interdependence between sufferers and practitioners frequently functions beyond nationality and state control. In establishing governance in newly formed border regions, successor states faced not only political competition from other states but also internal social challenges, as the intimate bond between sufferers and physicians proved resistant to state penetration and control. The classic state-doctor-patient hierarchical relationship, in which doctors acted as agents of the state, often failed. In many cases, trust, mutual agreement, and humanitarianism between sufferers and medical personnel transcended ideological or national affiliations.

Styria offers a compelling example of intimacy amidst rising nationalism and violence. Franz Kamniker, head doctor at the Radkersburg hospital and a supporter of the Austrian cause, was part of the Styrian delegation at the 1919 Saint Germain peace conference and was elected mayor in 1921 (Kamniker, 1919; Kurahs, 1987). While advocating for higher fees to exclude non-pertinent patients, Kamniker occasionally defied political logic. In 1922, he arranged for poor sufferers, who were KSCS citizens and acquaintances, to be transferred from Radkersburg to the Graz asylum for better care, aided by his personal connections (cf. StLA, FH, b. 219, f. 28224, b. 220, f. 26369). Despite his nationalistic stance, Kamniker sometimes set aside ideology to prioritise individual welfare and humanitarianism.

Similarly, Franc Steinfelser, a Styrian surgeon identifying as Slovenian and serving in the KSCS army, was sent to manage the medical crisis at the Radkersburg hospital during the Yugoslav occupation (November 1918–July 1921). Thanks to his professional and personal qualities, he earned the trust of all patients, including German-speaking ones. After the demobilisation of the Yugoslav troops, Steinfelser wrote a report recounting a moment of strong emotional connection with the German-Austrian patients:

> *Every doctor, and certainly a surgeon who has saved countless lives, wins the hearts of his patients over many years of service. Therefore, I hope the following fact is not seen as self-praise when I say that, as I left the hospital, all the patients had tears in their eyes. Even the German patients, in the presence of German officials, grasped my hands and pulled me to their beds. There is a widely held sentiment in the city and surrounding area that my departure as a doctor is deeply regretted. However, these are difficult times, and political conditions often push human feelings into the background.* (ARS, ZOzSiI, b. 13, f. 7877)

CONCLUSION

Taking into account humanitarianism, intimacy, and even affection that could develop between patients and the medical profession during the precarious and turbulent post-First World War years helps address the paper’s initial question: how were broken networks of trust rebuilt through public health, and who were the main actors in this process?

The reconstruction of public health in the post-Habsburg borderlands was neither a linear state-to-state process nor exclusively state-driven. While successor states sought to use healthcare as a tool of governance, biopolitical control, and national homogenisation, the realities in hospitals, clinics, and communities revealed a far more intricate web of negotiations, adaptations, alliances, and resistances involving actors well beyond the state. Physicians, patients, local authorities, and informal care networks actively shaped post-war healthcare, often transcending political borders, legal classifications, and nationalist agendas.

Trust emerged as a decisive factor, not merely as an instrument employed by the successor states to secure the loyalty of unfamiliar local populations in newly acquired border territories. The reactivation or recreation of trust networks after their wartime disruption occurred through both formal and informal practices and relationships within the public healthcare sphere. This process neither simply replicated imperial structures and pre-war patterns nor entirely broke with them, but instead blended continuities with innovations in medical practice and public health management. Post-war public health was also shaped by pragmatic strategies and humanitarian impulses originating from non-state actors. The agency of patients and local communities in borderland contexts, together with the ethical commitments of medical professionals, often challenged top-down directives, fostering cross-border cooperation and mutual support that transcended newly drawn geopolitical boundaries and eluded state control. The intimate doctor-patient relationship, imbued with emotional, cultural, and ethical dimensions, proved resilient amid political violence, economic hardship, and nationalist pressure. By moving beyond a state-centred narrative, this study shows that post-war public health was a shared, negotiated space where inclusion and exclusion were continually redefined. In this hybrid arena, the making and unmaking of trust depended as much on pragmatic needs, local agency, and interpersonal or emotional bonds as on national policy. This reveals that the governance of health in the post-Habsburg borderlands was inseparable from the social, cultural, and emotional ties linking individuals both to one another and to the new institutions that claimed to serve them.

ZDRAVLJENJE IN GRADNJA ZAUPANJA: DRŽAVE, ZDRAVNIKI IN PACIENTI V POSTHABSBURŠKIH SISTEMIH JAVNEGA ZDRAVSTVA: MEJNA ZGODOVINA JAVNEGA ZDRAVSTVA

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POVZETEK

Članek analizira razdrobljenost habsburških struktur javnega zdravja po razpadu Avstro-Ogrske prek primerjalne analize dveh novih obmejnih regij v treh posthabsburških državah: Julijske krajine pod Kraljevino Italijo, slovenskega ozemlja v Kraljevini Srbov, Hrvatov in Slovencev ter obmejnih dežel Koroške in Štajerske v republiki Nemški Avstriji. Iz transnacionalne perspektive obravnava prizadevanja za vzpostavitev treh novih sistemov javnega zdravstva, ki so se, paradoksalno, zgledovala po prejšnjem »federalnem« cesarskem sistemu. Tri države naslednice so povezovale skupne povojne krize, migracije in globalni sanitarni izzivi. V tem procesu države niso bile edini akterji, temveč so delovale znotraj kompleksnejšega sistema upravljanja javnega zdravja, ki je vključeval zdravstvene delavce, lokalne civilne družbe in skupnosti. Ti akterji so se spopadali z izzivi obnove omrežij zaupanja in pripadnosti, ki so presegali pravne in administrativne okvire. Če se oddaljimo od pripovedi o vseprisotni in vsemogočni državi, je treba razširiti razumevanje javnega zdravja. To ne sme biti omejeno zgolj na biopolitiko kot orodje državnih projektov homogenizacije, nadzora in discipliniranja nenormativnih posameznikov in skupnosti. Nasprotno, javno zdravje predstavlja integrativni prostor interakcije in pogajanj med različnimi akterji – najprej med zdravniki in pacienti –, ki so skupaj iskali nov red in prenovljeno identiteto v posthabsburškem obdobju.

Ključne besede: javno zdravstvo, čas po prvi svetovni vojni, zaupanje, obmejna območja, Slovenija v Kraljevini SHS, Julijska krajina, avstrijska Štajerska, avstrijska Koroška

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THE COST OF THE "UNCLAIMED": PERTINENCY AND HEALTHCARE ADMINISTRATION IN ITALY'S ADRIATIC PROVINCES, 1919–1927

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ABSTRACT

This article explores the intersections of the political citizenship and healthcare management in Italy's newly annexed provinces from the Treaty of Saint Germain's coming into force to the Fascist legal absorption of the new territories in the reforms of 1926. It examines the role of Liberal internationalist philosophies and policies in the shaping of borderland practices and traces the continuities of Liberal approaches into the Fascist period, focusing on local strategies to balance humanitarian care concerns with nationalizing priorities and demographic policies.

Keywords: Adriatic provinces, healthcare, citizenship, pertinency, Liberal internationalism

IL COSTO DEI "NON RICONOSCIUTI": PERTINENZA E AMMINISTRAZIONE SANITARIA NELLE PROVINCE ADRIATICHE D'ITALIA, 1919–1927

SINTESI

Questo articolo analizza l'intreccio tra cittadinanza politica e gestione sanitaria nelle nuove province annesse all'Italia, dal momento dell'entrata in vigore del Trattato di Saint-Germain fino all'assorbimento giuridico dei territori nelle riforme fasciste del 1926. Viene esaminato il ruolo delle idee e politiche del liberalismo internazionalista nella definizione delle pratiche nelle zone di confine e vengono tracciate le continuità degli approcci liberali durante il periodo fascista, con particolare attenzione alle strategie locali volte a bilanciare le esigenze di assistenza umanitaria con le priorità nazionalizzatrici e le politiche demografiche.

Parole chiave: Province adriatiche, sanità, cittadinanza, pertinenza, internazionalismo liberale

> *Health legislation and administration constitute one of many factors which go to form the public life of a nation. Unlike political institutions, health institutions do not arise out of any organic unity and cannot develop on a definite plan. The changes and innovations introduced in the course of years have, for the most part, been made haphazard. The problems have arisen from the vicissitudes of life itself. In short, the needs of the moment have determined the intervention of the legislator and of the administration.* (Štampar, 1925, 5)

At the head of the Kingdom of Serbs, Croats, and Slovenes (KSCS) Department of Hygiene and Social Medicine from 1919 to 1931, Andrija Štampar wrestled with legislative and administrative chaos left by the war. His observations, recorded in a book commissioned as part of the League of Nations' Health Organisation's effort to understand the "distinct character" of national health organizations and to help advance collaborative global health initiatives, reflected the Yugoslav response to the "vicissitudes of life" and the shift from wartime exigent care to peacetime recovery. On both sides of the new Italian – KSCS border, in communities devastated by fighting on the Italo-Austrian war front, labyrinthine international treaties governed the actions of legislators and administrators who scrambled to craft healthcare processes and policies. But Štampar's counterparts on the Italian side faced a legal and national climate unlike that of other successor states. Rather than collaborate in a new healthcare system, local authorities in the new Italian borderlands had to remold healthcare and services to fit the Italian national system developed over the decades since Unification of the Italian state.

Administrative chaos in capitals like Belgrade, Vienna, and Budapest allowed local administrators flexibility and provided opportunities for independent action in the new successor states. In Italy's new lands, civil servants managed public health in a framework constructed under the Habsburgs, modified according to the standards of Liberal Italy after 1918, and transformed by the Fascists seeking to impose a national healthcare regime after 1922. Healthcare administrators in Italy, as in other European successor states, had little influence in medical or treatment decisions and, in most cases, were not involved directly in patient care. Instead, they struggled to reconcile local public health needs with national aims and to manage healthcare systems in an international climate driven by lofty humanitarian, internationalist ideals derived from nineteenth-century Western imperial arrangements and assumptions rather than grounded in meeting healthcare exigencies in war-torn lands. Their responsibilities included negotiating the care of "unclaimed" individuals stranded by international agreements in the interstices of competing national public healthcare systems.

Healthcare debates were at once intensely local, reliant on specific details of law, family, and territory, and broadly international, reflecting divergent ideological assumptions and interpretations of governments' obligations. The loss of men killed or wounded in the war compounded by the numbers missing, dislocated, or simply absent, had a profound impact on the dynamics of families and societies. Healthcare networks predicated access to entitlements on men's rights and extended them to women and children on the principles of dependency or rights derived through fathers or husbands. The absence of men, juridical heads of household, created legal inconsistencies, anomalies, and gaps that altered the realities of care in the post-World War I world. The Regional Commission for War Orphans in Italy’s new territory of Venezia Giulia reported in 1922 that there were more than 20,000 orphans in the territory, more than 4,000 in the city of Trieste alone. Some 6,500 were widows of whom 1,414 were in Trieste (Vinci, 2012b, 47). As the Adriatic territories transitioned to Italian sovereignty, municipal, provincial, and national authorities parsed healthcare responsibilities with an eye to balancing nationalization, recovery, and security needs. In the interwar period, the new “biopolitics of constructing community” emerged as a key concern and aspect of social policy across Central Europe (Borowy, 2009, 17).

HEALTH CHALLENGES AND THE PARIS PEACE

International negotiators at the Paris Peace Conference recognized the global nature of health challenges and the need to integrate health care systems. Article 23 of the League of Nations’ Covenant, included in each of the Paris Treaties, promised that signatories would “endeavour to take steps in matters of international concern for the prevention and control of disease” (League of Nations, 1920, 10). But Liberal internationalists advocating for human rights, self-determination, and democracy in new sovereign nation-states overlooked their inability to compel states to act in the interests of the collective (Petruccelli, 2020, 119).

Both Italy and the KSCS signed the League of Nations’ Covenant, but the inchoate KSCS, a compound successor state, cobbled together from Serbia and lands forfeited by the losing powers, was more fragile than the Italian state established in the mid-nineteenth century. In the international arena, although arguably the “least of the Great Powers” (Bosworth, 1980), Italy was one of the Principal Allied and Associated Powers and recognized as a Liberal state promoting “progress” (Petruccelli, 2020, 120). The Italians took advantage of the asymmetry of power and, using their representation on the League of Nations’ Commission on New States, crafted general protections for national and ethnic minorities that favored Italian circumstances and interests (Rosting, 1923, 646–648). Italy’s status as a victor, successor, and liberal state, enabled authorities in Rome to control former Habsburg subjects’ access to citizenship and entitlement to public healthcare. It also justified their regulation of the status of healthcare professionals and institutions.

Article 25 of the League’s Covenant called for voluntary cooperation of national Red Cross organizations for “improvement of health, the prevention of disease and the mitigation of suffering throughout the world” (League of Nations, 1920, 11). Reliance on the well-established Red Cross networks enhanced the possibilities for collaboration due to the Red Cross’s reputation for transnational, international efforts and special status of neutrality on the battlefield (Wu, 2023, 224), but it also reinforced Liberal internationalist hierarchies (Petruccelli, 2020, 117), inherent in the Red Cross organization’s national structure and funding model. Even before World

War I, the US government recognized the American Red Cross’s value in spreading US influence and liberal, democratic values around the globe (Wu, 2023, 224–225). In a volume exploring the American Red Cross’s efforts in wartime Italy, the American Red Cross claimed the high moral ground in imperialist language, noting that the US came to Italy’s aid, not solely on a mission of “charity” but rather “to render justice.” The United States’ substantial financial assistance “translat[ed] into deeds the soul of America, in making it plain to the Italians that we were there to work as brothers, filled with a common enthusiasm and inspired by common ideals” (Bakewell, 1920, 5). American assistance flowed freely because Italy’s political liberalism was well established.

The League of Nations’ Health Organisation, founded as a provisional committee in 1921 and made a permanent organization in 1924, was intended as a tool of “practical usefulness in the field of international relations” (League of Nations, 1926, 10–11) but exacerbated the systemic inequities. Constructed through international efforts in International Office of Public Health, established in 1907 and dominated by French interests, and as a successor to the Interallied Sanitary Commission, formed by the Allied Powers during World War I, it replicated the prewar liberal structures of patronage in the imperial mindset (Wu, 2023, 219–222). Štampar’s volume on the KSCS, one in a series of fifteen surveys commissioned to foster transnational health cooperation with successor states and re-assigned colonial and developing regions, implicitly acknowledged the inequality. Funded by the Rockefeller Foundation in partnership with the League of Nation’s Health Organization, it provided a platform for the South Slav State to prove its commitment to international collaboration and its willingness to accept modern “civilizing” healthcare models and ideologies (Borowy, 2009, 178, n. 63), and to justify requests for the type of international assistance Italy already enjoyed.

Fundamental beliefs in the individual and “citizen linked to the state through national or civic identity” (Petruccelli, 2020, 117) formed the substructure of the modern Italian state, which traced its roots to ancient Rome. Citizenship had its roots in Roman domicile law or *lex domicilii* (Uddin, 2018, 292–294) and relied (and continues to rely to this day) on national belonging linked to territory. By the beginning of the twentieth century, pertinency or jurisdictional domicile, tied to territorial law, constituted a singular and permanent status under international law (Burgin et al., 1928, 12). Negotiators at the Paris Peace Treaties chose western definitions of “legal domicile” or pertinency as the key criterion to determine citizenship, and citizenship tied to territory became the basis for determining the limits of states’ responsibilities for individuals’ care.

HEALTH CARE AND PERTINENCY

In the new Italian borderland, the Italian juridical nation-state clashed with the traditional Habsburg municipal framework developed in the nineteenth and early twentieth centuries and constructed on local rights of *Heimatrecht*, which relied on the primacy of Church and Canon law in Europe and on the Church's administration of lands and maintenance of population rolls (Burgin et al., 1928, 34). *Heimatrecht* functioned in an environment where internal passports had been abolished in 1857, and in healthcare, it served as a means of "managing and re-apportioning risk and misfortune across the empire" (Toncich, 2022, 524–525). It was therefore incompatible with Italy's laws and ethnic citizenship in the Liberal State (Caglioti, 2014, 448–449), conceived on the foundations of the Napoleonic codes and citizenship privileges and rights associated with secular Enlightenment ideas.

Article 70 of the Treaty of Saint Germain "Clauses Relating to Nationality" granted former Austrian Habsburg subjects rights of citizenship in the state with sovereignty in their territory of legal domicile (Burgin et al., 1928, 34). But Italy objected to automatic citizenship in the Adriatic provinces, and exercising power as a negotiating partner pushed through Articles 71 to 75, which granted an exception to *ipso facto* citizenship and required those not born and continuously resident on new Italian soil to petition individually (Treaty of St. Germain, 1919). Habsburg pertinency did not recognize ethnonational identity, and legally did not differentiate pertinency of origin from pertinency derived from residence. The Habsburg population rolls indicated place of birth but did not record ethnicity, national associations, or loyalties. *Heimatrecht* in lands annexed to Italy could not, therefore, reliably offer access to Italian citizenship (Caglioti, 2014, 448–449). Prewar internal Habsburg migration affecting the Adriatic Littoral, where the crownlands of Cisleithania and Transleithania had met and where maritime employment was linked to Mediterranean networks, further complicated the local situation.

When the Saint Germain treaty came into force, individuals flooded Italian government offices with citizenship requests, adding to the already overwhelming backlog of cases created by Italy's suspension of naturalization processes from July 1915 to the end of the war (Caglioti & La Lumia, 2021, 10). In addition to the Italian legal exceptions and jurisdictional inconsistencies, differing assumptions and social philosophies created an overwhelming number of contested cases. Italian authorities turned to local authorities in the Adriatic for assistance, creating advisory commissions to consider citizenship petitions and adjudicate individual cases in borderland communities. In the years immediately following World War I, the Civilian Commission of Venezia Giulia (CGC-VG), the transitional civilian authority headquartered in Trieste, was predisposed to generosity in extending social services to those in need. Habsburg *Heimatrecht* had developed in an imperial structure consistent with notions of public beneficence and Catholic responsibility for the welfare of the community. Prior to official annexation in early 1921, a report directed to Rome noted the CGC-VG's dedication to the Italian government's "highly humanitarian work" and desire to "extend the same social assistance established for its own combatants to the invalids, widows and orphans of soldiers formerly belonging to the Austro-Hungarian Army and Navy and living in the territories within the Armistice line" (Vinci, 2012b, 47). This may have been the result of a magnanimous postwar attitude and part of a propaganda show to demonstrate Italian benevolence toward former enemies (Vinci, 2012b, 47) but, after the war, the Italian government appeared eager to welcome new populations and willing, especially through organizations like the National Initiative for Assistance to Redeemed Italy (ONAIR) (Downs, 2018, 1089–1090), to provide welfare and assistance. Despite the nationalist bent of these organizations, local civil servants' magnanimity seemed to extend to members of all autochthonous populations even into the early years of Fascist rule, as long as they were not labelled Austrophiles or political enemies (Hametz, 2019).

Local officials looked past lapses in moral conduct and ethnic uncertainties to offer assistance to Elena Stoic Alloy, a widow born in 1866 whose domicile derived from her husband and who Municipal Commissioner (Questor) Umberto Molossi noted was in a "delicate state of health, living in miserable economic conditions" (AdSTS, Pref., Uff. Citt. 4373, Alloy). In November 1924, the Prefect of Trieste asked the Citizenship Office to clarify Alloy's status so that the city could pay for her arterial sclerosis treatment. Police and mayoral reports on her conduct, required to process her citizenship claim and part of every citizenship file processed after 1922, revealed a checkered past that included living a "rather immoral" lifestyle with several men before her marriage and abandoning several children, including a twenty-five-year-old daughter whom officials had tracked down in the city. "Irregular" family relations, while they did not fit the national Fascist mold, were familiar to civil servants in the borderland. Venezia Giulia's rate of illegitimacy was among the highest in Italy (three or four times the average) and in 1919, war orphans and abandoned minors constituted two percent of the population (Gobbato, 2012, 65).

But Stoic's "irregularity" extended further. While she was "not adverse to Italian institutions," she was "not of purely Italian sentiments," but "of Slovene nationality," a fact that Molossi dismissed as inconsequential given her origin in Orle (Lower Carniola), Slovenia. Sympathetic authorities granted her citizenship in November 1924 contravening requirements for proof of Italian nationality through language, culture, or associations and clearing access to public health assistance (AdSTS, Pref., Uff. Citt. 4373, Alloy).

ACCESS TO HEALTH CARE

In the new Italy, Catholic attitudes may have prevailed in humanitarian practice, but the state adopted a more "scientific" approach to managing population and public welfare. Citizenship served as the vehicle to obtain or maintain access to pensions, social benefits, and healthcare. A case in Lussinpiccolo (Mali Lošinj),[1] in the Croatian Littoral, demonstrates the effects of the transition from Habsburg *Heimatrecht* to Italian liberal law and the impacts on healthcare of the shift to reliance on nationality as a criterion of legal citizenship. In 1922, the Citizenship

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[1] Place names generally appear as they are written in Italian documents, no matter what ethnic or national origin their form reflects. Additional names are listed where clarification is helpful or reflects names that would have been used in the Habsburg monarchy or were more familiar in the polyglot borderlands.

Commission in the Sub-Prefecture of Lussino denied a citizenship request on behalf of Federica Madarsz by her mother. Born in Nagykanizsa (western Transdanubia) in September 1890, Madarsz and her mother resided in Lussinpiccolo, but both had pertinency in the new state of Hungary. Provincial authorities in Venezia Giulia, acting on behalf of the national government, sided with the local commission and rejected Madarsz and her mother's petitions to opt for Italy. Officials noted the women's upstanding moral character but found them lacking in "Italian sentiments." The officials' pecuniary motives were clear. The women could not afford the tax required to take the citizenship oath, and as Madarsz was being treated for mental illness and dependent on her mother, officials argued that she lacked the capacity to exercise the citizenship option (AdSTS, Pref., Uff. Citt. 4534, Madarsz). Effectively, they judged Madarsz competent to harbor Hungarian sentiments, but incompetent to opt for Italy. Denying her ability to opt, the municipality avoided the liabilities associated with Madarsz's medical care.

From the Risorgimento, Italy lacked a universal conception of public welfare and struggled to balance beneficence, assistance, and insurance approaches to public care (Quine, 2002, 38). After World War I, while Italy remained reliant on philanthropic institutions, evident in the new territories in the work of ONAIR, a collaborative effort of the International Red Cross and the philanthropic intervention of the Duchess of Aosta (Vanni, 2021, 361), increasingly the Italian state assumed responsibility for public health and social welfare (Gobbato, 2012, 85). Along with demographic information, land ownership, profession, and evidence of Italian ethnicity by descent, origin, and/or language, municipal authorities noted petitioners' insurance status on the citizenship application forms. For example, Giuseppe Bisiach (or Biziak), born in Trieste in 1896, with pertinency in Vrhnika (Oberlaibach), an employee of Libera Triestina shipping since 1912, was a member of the District Fund for the Sick (AdSTS, Pref., Uff. Citt. 4391, Bisiach). Liberal authorities counted on such memberships, a holdover of workers' mutual societies and aid organizations associated with Habsburg "humanitarian socialism," to alleviate some government burdens. But by the mid-1920s, these associations had all but disappeared. Identified by Mussolini as "instruments of class struggle" based on "social hate," mutual aid societies were dissolved or absorbed into the Fascist framework of the Labor Charter of April 1927, which advocated national health insurance as an "embrace of unity and mutuality" under the corporatist doctrine (Taroni, 2021, 99–100).

By the early twentieth century, European nations' manipulation of healthcare as a tool of foreign and domestic policies was well established (Borowy, 2009, 15–16). Healthcare accounting disputes born of the transfer to Italian sovereignty lingered on for as long as a decade after the war. Administrative restructuring related to the standardization of laws, the restructuring of Prefects' offices and duties in anticipation of the coming into force of national reforms of 1925 and 1926, and the concurrent dissolution of borderland Citizenship Commissions brought many unsettled healthcare cases to light. Most could be traced to conflicting, contradictory, or unarticulated aspects of postwar settlements, and they reflected the Habsburg history of care for the working classes and the system in which, by the beginning of the twentieth century, even the indigent enjoyed access to care (Toncich, 2022, 526). After the war, when citizenship rather than local rights determined access to entitlements, local authorities deliberated over responsibility for individuals’ medical costs incurred in hospitals and other health institutions. International agreements between the Habsburg monarchy and Italy relating to payment of indigent migrants’ healthcare dated to the Habsburgs’ cessation of territory to the emerging modern Italian state in 1859 and 1866 (Toncich, 2022, 529). The collapse of the Habsburg monarchy and the division of Adriatic territories into the Italian and KSCS states compelled individuals already navigating familial disruption and concerned with access to entitlements to face ethno-nationalist scrutiny. Also under scrutiny were former Habsburg healthcare professionals not born and continuously resident in the new provinces, who were compelled to petition the new Italian state for citizenship. Authorities’ legal, political, and social assumptions influenced their decisions on public health care and laid bare the contradictions in national policies and practices as the Fascist government gained hold.

Anna Karner (or Carner), a widow being treated by the Anti-Tuberculosis Clinic in Trieste in October 1925, was the mother of children who met the birth and continuous residency requirements and qualified for automatic Italian citizenship. But Karner was born in Weissenstein near Villach and her pre-marriage pertinency was traced to Innsbruck, so she was deemed Austrian. She had lived in Trieste since 1903, and her husband acquired *Heimatrecht* in the Adriatic city in 1910, but he died in 1917 in a camp hospital in Carinthia. She received a war widow’s pension as outlined under the terms of the Saint Germain Treaty, but as her husband died before the Armistice, his pertinency did not automatically secure her citizenship rights (on widows, cf. Hametz, 2019; 2021). The municipality insisted on Karner’s “foreignness,” taking advantage of her Austrian origins to cast aspersions on her loyalty and deny her Italian support, contending that her husband’s choice to reside in Trieste and Habsburg officials’ coincident decision to include him and his family on population rolls in the Adriatic city were not binding in her case. Their contention implied that citizenship in Italy demanded a higher standard of loyalty to the nation-state. At the Trieste Prefect’s suggestion, officials in the Interior Ministry intervened, and naturalized Karner by royal decree, regularizing her status in October 1925. Still, in 1929, the municipality questioned the clinic’s claim that Karner was an Italian citizen. The Prefect, representing the province and the national government, affirmed her citizenship, supporting the care facility’s claim (AdSTS, Pref., Uff. Citt. 4445, Karner).

Destruction of the population rolls in Ronchi dei Legionari near Monfalcone during the war opened the door for doubt about Nicolò Pacor’s status when, in 1926, the Regina Elena Civic Hospital in Trieste inquired about payments for his wife Lucia’s care. Local authorities initiated an investigation, tracked him down in the city, and secured affidavits with the information to settle the claim. Pacor’s native origins, long residence in Monfalcone, and interactions in the Italian language with municipal authorities convinced them of his Italian national identity, and they acted with alacrity to secure his citizenship rights. The Prefect’s office even took the extraordinary step of issuing a decree securing the family’s full citizenship rights under the expired provisions of Articles 70 and 71 of Saint Germain (AdSTS, Pref., Uff. Citt. 4572, Pacor), rather than requiring him to undergo the more stringent process of naturalization.

In the case of Rosa Sardoz, a widow born in Draga (Croatian Istria), who died in the Hospital for Chronic Patients in Trieste on October 4, 1923, local reluctance to assume liabilities for healthcare costs forced the Prefect to adjudicate the citizenship of a dead woman. On September 12, 1927, a municipal civil servant wrote to the Prefect seeking to settle Sardoz’s outstanding medical debts. Sardoz applied for Italian citizenship in June 1922. In February 1924, the hospital sought affirmation of her citizenship from the Prefect, but more than three years later still awaited an answer. In September 1927, nearly four years after her death, the Prefect granted her Italian citizenship under the terms of election, based on her legal domicile in Trieste (AdSTS, Pref., Uff. Citt. 4613, Sardoz).

PUBLIC EMPLOYEES

Public employees’ mobility in the former empire created additional problems, and the treaty provisions prohibited acquiring citizenship based on pertinency or residence rights derived from official government service. In 1926, the Citizenship Office in Zara, anticipating the shift to Trieste of jurisdiction for all borderland citizenship claims in Fascist restructuring, sought to resolve an outstanding claim by the psychiatric hospital in Zadar (Zara) related to Simeone Fabianich’s stay from August 28, 1923 to February 20, 1924. A Habsburg judge assigned to the Commercial Maritime Court in Trieste in 1914, Fabianich was domiciled on the island of Pag (Dalmatian Croatia). After the war he opted for Italy, and while the Citizenship Commission in Trieste voted unanimously in his favor, the Prefect noted that the treaty precluded granting citizenship by virtue of government office. In theory, pertinency defined where an individual’s legal rights were situated, no matter where their residence might be (Burgin et al., 1928, 4–5), but Fabianich’s official “domicile of assistance” remained unclear due to his transience for employment, healthcare, and personal reasons. At the time of the Armistice, Fabianich was legally resident in Trieste, but he was living in Rome. In 1925, he was assigned to the court in Koper/Capodistria but was living in Zadar. The Prefect of Trieste, taking on the case in April 1926, deemed Fabianich’s situation “worthy of special consideration” and working with the Ministry of the Interior, declared Trieste as his official domicile and, in contravention of the provision for office holders, issued the citizenship decree under the (expired) citizenship clauses of the Treaty of Saint Germain (AdSTS, Pref., Uff. Citt. 4440, Fabianich).

Local civil servants in the borderland were uniquely qualified to understand the Adriatic landscape and ethno-nationalist relationships that affected healthcare management and social welfare decisions. Many civil servants in municipal and provincial offices in the Adriatic provinces began their public service careers in the Habsburg monarchy and remained in or resumed local government posts under Italian sovereignty. Under Habsburg *Heimatrecht*, their responsibilities had included negotiations with other localities for recompense of hospital and medical costs. After the war, what had been an internal accounting procedure became a cross-border transaction. The Italian successor state inherited lands primarily from the Cisleithan part of the empire or Austria but, by 1925, had also annexed Hungarian Crown lands along the Adriatic coast. The situation was more complicated for the KSCS, which included Serbia and other independent states created in 1878, some territories added in the Balkan Wars, as well as Austrian and Hungarian lands.

UNCERTAIN BORDERS

Drawing the boundary between Italy and the KSCS had been a particularly thorny problem for negotiators at the Paris Peace because, from the perspective of the negotiating liberal powers, "ethnic, cultural, and military lines" that guided border decisions did not coincide in a clear line of demarcation (Bowman, 1924, 262) and until Italy's annexation of Rijeka (Fiume) in 1924, borders in Italy's eastern Adriatic provinces continued to shift. Further, the ethnic ties, beliefs, or origins of members of the local populations could not be ascertained with any certainty, making it impossible to apply nationalist standards that included proof of Roman, Venetian, or Italian culture, language, or origins.

In 1924, uncertain borders left Maria Pacher, a recovering patient at the Regina Elena hospital in Trieste, effectively stateless. At the insistence of the hospital, Pacher's daughter and son-in-law wrote to the Prefect of Trieste to inquire about responsibility for the hospital costs. Living on public assistance since 1922, granted based on her husband's legal domicile established in Trieste since 1896, Pacher's family believed her to be an Italian citizen. Her children, born in Italy's new territories and registered on the population rolls, enjoyed full rights of citizenship. But Pacher's husband died in January 1900, decades before World War I. After the war, Italy's contention that when a woman's husband died, she lost her domicile of dependency and reverted to her domicile of origin (Uddin, 2018, 296) and that domicile of origin is never obliterated but remains in abeyance and resumes automatically if the domicile of choice is relinquished (Burgin et. al, 1928, 8), meant that Pacher's birth in Maribor (now Slovenia) made her a resident alien in Italy. Following the principle that widows' cases should be treated with the maximum latitude allowed under the laws, a position adopted by 1924 but not recognized in official policy until 1926 (Hametz, 2019, 79–80), the Prefect proposed naturalization under the 1912 Italian law. But, when Pacher died in March 1925, her case was unresolved (AdSTS, Pref., Uff. Citt. 4572, Pacher).

In Pacher's case, civil servants may have invoked the local time-honored strategy of stalling on payments. In Habsburg Istria, municipal authorities settled accounts at a glacial pace burying cases in paperwork or losing them in the interstices of bureaucracy to forestall paying debts to larger centers like Trieste (Toncich, 2022, 526). The strategy continued after World War I. ONAIR consistently complained of the significant delays in receiving government subsidies (Gobbato, 2012, 79). National practices of delay trickled down to the local level, and avoidance strategies sometimes paid off for municipal authorities.

Giuda Albahari, born an Ottoman subject in Sarajevo on November 11, 1890, died in Trieste on July 27, 1923, having been a patient at the Regina Elena Hospital. After the war, he had opted for Italian citizenship, and the decree was prepared. However, he never swore the oath of allegiance nor paid the required tax. In 1925, when the hospital asked the municipality to settle his bill, local authorities turned to the Prefect’s Office for proof of his citizenship and their liability. The Citizenship Section in the Prefect’s Office noted Albahari’s failure to complete the citizenship process and sought, to no avail, to contact his widow. She was untraceable. The hospital was left with the daunting prospect to seek reimbursement for the treatment of a subject of the defunct Ottoman empire (AdSTS, Pref., Uff. Citt. 4372, Albahari).

PERSONAL CONNECTIONS

Despite increasing Fascist pressure to forge a “pure” national community, personal contacts and local support networks played a role in citizenship determinations. Antonio Kampos’s pending citizenship case was quickly settled in 1926 when he needed to secure coverage of healthcare costs for his young son Mario’s hospitalization. Born in Podplat in 1859 and with pertinency in Kostrivnica (now eastern Slovenia), Kampos worked in Trieste and the city’s environs for nearly three decades and from 1924 was employed as a gardener at Miramare Castle. In May 1924, the Prefect approved his petition for citizenship based on long residence and the practice of his profession in Trieste for more than ten years. But, when the hospital inquired in 1926, his citizenship request had stalled, ostensibly because his tax waiver was pending. The delay was attributed officially to Kampos’s economic need, but evidence suggests that he may have procrastinated in completing the paperwork and swearing the oath due to reluctance to forswear his Slovene heritage and origins. Kampos’s children all attended Slovene schools, through the years after the Gentile educational reforms of 1923 and until all non-Italian schools were closed and education in other languages was prohibited in November 1925 (on education prohibitions cf. Gobbato, 2012, 73–74). His original petition for citizenship offered extensive documentation of his employment and trustworthiness as a gardener in various villas and institutions, including his devotion to patients at the Sanatorium in Sagrado during the war. All attested to his moral character and industriousness rather than his commitment to Italy. In an unusual step, the official in the prefect’s office who approved his petition in 1924, perhaps anticipating national reticence, noted “all attesting (to his Italianness) are personally known to me” (AdSTS, Pref., Uff. Citt. 4490, Kampos). Once his son’s treatment was in question, Kampos’s citizenship case, which had languished for two years, was quickly resolved. In 1928, when the hospital checked again, documents showed that he had received the tax relief and sworn the oath shortly after the 1926 inquiry (AdSTS, Pref., Uff. Citt. 4490, Kampos).

As the New Provinces were enveloped in Fascist legal reforms of 1925 and 1926, the “national purism” of increasingly totalitarian border fascism (Pirjevec, 2023, 15) infected local authorities, emboldening them to adopt persecutory nationalizing stances that put them at odds with national authorities beholden to international laws and practices governing citizenship and healthcare. For six months beginning in October 1929, Luigi Bilucaglia, the mayor of Pula (Pola), bickered with the provincial hospital, the Municipality of Pola, the Prefects of Pola and Trieste and, presumably, the Ministry of the Interior over a request for reimbursement of a widow’s week-long hospital stay in 1921, more than eight years earlier (AdSTS, Pref., Uff. Citt. 4392, Blascovich). On receiving assurance that Gertrude Blascovich was accorded Italian citizenship by election in December 1922, the municipality referred the matter to the mayor’s office. Blascovich’s petition in 1921 noted her family’s Italian sentiment and her long residence in Pula, and she provided the documents to prove legal domicile in Pula and her widowed status. Her six children, all over the age of majority by the time of her petition in 1921, were native born and legally domiciled in Pula (and listed on their father’s pertinency certificate of 1907) and had received Italian citizenship based on their inclusion in Pula’s municipal rolls. Despite Blascovich’s close attention to the provisions and proof that her children were educated in Italian schools in the Habsburg monarchy, evidence of ethnic allegiance that predated by decades the nationality requirements set in 1920, Bilucaglia, acting with animus, challenged her citizenship claim.

Bilucaglia’s obstinance reflected the climate of exaggerated border nationalism (Vinci, 2011) and his zealous Fascism. A native of Pula and an ardent Italian irredentist in Habsburg Istria, he fought for Italy in World War I, participated in Gabriele D’Annunzio’s March on Rijeka and, prior to embarking on his administrative career, served as a leader of the local Fascist squads directing violence against non-Italians (Mandić, 2020). His objections rested on the unsympathetic interpretation of the law that held that a woman resumed her domicile of origin on her husband’s death. He insisted that Blascovich’s birth in 1864 in Mirna Peč (Hönigstein), a municipality of Lower Carniola, relieved Pula of responsibility for her healthcare. When provincial officials and the citizenship authorities in Trieste forced him to acknowledge Blascovich’s domicile rights, Bilucaglia continued to fight, insisting that the treaty provisions required both legal domicile and birth in the new provinces. In addition, he argued that because the decree was dated December 1922, Blascovich was not a citizen in July 1921 when the costs were incurred. His tone suggested that he may have resented his subordination to the Trieste Prefect in citizenship matters. Prior to July 1923 and after 1926 Trieste had authority in citizenship matters in Venezia Giulia and the new Adriatic territories, but in the intervening years, local Prefects in Istria and Udine exercised authority (Regio Decreto 15 luglio 1923, no. 1624). Finally, the exasperated hospital director appealed to the Prefect in Trieste, noting that the mayor’s position left Blascovich without legal domicile, a status precluded by international law (Uddin, 2018, 291–292). In April 1930 came the ruling, relayed to Bilucaglia from the Pula Prefect’s office. The decree’s validity dated to the Saint Germain Treaty’s coming into force in 1920 (AdSTS, Pref., Uff. Citt. 4392, Blascovich).

Health Care Workers

While physicians were expected to embrace corporatism, “like priests cultivating the faith in Fascism” (Taroni, 2021, 112), and despite increased accountability and surveillance of professionals and professional organizations, healthcare professionals seemed welcome in the Italian national community, even if they had a tenuous Italian ethnic identity. Many medical professionals were trained in Vienna, Prague, Graz, or Innsbruck, in Austrian or German medical academies, internationally recognized as on par with or even superior to Italian institutions (Vinci, 2012b, 50–51). Fascist Italy sought a “purely” Italian national community, but chronic shortages of trained medical personnel, especially in rural areas, plagued the peninsula as well as lands inherited from the Habsburg monarchy. In 1919, Štampar criticized the urban orientation of Viennese medicine and medical doctors’ lack of attention to rural areas and urged them to take a greater role in supporting the KSCS’s national public health life (Zylberman, 2004, 81).

Shortages of medical personnel prompted leniency with respect to nationality requirements for doctors like Alfonso Wittemberski, born in Lviv (Galicia, now Ukraine) in 1871, who had been in Pola since 1906 and was accorded citizenship in 1924. His mother was Italian, he was well known and possessed property in Sagrado, proving his fitness for Italian citizenship (AdSTS, Pref., Uff. Citt. 4681, Wittemberski). Giulio Mahler, with pertinency in the former Hungarian spa town of Buziásfürdő, which became part of Romania as Buziaş after the war, gained Italian citizenship in February 1923. A doctor in Opatija (Abbazia) since 1899, he was employed at the Voloska (Volosca) Sanatorium. Officials noted that he was Hungarian, but spoke Italian well (AdSTS, Pref., Uff. Citt. 4535, Mahler).

Fanny or Francesca Kamensek, a nurse, was granted Italian citizenship despite her “Slavic origin,” attendance of Slavic schools, and pertinency in Selce (Dalmatian Croatia). Her petition noted that she was of Italian sentiments, but also that she sought citizenship to maintain her position at the local S. M. Maddalena Hospital. The only one of her siblings who had reached the age of majority at the time of the Armistice, Kamensek filed for Italian citizenship at the same time as her mother, widowed since 1923, and who sought access to her husband’s pension due to death from a wartime injury. Officials noted that the mother Orsola spoke little Italian, that the family “used the Slavic language at home,” and that they “did not seem to nurture real Italian sentiments.” Policy precluded awarding citizenship to those who sought it solely for financial gain. Nonetheless, in 1925 and 1926, Orsola and then Fanny Kamensek received citizenship under the terms of election (AdSTS, Pref., Uff. Citt. 4490, Kamensek).

Professional standing was also likely a factor for Alda Dabcevich, a lay sister at the Civic Hospital of Trieste. Born in Trieste in 1893, she was granted citizenship in Trieste in 1924, despite her father’s decision, as a mercantile captain from Dobrota, Dalmatia, to accept Yugoslav citizenship. Her brother Egone, working for Lloyd Triestino also sought and gained Italian citizenship despite officials’ uncertainty regarding his language and nationality. The local commissioner noted that he spoke French, English, Italian, and German, and used Italian. But, the police (carabinieri) report was less precise and different, citing simply “Slavic” origin (AdSTS, Pref., Uff. Citt. 4424, Dabcevich).

CONCLUSION

The cited cases offer a glimpse of the idiosyncrasies of health care policy in the Adriatic borderlands as local authorities and populations struggled to navigate the abrupt legal end of *Heimatrecht* and to adapt to the Italian state system. While Fascist authorities in Rome made increasingly stringent nationalist demands, local authorities negotiated the realities of public health care and individuals’ lives and circumstances on the ground. For widows, children, and the infirm, humanitarian impulses affected interpretations and action on national policy. Imprecision masked ethnic affiliations that did not accord with nationalist expectations. Local authorities’ alacrity to be absorbed into Italy was tempered by the recognition of the unique circumstances of the borderland and traditional Habsburg rights and privileges that were poorly understood and not accepted in Rome. They struggled to remold social networks and reconstruct social safety nets conceived in the Catholic empire to fit the expectations of the liberal secular Italian state.

In Italy, biopolitics and demographic “health” were increasingly ensconced in national policy as the Fascist government tightened its hold. Fascist demographic programs promoted health, “purity” and individual sacrifice in the interests of the national community, but collaborative liberal internationalist initiatives coexisted with exclusionary demographic and health policies. Processes to ensure the “quality” and desirability of peoples and populations were believed to be fundamental to the health and development of the nation (Borowy, 2009, 17, 24). The Fascists capitalized on Italy’s internationalist Liberal bent and international influence of the immediate postwar years. Playing host to League of Nations’ Health Organization international exchanges, which peaked in the late 1920s (Borowy, 2009, 196–205), they boasted of population policies linked to the national demographic program, touting Italy’s social health achievements on an international stage (Borowy, 2009, 284; Ipsen, 1993, 75).

Research on health management and its intersections with politics, national programs, and international laws offers a complement to disease-focused healthcare studies and reveals much about institutional and national approaches and philosophies in the global health environment. Exploring the intertwined relationship between citizenship and national healthcare in Central Europe in the Italian-KSCS borderlands in the wake of World War I reveals how Liberal internationalism that sustained hierarchies of populations drew lines between “civilized” and “uncivilized” societies and how commitment to self-determination predicated on ethno-national homogeneity affected the management and practice of public healthcare on an international scale. Health management systems that developed in the interwar period were not simply failed initiatives swept away with the coming of World War II. They provided the framework for international healthcare management and models for the interface of states with international institutions. The legacies of Liberal bio-politics and post-World War I development of international health networks provided the foundations for international healthcare that developed after 1945 (cf. Vinci, 2012a, 10–11) and continue to hold sway today in the liberal global healthcare environment.

STROŠEK "NEŽELENIH": DOMICIL IN ZDRAVSTVENA UPRAVA V ITALIJANSKIH JADRANSKIH PROVINCAH V LETIH 1919–1927

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POVZETEK

*V novih jadranskih provincah Italije so v desetletju po prvi svetovni vojni javni uslužbenci upravljali javno zdravstvo v okviru, ki si je prizadeval uveljaviti enoten nacionalni zdravstveni sistem. Ta je bil vzpostavljen že v času habsburške monarhije in nato prilagojenem standardom liberalne Italije ter nazadnje preoblikovan pod fašističnim režimom. Njihove pristojnosti so med drugim zajemale urejanje oskrbe oseb brez državljanstva oziroma »neželenih oseb« (*unclaimed persons*), ki so zaradi prepletanja mednarodnih sporazumov in nacionalnih predpostavk obstale v vrzelih med različnimi sistemi javnega zdravstva. Liberalno-internacionalistična načela, ki so usmerjala vzpostavljanje globalne zdravstvene mreže, so temeljila na modelu nacionalne države. Ta načela so se prenašala tudi na lokalno raven ter vplivala na pravni položaj posameznikov v odnosu do nasledstvenih držav, na njihovo vključevanje v povojne skupnosti po prvi svetovni vojni ter na njihov dostop do socialnega varstva in z njim povezanih pravic. Namesto da bi sodelovale pri oblikovanju novega nacionalnega zdravstvenega sistema na obrobju države, so morale italijanske oblasti zdravstvene ustanove in socialne službe na obmejnih območjih preoblikovati tako, da so ustrezale sistemu, razvitem na Apeninskem polotoku in centralno upravljanem iz Rima. Biopolitika oblikovanja nacionalne skupnosti na obmejnem prostoru je temeljila na interpretacijah mirovnih pogodb po prvi svetovni vojni ter na presoji o upravičenosti posameznikov do pravic in o odgovornosti države zanje. Lokalni uradniki tako niso zgolj izvajali mednarodnih standardov in politik, temveč so razvijali lastne prakse in strategije za reševanje anomalij, ki so izhajale iz neskladij med habsburško in italijansko pravno tradicijo ter upravnimi praksami. S tem so dejavno sooblikovali etnične in nacionalne razsežnosti zdravstvenega in socialnovarstvenega sistema v italijanskem obmejnem prostoru.*

Ključne besede: jadranske province, zdravstvo, državljanstvo, domicil, liberalni internacionalizem

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SHATTERED MINDS IN SHATTER ZONES: PSYCHIATRY AND GENDER AFTER THE GREAT WAR IN THE CARINTHIAN BORDERLANDS

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ABSTRACT

This article contextualizes questions of citizenship at the intersections of gender, statehood, and notions of 'normalcy' in post-1918 Carinthia. Integral to this study is the analysis of psychiatric files of female patients in the aftermaths of the Great War as pertinent, yet generally overlooked sources for microhistorical approaches towards post-conflict nation building. For this contribution, women's psychiatric records of the Landeskrankenanstalt *(Provincial Hospital) in Klagenfurt/Celovec for the period from 1918 to 1923 are investigated. At the nexus of in/sanity, patriarchy, and patriotism, such documents can shed new light on processes of in- as well as exclusion of certain individuals, especially when of the 'other' sex and 'unchaperoned'.*

Keywords: gender, psychiatry, interwar period, Carinthia, trauma, migration, citizenship

MENTI DISTRUTTE IN ZONE DISTRUTTE: PSICHIATRIA E GENERE DURANTE LA GRANDE GUERRA NEL CONFINE CARINZIANO

SINTESI

Questo articolo contestualizza le questioni di cittadinanza all'intersezione di genere, stato e nozioni di "normalità" nella Carinzia post-1918. Parte integrante di questo studio è l'analisi delle cartelle psichiatriche di pazienti di sesso femminile nel periodo successivo alla Grande Guerra come fonti pertinenti, ma generalmente trascurate, per approcci microstorici alla costruzione della nazione post-conflitto. Per questo contributo, vengono esaminate le cartelle psichiatriche delle donne del Landeskrankenanstalt (l'ospedale provinciale) di Klagenfurt/Celovec per il periodo dal 1918 al 1923. Al nesso di in/sanità, patriarcato e patriottismo, tali documenti possono gettare nuova luce sui processi di in- nonché di esclusione di determinati individui, specialmente quando appartenenti all'altro' sesso e 'senza accompagnatore'.

Parole chiave: genere, psichiatria, tra le due guerre, Carinzia, trauma, migrazione, cittadinanza

INTRODUCTION[1]

This article deals with psychiatric charts of the *Abteilung für Psychiatrie* (the psychiatric ward) at the *Landeskrankenanstalt* (Provincial Hospital) in Klagenfurt/Celovec, the capital of Carinthia. The contribution seeks to explore the fate of hospitalized women and girls, many of them displaced persons, *after* armistices and peace treaties for the approximate period from 1918 to 1923. For the research at this specific psychiatric ward in Klagenfurt, up to 1,000 records of female patients were inspected for the given years from 1918 to 1923, highlighting socio-political and socio-economic dimensions rather than aspects of medical historiography.

In order to tease out symmetries or discrepancies and to conduct a contrastive analysis between war and peace times, also the charts before 1918 were examined, and, ostensibly, there could be registered a distinct paradigm shift with new arrivals towards the end of the First World War: Until 1918, the average resident in the clinic had been a local citizen, either diagnosed as insane from birth or early adolescence, therefore spending their entire adulthood in care there as a long-term case, or, alternatively, as an elderly, senile woman, who had been basically retired there until she deceased. From 1918 onwards, however, there can be detected an immediate and significant influx of women patients with local backgrounds as well as with trajectories of 'refugeedom' (Gatrell, 2013) pouring into this clinic, which lends itself to a comparative study of various female patients and their treatment by the clinic's staff.

Quite palpably, this sudden rise in local women and girls being admitted to this psychiatric ward interfaces with the complexities of *total war*, first and foremost, the blurring of frontlines. More precisely and in the specific case of Carinthia, there happened a war after the actual one, because towards the end of the First World War, forces of the Kingdom of Serbs, Croats, and Slovenes took control of the provincial capital Klagenfurt and laid claim to the geographic basin landscape, in which it is located. Subsequently, the Carinthian population formed ad-hoc militias, and this guerrilla warfare with paramilitary clashes and the numerous stand-offs between the two adversaries also produced atrocities against nearby female civilians, committed by both sides – especially in the form of sexual assaults – with the inevitable consequence of these heavily traumatized local women and girls being brought mostly by their family members to the psychiatric clinic in Klagenfurt (Weimann, 2008; Révész, 2016).

Parallel to that, there can be found the 'single' female refugee, ending up in this clinic after escaping from the various theatres of war, particularly in the south-eastern parts of Europe. Therefore, the clinical charts in Klagenfurt are a useful reservoir for deciphering and teasing out differing treatments of the many female patients, according to whether they were classified as 'local' or 'foreign.' During this era, the medical staff

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on the psychiatric ward in Klagenfurt was confronted with waves of 'alien' women and girls pouring into the clinic as traumatized refugees and displaced persons. In many instances these women lacked decipherable national backgrounds or family ties. Thus, this contribution concerns itself with women and girls who ended up outside the invisible yet powerful confines of sociocultural belonging. In the polarity of citizen versus non-citizen, these women – usually displaced persons without male guardianship or any other family relations – could at best exercise a form of 'para-citizenship' (Wernitznig, 2025a, 68–74), hidden behind the walls of a mental clinic. The term para-citizenship has been chosen to signify women patients' parallel existence as 'non-normative' citizens alongside 'mainstream' society in the 'outside' world.

Their para-citizenship, juxtaposing the agenda of a newly constructed state after conflict by delineating 'alienness,' served as a welcome matrix for this very same state and its citizens to craft a new nationhood. Austrian postwar citizenship relied on dualisms that differentiated the 'imagined community' (Anderson, 1983) of the First Republic from peoples and entities that were understood as 'corrosive.' Citizenship, its entitlements, and its duties turned into a crucible for defining public and private space during the Austrian postwar transition from Dual Monarchy stretching across Central Europe to a democracy with universal suffrage that comprised the 'butchered Alpine rump' of the former Habsburg lands. Therefore, concocting an imagery of para-citizens who were doomed to represent the 'other' – for example, in terms of ethnicity, gender, or religion – became pertinent to assist the rebirth of 'Austrianness.' This marginalization of such para-citizens as involuntary in-between and preferably temporary inhabitants clearly was a byproduct of systemic bias. In many ways, the neologism para-citizenship can constitute a helpful blueprint to disentangle the manifold components on the nuanced spectrum of citizenship in any given country or during any given epoch (Wernitznig, 2025a).

With the specific time frame of this study, the term para-citizenship particularly helps to locate and dismantle debates about 'native' versus 'foreign' subjects and their ramifications for private versus public spheres (Habermas, 1962). As citizenship per se underwent a metamorphosis in the interwar years with the introduction of the female franchise, the creation of new borders as well as borderlands, and displaced persons on an unprecedented scale, such 'surplus' citizens in many cases ended up alongside, *not* within, 'mainstream' society. In this scenario, the ingredient gender and its frequent medicalization often turned female bodies (and minds) into post-armistice battle grounds over procreation and national reconstruction that gravitated around maternalism, masculinities, and social welfare.

Accordingly, for such areas with particularly high levels of military and paramilitary violence, psychiatric documents of refugee women and girls deriving from various demographics and social strata and admitted to mental asylums (as was the case in Klagenfurt) during and after these armed conflicts can represent crucial and helpful, albeit to this day mostly omitted, sources for scholarship. Moreover, such psychiatric files can be pertinent to examine the wider implications of intricate dynamics and processes in post-conflict societies, such as in- and exclusion methods and strategies amidst socio-political challenges, like, for instance, 're-traditionalization' and 'cultural' demobilization, particularly for defeated nations (Quine, 1996; Allen, 2005). They reflect and elucidate trauma that stemmed from the war and sometimes arose even more forcefully in its wake with new sociopolitical challenges.

(POST-)WAR TRAUMA AND THE 'SECOND' SEX IN THE FIRST REPUBLIC

Containing narratives of both patients and medics through the prism of psychiatry, the herein analysed clinical protocols provide useful insights into the panorama and goings-on of everyday life outside of the hospital walls, in what is usually termed 'regular' society (Nolte, 2003; Brändli, Lüthi & Spuhler, 2009). Evidently, the medicalization of inmates' previous experiences in this outside world is not free from cultural, economic, and ideological connotations and as such frequently includes fruitful information beyond mere anamneses and diagnoses. Noticeably, such medical records become a foil for gendered expectations of 'dysfunctionality,' as opposed to 'conformity.'

Quite remarkably and surprisingly, however, this area of research has not yet attracted a lot of attention in historiography, particularly when it concerns women patients. Whereas there exists a fair amount of literature about combatants' trauma (Loughran, 2010; Reid, 2010; Leese, 2014) and some in-depth studies of psychiatric records (Robinson, 2020) that are based on the phenomenon of so-called 'shell shock,' emerging particularly within the context of the United Kingdom after the Great War, female patients on mental wards still do not feature prominently on the scholarly radar. The academic focus is almost exclusively placed on wartime traumas of military personnel with some rare exceptions (Keown, 2018; 2019; Wernitznig, 2021). In contrast, there continues to persist a certain historiographic myopia towards non-combatants and their traumata, ordeals, and disorders on the home front and after armistices. This situation is especially deplorable, because psychiatric files of women and girls especially traumatized by 'refugeedom' and (para)military sexual violence most of the time represent the only documentation of such life stories, although from a gendered perspective.

Generally, all women patients, whether they were local residents or 'alien' refugees, experienced a denial of trauma diagnoses in comparison to their male relatives and veterans. Habitually eliminated from the equation of war and trauma by the medical community, physicians' assessments of female civilians with mental problems were mostly devoid of the diagnostic terminology that was otherwise readily applied to soldiers' anamneses. This exclusivity and bias towards male patients and their war traumata, naturally, cohered with patriarchal blueprints or political intentions of demobilization and the restoration of conventional gender roles after 1918 (Kuhlman, 2008).

As the nexus of gender and trauma became by and large institutionally and socially suppressed, female portrayals of mental illnesses were, at best, deprioritized or sidelined next to male patients' tales and chronicles. Hence questions and parameters of sanity became intersected with gender expectations, especially in post-conflict eras, and Foucauldian power structures are flagrant in the investigated psychiatric charts (cf. Foucault, 1961; 1975; 1988). Consequently, discourses about female patients and their potential insanity are embedded in hierarchies, both deriving from the intrinsic institutional structures of psychiatric wards and the external layers of policies in the wake of the First World War.

Psychiatric protocols therefore also integrate and are characterized by alienation or 'othering' processes that establish artificial orders, with refugee women ranking decidedly lower. This female 'Other' and the distinct ellipsis of trauma rhetoric in her psychiatric accounts rendered by exclusively male diagnosticians, further evidences and perverts gendered traumata into a *troumatisme*, a 'hole in the truth,' as coined by Jacques Lacan, in post-conflict patriarchy and patriotism:

> *When I speak of a hole in the truth, it is not, of course, a crude metaphor, it is not a hole in a jacket, it is the negative aspect that appears in what pertains to sexuality, precisely its inability to reveal itself. That is what psychoanalysis is about.* (Lacan, 2005, 34)[2]

Stigmatized and silenced by such 'holes in the truth' that prevented the female patients to 'become whole' again, women's voices were thus heavily outnumbered by data on combatants' mental health during and after the war.

Unsurprisingly, the clinical recognition of traumata and their aftershocks as Post-Traumatic Stress Disorder (PTSD) was initially monopolized by the military and reserved for armed forces: Harking back to Eugen Bleuler's pioneering oeuvre *Dementia praecox oder Gruppe der Schizophrenien* (1911), translated into English as *Dementia Praecox or the Group of Schizophrenias* only in 1950, US psychiatry of the 1960s formulated the novel concept of PTSD against the backdrop of the Vietnam War and its many veterans' mental ailments. Finally in 1980, PTSD, hence deriving from and biased towards specific atmospheres of warfare and their aftermaths for fighting forces, was finally adopted into the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association.

Over the last decades, the field of PTSD and trauma studies has subsequently readapted perspectives on gender (Kimerling, Ouimette & Wolfe, 2002) and mushroomed beyond an exclusively military focus, ranging from postcolonial to transgenerational trauma (Denham, 2008; O'Laughlin & Charles, 2015). The increasing globalization and thematic inclusiveness of approaches towards PTSD also epitomized a deconstruction and redefinition of traditional assessments of war-related traumata in- and outside of Europe after 1945 (Leese & Crouthamel, 2016; Kivimäki & Leese, 2021). This article also attempts to fill in some blanks of previously neglected themes in PTSD and trauma historiography (LaCapra, 2014; Leese, Köhne & Crouthamel, 2021) and endeavours to remedy the gendered asymmetry of war-induced traumata in clinical institutions, such as the mental asylum of Klagenfurt.

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[2] *Quand je parle d'un trou dans la vérité, ce n'est pas, naturellement, une métaphore grossière, ce n'est pas un trou au veston, c'est l'aspect négatif qui apparaît dans ce qui est du sexuel, justement de son inaptitude à s'avérer. C'est de ça qu'il s'agit dans une psychanalyse*. (Lacan, 2005, 34)

For instance, the aforementioned monopoly of trauma diagnoses, reserved for male patients, hence even resulted in misogyny towards institutionalized women, especially when they were refugees or displaced persons. The mapping of mental illness was thus heavily determined by an intersectionality (Crenshaw, 1998) of sex, class, and ethnic or migratory backgrounds and in most instances served as an administrative tool for socio-political ends. Overall and quite perturbingly, for all women patients, whether local or foreign, the Freudian definition of hysteria (Freud & Breuer, 1895), deriving from the nineteenth century, prevailed, and they remained gridlocked in such stereotypical and gender-related notions of ‘feminine’ symptoms (Croft, 2012; Tasca et al., 2012).

Nevertheless, whereas local women and girls who suffered from gendered violence as a result of the post-1918 battles on Carinthian soil were released rather swiftly from the clinic after a couple of days or at most weeks into their traditional family unit and local community, refugee women and girls, especially when perceived as unchaperoned – without a patriarch or a spouse – were kept on the ward for an, on average, disproportionately long period of time of at least several weeks or even years. Notably, there can be unearthed permanent admissions into this clinic from a quite heterogenous pool of female refugees, covering all ages, diverse occupations, social, educational, and religious backgrounds. For instance, two cases that are representative for refugee women and girls, who displayed quite reasonable symptoms of stress and trauma without hereditary signs of mental illness after experiencing the full brunt of war and displacement, were M. S. and O. Z. (AT-KLA 655-2 Se, b. 28).[3]

The refugee and widow M. S. (*1889 Škofja Loka; †1926 Klagenfurt) who spent the war on the frontlines as a trained nurse in Galicia and Russia, ended up in the clinic in Klagenfurt in May 1921 and was kept there until April 1926, when she died of *myodegeneratio cordis*, a deficiency of the heart muscle, not, as has to be stressed, from a mental condition. Experiencing the war like soldiers on the frontline, M. S. was exceptionally outspoken about casualties, encountering many nationalities in the firing range, who were all shot dead in her accounts: Italians, Serbs, German-speaking Austrians, Hungarians, and Galicians of various ethnicities.

A particularly tragic case was the adolescent and unmarried O. Z. (*1902 Homec; †1927 Klagenfurt), who had to flee from Gorizia to the second-largest city in Carinthia, Villach/Beljak, where she was diagnosed with *dementia praecox* and tuberculosis. An important factor in her anamnesis was that there were no reported cases of insanity in her family history, so it could be concluded with certainty that her state was not hereditary. Only eighteen years of age, she was sent to the psychiatric ward in Klagenfurt in December 1920, where she passed away six years later. As exiles from the southeast who did not fit into the fabric of society and who had no paterfamilias or male guardian to take care of them, M. S. and O. Z. were kept extraordinarily long behind the hospital walls until their premature demise.

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[3] For ethical reasons, the patients’ names are anonymized by only providing their initials.

Regarding admission procedures and logistics, every woman and girl had to state her nationality upon arrival in the clinic, which was one of the various assessment criteria of whether she possessed a lucid mind, besides, for instance, solving mathematical equations. In fact, this rigorous testing could have quite drastic consequences for the examinee. For example, a woman or girl, who was not quite sure or slightly hesitant which new nation she belonged to in the general post-1918 turmoil of rapidly shifting borders in certain regions after the dissolution of Austria-Hungary, was automatically declared insane (AT-KLA 655-2 Se, b. 33). This is even more deplorable, because most exiles from Eastern and South-Eastern Europe were usually described as not being able to speak German. So, on their forms, the *laissez-faire* comment 'communication not possible' can be discovered. Consequently, simply by lacking the linguistic ability of making oneself understood, these patients ended up being classified as insane, since adequate verbal delivery was one vital assessment coefficient (AT-KLA 655-2 Se, b. 30). Therefore, where the demarcations of insanity were sometimes drawn very much depended on issues of nationality or in- and exclusion processes.

Similar to the tactic of 'stowing away foreign arrivals' and hiding as well as muting and sedating them behind hospital walls, the method of exclusion by transferring them beyond state borders was another strategy by the administrative staff. Incidentally, it was also a frequent policy to return refugee women, when logistically feasible, to their former native countries to avoid costs. Thus, these patients were moved by authorities across transnational borders that, ironically, were otherwise sometimes almost completely sealed or at least less porous for 'sane' travellers. This was the case, for instance, with R. W. (*1898 Heilbronn) (AT-KLA 655-2 Se, b. 29), handed over to Italian authorities, and M. U. (*1901 Kranj) (AT-KLA 655-2 Se, b. 31) who was returned to Preddvor after brief stints at the clinic for amentia from August to September of 1923. What all these female refugees had in common was a profound tapestry of stories about loss and obliteration, rarely ever acknowledged in their value as *Zeitzeugen* or eyewitnesses of wars and their aftermaths (Mitroiu, 2018). Rather, they were either locked away permanently or deported across borders to make them invisible as noncitizens of the other sex.

From a historiographic and global perspective, the dynamics of citizenship and gender are associated with a multitude of complex factors, such as coverture laws based on the Napoleonic Civil Code or the struggle for equal franchise, to name but two (Kerber, 1997; Canning & Rose, 2001; Sulkunen, Nevala-Nurmi & Markkola, 2009). Postwar transformations of state frameworks and political systems led to additional changes concerning the rights of citizens (Kerber, 1990; Aoláin, Haynes & Chan, 2011; Bader-Zaar, 2017). Since the concept of citizenship is usually bound to gendered notions that tend to reaffirm stereotypes of 'masculinities' and 'femininities,' post-conflict sociopolitical changes tend to affect women and men differently (Vogel, 1991; Walby, 1994; Inglehart, Norris & Welzl, 2002). In conjunction with reconstruction, national ideologies are intertwined with gender identity to a great extent, and women's status in society is frequently determined by their biological function of childbearing. As keepers of the hearth and caretakers of future generations of citizens, they are easily ascribed the roles of 'boundary-markers' (Pettman, 1996, 187, 195–196) within sociocultural and socioeconomic processes of postwar transitions.

Consequently, statelessness as a lack of determinable nationality or belonging to a 'collective' during destabilized postwar times further increased the vulnerability of female patients from Eastern and South-Eastern Europe who came under the custody of Austrian bureaucrats and physicians alike. By assessing medics' protocols and reports, this chapter aimed to unpack the status of para-citizenship assigned to these female and 'foreign' residents. More specifically, the diametrical treatment of 'alien' and 'native' patients corroborated the political status and value of women beyond private spheres when it came to the curtailment or boosting of civil rights (Wilford & Miller, 1998; Yuval-Davis & Werbner, 1999). As was teased out, obtaining citizenship could be inherently volatile for those who did not deserve it in the eyes of national and international authorities or officials.

Interestingly, all of these mostly stateless women and girls at the clinic were described in the psychiatric records as intellectually fully aware, without so much as a remote hint towards moderate mental conditions, much less severe streaks of insanity. This is particularly remarkable, because it has to be remembered that – as explained previously – most of them had to operate in the German language, when scrutinized with complex questions by the psychiatric personnel, and not their native tongue, whilst answering these queries.

The narratives of stateless and working-class female refugees also exemplify the administrative no (wo)man's land of 'unchaperoned' or 'surplus' females, whose nationality could not be determined and who thus could not be sent 'back to where they once belonged' (Bhabha, 1998). They were viewed as single, 'unprotected' women without a paterfamilias or any other male provider, frequently stigmatized as prone to promiscuity and as a menace to society. Furthermore, they were castigated as impoverished, underprivileged women without qualifications or training, whose migratory background was conflated with aspects of class or milieu, ethnicity, and lack of education. A closer investigation of their files shows multiple levels of alienation within their search for refuge and asylum and sheds additional light onto gendered historiographies of displacement.

As the given practical examples of the psychiatric institution in Klagenfurt validate, narrative acts by the female patients as methods of self-expression and hence healing (Pennebaker, 1990) were either obstructed or forged to accommodate political landscapes and interests in post-war transitions. For instance, social psychologist James W. Pennebaker underlined the importance of detailing one's traumatic experience as a path to recovery:

> [*T*]*ranslating our thoughts into language is psychologically and physically beneficial. When people write about major upheavals, they begin to organize and understand them. Writing about the thoughts and feelings associated with traumas, then, forces individuals to bring together the many facets of overwhelmingly complicated events. Once people can distill complex experiences into more understandable packages, they can begin to move beyond the trauma.* (Pennebaker, 1990, 193)

CONCLUSION: PARA-CITIZENSHIP AND PATRIARCHIES

Since certain individuals were not necessarily welcome in the phases of nation building of the First Austrian Republic, clinical diagnoses therefore bore the potential to become powerful filters for questions of citizenship, nationhood, patriotism, and refugeeism. Obstructed by language and bureaucratic barriers, non-Austrian female inmates were denied an adequate 'talking cure' (Breuer, 1955, 30) that could have helped to verbalize their gender-based traumas in their own, unique voices. This lacuna of substantial patient-doctor exchange dovetailed with post-war transitions that cogently proscribed integration of 'subversive subjects,' such as female foreigners without roots in the local communities. Dominated by omission and isolation, their stay at the clinic prevented any stage of socio-psychological recuperation, which would have been a first step towards both deconstructing their traumatic episodes and joining post-conflict society as equal citizens. As Judith Lewis Herman asserted in her seminal study of much-overlooked gendered violence, for example, regarding sexual assaults, incest, and wife battering:

> *Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience.* […] *The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery.* (Herman, 1997, 133)

This non-narrativity or silencing of medical patients on the psychiatric women's ward in Klagenfurt did not simply play along designs and fabrications of national identity or traditional gender norms, but it also evinced policies of newly forming statehood that were geared towards the building of a 'homogenous' nation amidst interwar migration and exile. Female refugees or displaced persons, who did not fit into the given profile of a 'typical' Austrian citizen, were either conveniently placed in the mental asylum – the only asylum they were granted – to conceal them like O. Z. or, alternatively, transferred beyond borders by means of psychiatric diagnoses as shown by M. U. In both cases, clinical protocols frequently turned into a meta-text for post-war politics, inducing and engineering a new beginning and a collective identity as First Republic.

Citizenship for these foreign women and girls with suspected mental conditions remained largely static, cemented by bureaucracy inside and outside of the asylum walls, and went deeper and far beyond what Ruth Lister describes as dialectics or denial of citizenship and public-private dualisms (Lister, 1997; 2001, 323–332). The 'foreign arrivals' who ended up at the psychiatric institution in Klagenfurt faced discrimination, belittlement, and occasionally outright scorn on the basis of gender, ethnicity, and class. Diagnosed with 'madness,' they were excluded from the national body politic, deemed 'dysfunctional' individuals during an age of state formation and tremendous migratory fluctuation. Their claims to citizenship therefore illustrate a vertical alignment ensuing from social practices. Exposed to the scrutiny of civil servants *as well as* that of medical practitioners, their pursuit of attaining equity and respectability stagnated and was largely devoid of prospects to become naturalized as an Austrian citizen, especially when evaluated and deflected against their fellow Austrian, nonmigratory inmates at the psychiatric ward and beyond it.

Alongside bureaucracies of *jus soli* and *jus sanguinis* in post-1918 Austria, the psychiatric wing in Klagenfurt turned into an arena to calibrate and legitimize citizenship by fickle standards with counterproductive results for most migrant women patients. For instance, Elizabeth Cohen's simile of a reversed pyramid excellently typifies this adverse balance that tips against 'non-national elements' in society: 'Citizenship becomes an inverted pyramid that balances the heavy weight of rights on their connections to a narrow subset of specific acts and goods. Only the tip of the pyramid remains truly fundamental' (Cohen, 2009, 24).

The freshly installed Austrian democracy necessitated a reorientation of the intricacies and idiosyncrasies of citizenship. As Frederick Cooper, for example, underlined:

> *Citizenship entails belonging to some sort of political collectivity. It is a different type of relationship than that of a follower to a leader, be it a lineage elder, a chief, a noble, or a king. We could characterize these personal relationships as 'vertical,' while citizenship – as membership in a political entity – is 'horizontal.' Citizens exist in relation not just to a leader or in a more abstract sense to a state, but to each other. This distinction in ideal types is further complicated by each historical situation. Citizens are not only connected horizontally to their fellow citizens, but vertically to people with more or less wealth, power, or influence than they have. The degrees to which these different sorts of attachment play out vary greatly.* (Cooper, 2018, 5)

Yet the looming shadow of Austrian citizens' former 'vertical' liaisons with the Habsburg monarch and empire precluded a swift or unproblematic conversion to a more 'horizontal' set-up of intra-citizen exchange, particularly with the multidimensional inclusion of new members or former enemies from across borders and geo-political strategies or interwar chess games. More precisely, the Austrian situation of reinvented nationality and state belonging also went hand in hand with the newly and usually violently drawn borders that transformed the country – here we might recall the lyrics of the Carinthian *Heimathymne* (homeland anthem), which describe its borders drawn with blood: 'Where the border was written in blood' (*Wo man mit Blut die Grenze schrieb*).

A pivotal point in post-1918 Austria was the gendered restoration of traditional family milieus with rigorously masculinized and feminized roles. This restoration was mostly accomplished by sending women back to the hearth after the war effort on the home front to make room for returning veterans on the labour market. Policymakers promoted maternalism in particular, due to the decimation of Austria's male population on the battle fields. As many men had fallen on the front, women were encouraged to maintain their patriotic duties as keepers of hearth and home (Wernitznig, 2025b). Thus, and as discussed earlier, Austrian patients in the women's psychiatric wing were generally released after shorter periods, so that they could return to childrearing and childbearing. Equally, local female patients in their roles as wives, fiancées, or girlfriends were denied an adequate acknowledgement and treatment as rape victims who had survived attacks by enemy soldiers. As some of their husbands and male partners returned as mentally and physically wounded veterans, addressing these ‘sexual conquests’ by invading armies could have evoked the image of an emasculated and hence denigrated society and fatherland in the aftermath of the war (Marks et al., 2009; Robertson, 2018).

Inversely, the foreign women patients were denied autonomy by a clinical system geared towards the bureaucratic disappearance, or ‘de-selving,’ of female refugees. As defined by Maroussia Hajdukowski-Ahmed (2008, 37–38): ‘“De-selving” does not mean a loss of identity and culture, but rather the gradual erosion of *agency* imposed by the organizations, spatial configurations, laws, and relationships they confront in their refugee experience.’ In many cases, this loss of agency engendered a second-hand citizenship with diminished rights.

Austria’s post-1918 quest for statehood and stability emphasized democratization and social cohesion, despite lingering racialization. Alongside ethnicity, class, and gender, this desired cohesive canvas of post-war Austrian society further necessitated outlines of ‘normality’ to foster a new Republic that was partly demarcated by a ‘shatterzone’ (Bartov & Weitz, 2013). Psychiatric care in that respect became imperative to separate ‘surplus’ citizens – particularly female and from areas of newly defined states and previous Habsburg territories – whose biographies of trauma and alienness alluded to fragmentation rather than social cohesion or national unity. Tangibly, politics of difference and migrancy are steeped in racial discrimination and a fixation on statelessness. Dissecting these nationalizing politics of identity through a psychiatric lens sheds light on how undesired individuals are labelled as para-citizens, unable to partake fully in everyday life as a result of being rendered ‘beyond the norm’ in the short twentieth century. With evermore pressing waves of migration worldwide in this century, such para-citizens, who are mostly consigned today to permanent refugee camps without prospects of entering any mainstream society, risk becoming the norm rather than the exception.

RAZKOLI V DUŠEVNOSTI NA PORUŠENEM OBMOČJU: PSIHIATRIJA IN SPOL PO PRVI SVETOVNI VOJNI V KOROŠKEM OBMEJNEM PROSTORU

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POVZETEK

Članek kontekstualizira pripovedi begunk na alpsko-jadranskem obmejnem ozemlju Avstrije, Italije in Slovenije po prvi svetovni vojni skozi vidik psihiatrije. Z uporabo različnih kliničnih virov begunk in deklet v Deželni bolnišnici v Celovcu in o njih, želi ta prispevek uporabiti mikrozgodovinski pristop, ko raziskuje transnacionalne posledice v post-konfliktnih obdobjih in območjih. Na tej psihiatriji je poleg domačink in deklet pristalo veliko razseljenk in begunk iz vzhodne in jugovzhodne Evrope, ki so doživele travme med prvo svetovno vojno. Zato so psihiatrični domovi pogosto služili tudi kot omejitev za ženska človeška bitja, ki so kljubovala »običajnim« klasifikacijam. Ker pripovedi teh zdravstvenih kartotek odražajo več kot preproste anamneze ali diagnoze, članek o njih posebej razpravlja v zvezi s politično rekonstrukcijo družbe – ne z vojaškega ali družbenoekonomskega vidika, temveč z obravnavanjem vidikov in podob »normativnih« državljanov. Hkrati so psihiatrične kartoteke razseljenih civilistk – ki so bile zaradi svojih travmatičnih izkušenj sprejete v lokalne umobolnice – pomembni, a doslej zelo spregledani zapisi, ki posredno beležijo politiko spola po prvi svetovni vojni. Med demobilizacijo, obnovo in izgradnjo države v mladi prvi avstrijski republiki so se vprašanja državljanstva in begunstva križala s patriarhalnimi in patriotskimi predstavami o ženskosti, materinstvu in skrbstvu. Birokratski in kulturni diskurzi o migracijskem ozadju dislociranih in zlasti »brez spremstva« žensk in deklet po prekinitvi ognja so torej idealno služili kot prizma za begunstvo in apatridnost v prehodnih obdobjih.

Ključne besede: spol, psihiatrija, medvojni čas, Koroška, travma, migracije, državljanstvo

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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

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[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

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[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).

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[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]

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[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

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[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,

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[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),

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[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

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[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

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[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

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[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

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BIOLOGY OR ENVIRONMENT? DIAGNOSTIC TRENDS IN SLOVENIAN PSYCHIATRY FROM WORLD WAR I TO WORLD WAR II

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ABSTRACT

This article examines the role of psychiatrists and psychiatric institutions in the Slovenian environment during the tumultuous periods of World War I, the interwar years, and World War II. Drawing on quantitative and qualitative analyses of 2,220 patient files from the Ljubljana Psychiatric Hospital, it explores diagnostic trends, focusing on the role of biological determinism in explaining mental disease. The study highlights the influence of Habsburg-era scientific hereditary/biologically oriented traditions and the broader socio-political contexts shaping psychiatric practices. It also investigates how war psychological suffering was understood, documented, and occasionally dismissed, reflecting broader attitudes toward mental disease and disability in Yugoslavia.

Keywords: Slovenia, psychiatry, war, psychological suffering, biological determinism, Ljubljana Psychiatric Hospital, psychiatric diagnostics, World War I, World War II

BIOLOGIA O CONTESTO SOCIALE? TENDENZE DIAGNOSTICHE NELLA PSICHIATRIA SLOVENA DALLA PRIMA ALLA SECONDA GUERRA MONDIALE

SINTESI

Questo articolo esamina il ruolo degli psichiatri e delle istituzioni psichiatriche nell’ambiente sloveno durante i turbolenti periodi della prima guerra mondiale, degli anni tra le due guerre e della seconda guerra mondiale. Attraverso un’analisi quantitativa e qualitativa di 2.220 cartelle cliniche provenienti dall’Ospedale Psichiatrico di Lubiana, vengono esaminate le tendenze diagnostiche, con particolare attenzione al peso del determinismo biologico nell’interpretazione della malattia mentale. Lo studio mette in evidenza l’influenza delle tradizioni scientifiche di orientamento ereditario/biologico dell’epoca asburgica, insieme ai più ampi contesti socio-politici che hanno influenzato le pratiche psichiatriche. Viene inoltre indagato il modo in cui il trauma della *guerra fu compreso, registrato e talvolta sottovalutato, rivelando atteggiamenti più generali nei confronti della malattia mentale e della disabilità in Jugoslavia.*

Parole chiave: Slovenia, psichiatria, trauma di guerra, determinismo biologico, Ospedale Psichiatrico di Lubiana, diagnostica psichiatrica, prima guerra mondiale, seconda guerra Mondiale

INTRODUCTION[1]

In recent years, a growing body of scholarship has enriched our understanding of the social and cultural history of psychiatry in East Central Europe, also in the former Kingdom of Yugoslavia. These studies have centered on how psychiatric diagnoses and treatments mirrored the political and social upheavals of the region, particularly in the wake of the two World Wars (Antić, 2014; 2017; Karge, 2020; Hofer, 2004; Leese, 2018, 3–26; Coskos, 148–173; Seferović, 2020; D'Alessio et al., 2018; Brunner, 2000). A prevailing conclusion among researchers is that the Yugoslav psychiatric approach to war psychological suffering and neuroses bore unique characteristics, setting it apart from other, more extensively studied European contexts. It was with some exceptions especially after World War I largely dominated by biological and degenerationist frameworks, focusing on hereditary pathology and moral judgment rather than social factors.

These conclusions are largely based on sources from Croatian and Serbian hospitals and intellectual circles (Antić, 2014, 2017; Karge, 2020), leaving open the question of how this historiographical narrative might be complemented by sources from the Slovenian context. The Slovenian ethnic territory was in the interwar period in a great extent incorporated in the Kingdom of Yugoslavia (and another considerable part also in the Kingdom of Italy) and then, after World War II, in Socialist Yugoslavia.

Did psychiatrists in Slovenia, in the period before 1945, operate within similar paradigmatic constraints, dominated by biological and degenerationist frameworks, as some of their Croatian and Serbian counterparts, or do their practices reveal distinctive features?

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This paper examines the landscape of psychiatry in Slovenia during the tumultuous periods of World War I, the interwar years, and World War II. The first section offers a concise overview of the key figures in psychiatry in the Slovenian environment, focusing on their educational backgrounds, major scientific influences, and the paradigms shaping their theoretical and clinical work. Special attention is paid to their conceptualizations of the causes of psychiatric illnesses, especially how these ideas were informed by or reflected on the impacts of the two world wars.

In the second section, I address how these paradigmatic frameworks are manifested in the day-to-day practices of psychiatrists when working with hospitalized patients in the psychiatric hospital in Ljubljana. This section shifts the focus to an empirical analysis, drawing on records from the psychiatric hospital in Ljubljana during the same period. Using quantitative data extracted from 2,220 patient files, I explore the diagnostic categories applied, their evolution over time, and the possible reasons for these shifts. In the next chapter, I attempt to cross-examine these diagnoses with qualitative analysis of the patients' files in order to examine the presumed reasons for mental diseases[2] as well.

CENTRAL REFERENCES AND VANTAGES ON THE CAUSES OF PSYCHIATRIC DISORDERS

In the period between 1914–1945 the following psychiatrists mostly influenced the development and rationale of psychiatry of the Slovenian territory. Stevo Divjak and Fran Gerlovič acted as principals or directors of the *Ljubljana-Studenec Hospital for Mental Diseases*, which will be described in greater detail in the following chapter. The council of experts was further represented by Fran Göstl, Alfred Šerko, Mihael Kamin, Bogomir Magajna and Janez Kanoni. Some of them lectured at the then-incomplete Faculty of Medicine, part of the newly founded University of Ljubljana.

Almost all of the aforementioned psychiatrists had undergone a "Habsburg" or "Central European" formative period. They had completed their studies in the field of medicine in Vienna or more seldomly in Graz. Most also chose psychiatry as their field of specialty at these locations.

However, the younger generation (Kamin, Magajna and Kanoni) had completed both the practical and theoretical components of their university education as well as their specialty training, at least in part, in Yugoslavia. In this context, Zagreb played a particularly significant role (Kostnapfel, 1996). Furthermore, all of the aforementioned individuals pursued additional professional development elsewhere in Europe (Darovec, Milčinski & Skerbinek, 1991).

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[2] The terms *mental disorder* and *mental disease* are often used interchangeably, but they carry different connotations. *Mental disorder* is the preferred term in contemporary psychiatry, as it is more neutral and less stigmatizing. *Mental disease*, on the other hand, implies a biomedical model and is considered outdated and potentially stigmatizing. However, throughout this text I will use the term *mental disease*, as it reflects the historical usage found in primary sources (e.g. *duševna bolezen*), and is important for maintaining historical accuracy.

Referential studies show the interwoven nature of psychiatrists from the Slovenian environment, into the (post-)Habsburg intellectual and scientific world. Wagner von Jauregg is often named by the older generation. Krafft Ebing is also named alongside several other researchers the experts from Slovenia had access to during their specialty studies. The *Zeitschrift für Psychiatrie* is one of the scientific publications they reference in their articles. In their texts about mental diseases psychiatrists from Slovenia leaned especially upon Emil Kraepelin, Eugen Bleuler, Rudolf Pilz, and Julius Wagner-Jauregg.

These specific references to some extent point at what guidelines psychiatrists from Slovenia followed during their research and practice in the interwar period, as well those they opposed. A biological-determinist perspective on the causes of psychiatric disorders was unequivocally favored (Kanoni et al., 1965), likely shaping their assessment of the effects of war.

Immediately after World War I, Fran Göstl hypothesized the impact of war on the rise of mental diseases, particularly as he sought to motivate the relevant authorities (initially Italian, later Yugoslavian) to invest in the renovation of psychiatric hospitals—first in Gorizia, where he worked until 1919, and later at the psychiatric hospital in Ljubljana. However, he placed greater emphasis on the significance of physical exertion and poverty rather than psychological suffering.

For instance, in an article published in the Croatian medical journal *Liječnički Vjesnik* in 1920, he wrote:

> *That the number of mentally ill persons is increasing and will continue to increase as a result of the war is self-evident. The intense physical exertion in battle lines and trenches, the severe psychological distress to which soldiers were unaccustomed—concerns and grief for their families, the general deprivation among civilians—all explain this phenomenon. Inadequate and improper nutrition has caused widespread debilitation and reduced resistance, especially among women and children. Even in peacetime, these unfavorable conditions will persist, at least partially, for a long time and will only gradually improve. Their impact will not only adversely affect the present generation but also its progeny; consequently, cases of mental diseases will continue to multiply.* (Göstl, 1920, 550)[3]

In his 1924 popular monograph, *Misterij duše* (*The Secrets of the Soul*), Fran Göstl explored the causes of psychiatric illnesses amidst a noted rise in patient numbers. He acknowledged that some attributed this increase to the stress of modern life and civilization but argued that civilization could impact mental health both positively and negatively.

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[3] *Da število umobolnih vsled vojne narašča in bo še naraščalo, je umevno. Veliki napori v bojnih črtah in strelskih jarkih, nevajeni siloviti duševni stiski pri vojakih – skrb in žalost za svojce, splošna beda pri civilistih, – nam pojasnjujejo ta pojav. Nezadostna in neprimerna hrana je povzročila močno oslabelost in manjšo odpornost, zlasti pri ženstvu in otrocih. Tudi v miru bodo te neugodnosti vsaj deloma še dolgo trajale in se le polagoma zboljševale; vplivale bodo neugodno ne le na sedanjo generacijo, temveč tudi na zarod; množili se bodo i nadalje slučaji umobolnosti.* (Göstl, 1920, 550)

Göstl challenged the common belief, particularly among intellectuals such as writers, that psychological shocks from catastrophic events significantly contributed to mental diseases. While he recognized World War I's role in increasing cases of mental diseases, he emphasized the lack of comprehensive statistical data to substantiate this claim fully. Instead, he highlighted physical factors like exhaustion, malnutrition, and sleep deprivation, particularly among soldiers, as pivotal contributors to mental diseases, overshadowing the psychological effects of war horrors and homesickness.

To support his argument, Göstl presented two illustrative cases. The first was a soldier with a hereditary predisposition to mental diseases who developed an incurable disorder after being buried by a shell. The second was a neighbor who survived a bombing that killed two of her children. Despite temporary mental disorientation, she recovered quickly and later gave birth to a healthy child. These examples underscored his belief in the central role of hereditary predisposition in mental diseases. Göstl concluded that the primary causes of psychiatric disorders were hereditary degeneration and, critically, the widespread increase in alcoholism and syphilis, both during the war and more broadly (Göstl, 1924).

With regard to the impact of World War I on mental diseases, Alfred Šerko, another psychiatrist working at Ljubljana's psychiatric hospital, held a similar perspective. In his earlier works, Šerko did not advocate for a view that reduced the inner psychological world of an individual to mere materiality and cautioned against the complete subordination of psychiatry to neurology (Šerko, 1919). Nevertheless, he displayed unwavering skepticism regarding the existence of a purely psychogenic traumatic neurosis.

Šerko was aware of research supporting the concept of "traumatic neuroses," citing the works of German neurologist Hermann Oppenheim and French neurologist Joseph Babinski to illustrate these perspectives. However, he ultimately distanced himself from such views, aligning instead with authors who adhered to a biologically deterministic framework, including Philipp Jolly, Erich Strüpel and Alfred Hoche. He also endorsed the conclusions of the German military conference of 1916, which established a paradigm within the German medical community during World War I that dismissed the significance of war neuroses (Michl & Plamper, 2009).

Šerko described the mental disturbances observed in individuals following workplace accidents without physical injury as "annuity psychoses," a term suggesting that symptoms of mental diseases might be feigned or exaggerated with the intent of securing annuities from health insurance systems. In this regard, he diverged from the legal profession in Slovenia, which was more inclined to recognize "traumatic neuroses" when assessing eligibility for disability benefits. Notably, Alfred Šerko reportedly identified cases of malingering among soldiers during World War I, particularly while attending to hospitalized soldiers in Graz, thereby expressing skepticism about the legitimacy of such disorders in the absence of physical evidence of injury (Šerko, 1933).

Mihael Kamin, who worked in the Ljubljana psychiatric hospital in the 1930s, occasionally exhibited favor for biological-hereditary explanation for mental disease, at least at the beginning of his career. In fact, he was a member of the scientific committee of an otherwise sparsely active eugenic society (Cergol Paradiž, 2015).[4] At the time, he also drew his patients' family trees with no small amount of intensity. This was done in order to discover the causes of "endogenous psychoses." However, his efforts did not yield any particularly useful scientific results. Perhaps this is partly why he soon moved away from biological determinism.

Kamin was later described as "representing an advanced breed of young psychiatrists" acting "against the purely somatic orientation of psychiatry and against the anti-psychological spirit of […] excessive naturalistic psychiatry" (Kostapfel, 1996, 23). He also opposed neo-Lombrosianism and overemphasis on the link between criminal behavior and mental diseases. It was in this spirit that, in the early 1940s, despite being a fervent admirer of German psychiatry (Kamin, 1934–1935a; Kamin, 1934–1935b), he also opposed eugenic forced sterilization in principle. He was among the few psychiatrists in Slovenia in the 1930s who emphasized the importance of mental hygiene, modern psychotherapy, and the study of neuroses, from which, as he explained, "emerged the imperative to assess not only the patient's symptoms, personal characteristics, and immediate condition but also, and perhaps more importantly, their relationship to the entirety of their surroundings, their social class, the broader community, and the specific features of cultural development"[5] (Kamin, 1934–1935b, 293).

Kanoni, who refined his expertise in Munich during the 1930s, discussed Ernst Rudin's lecture on the forced sterilization of the "hereditarily inferior" in one of his contributions. While he did not unequivocally and directly reject eugenic methods, he nonetheless expressed disagreement with Rudin's clear-cut division between mental diseases stemming from environmental factors and those rooted in heredity. Kanoni argued that "even in hereditary diseases, the environment plays

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[4] In the 1920s and 1930s, eugenic initiatives appeared in Slovenian territory, promoted by political, medical, and academic elites such as Bogumil Vošnjak, Anton Brecelj, and especially anthropologist Božo Škerlj. Support for eugenics was driven by concerns over post-World War I national "degeneration" and the rise of Hygiene Institutes, which focused on public and generative hygiene. Škerlj conducted anthropometric studies and edited *Evgenika* (*Eugenics*) (1935–38), which advocated measures such as forced sterilization, though such policies were never legalized in Yugoslavia. The only partial eugenic legislation was the 1934 Act on the Suppression of Sexual Diseases, which was soon repealed. Eugenic discourse nonetheless spread widely through exhibitions, lectures, textbooks, and university teaching, and Yugoslavia even joined the International Federation of Eugenics Organisations in 1936. Slovenian eugenicists were divided: some advocated sterilization, while Catholic voices promoted positive eugenics like financial incentives for "fit" families. Unlike mainstream European eugenics, Slovenian writers avoided overt racism, often contrasting Slavic "peaceful eugenics" with aggressive German models. By the late 1930s, they distanced themselves further from Western eugenics, a position reinforced during World War II when Nazi occupation brought lethal eugenic policies, including mass euthanasia in psychiatric hospitals (Cergol Paradiž, 2015).

[5] *Iz študija neuroz je izšla nuja, da za presojo ni jemati v poštev edinole bolezenskega simptoma, osebe bolnikove in njegovega trenutnega stanja, ampak tudi predvsem njegovo razmerje do celotnosti njegove okolice, do njegovega družabnega razreda, do ljudske celote in do posebnosti kulturnega razvoja.* (Kamin, 1934–1935b, 293)

its role alongside hereditary factors, acting as a true determining factor [...]. There is no reason to believe that hereditary diseases cannot be preserved or that they are incurable"[6] (Kanoni, 1938, 28–29).

During World War II, when the Yugoslav part of Slovenia was occupied by Italian, German, and Hungarian forces, psychiatric institutions in Slovenia faced significant challenges. Patients from the Novo Celje psychiatric hospital, a psychiatric hospital that was established in Slovenia in the thirties, were deported to German-annexed Austria and euthanized (Ziherl, Čebašek-Travnik & Zupanič Slavec, 2007).

In contrast, psychiatrists in Ljubljana actively cooperated with the resistance movement in various ways. For instance, Kamin and Gerlovič sheltered resistance activists at the Studenec facility under the pretense of mental diseases. They trained these individuals to simulate psychiatric symptoms so effectively that they even deceived a visiting Italian military psychiatrist. Tragically, neither Kamin nor Gerlovič survived the war. They were arrested and executed by the German occupiers, while Kanoni was sentenced to life imprisonment. Their fates were likely sealed by betrayal from within the hospital staff (Darovec, Milčinski & Skerbinek, 1991; Milčinski & Maklecov, 1995).

DIAGNOSES

As already mentioned, my analysis revolves around the records of the Ljubljana psychiatric hospital.[7] Quantitative analysis of the diagnoses in these records proved to be highly challenging. A significant methodological limitation of the sample is the fact that I was only able to examine records of patients discharged before 1945.[8]

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[6] *Tudi pri dednih boleznih ima okolje pomembno vlogo poleg dednih dejavnikov, saj deluje kot odločilen dejavnik* [...]. *Ni razloga, da bi verjeli, da dednih bolezni ni mogoče obvladovati ali da so neozdravljive.* (Kanoni, 1938, 28–29)

[7] The institution known as the "Studenec madhouse" opened its doors in 1881 and was later renamed the Hospital for Mental Diseases, now the Psychiatric Clinic of Ljubljana. The hospital comprised several facilities: the central building at Studenec, a psychiatric ward at Poljanski Nasip, and St. Joseph's Hospice. Before World War II, the Hospital for Mental Diseases accommodated 472 beds at Studenec, 398 at Poljanski Nasip, and 120 at St. Joseph's Hospice (Zupanič Slavec, 2012). In the mid-1930s, the hospital admitted approximately four hundred patients annually, a number that increased to over five hundred by the end of the decade. During the World War II, however, the number of annual admissions dropped to approximately three hundred (Darovec, Milčinski & Skerbinek, 1991). In addition to this facility, interwar Slovenia had only one other psychiatric hospital, located in Novo Celje, which housed 380 beds (Zupanič Slavec, 2012).

[8] Records of patients who died prior to 1945 or who remained in the psychiatric hospital beyond that year were not available for analysis, as I received exceptional permission from the hospital to access only the files of patients discharged before 1945. Records from after 1945 are unavailable for historical research due to ethical concerns—specifically, the protection of sensitive patient data.

During the 1930s, deaths accounted for approximately one-quarter to one-fifth of all admissions, while during World War II, this proportion rose to nearly half. Thus, mortality data could substantially alter the statistical ratios (Darovec, Milčinski & Skerbinek, 1991, 187).[9]

Moreover, the variety and frequent changes in terminology used by medical personnel in the records necessitated the simplification of the presented graph. First, in cases where two diagnoses (e.g., depression and schizophrenia) were recorded simultaneously or consecutively, I selected the predominant or final diagnosis after careful consideration. Second, I grouped some narrower diagnoses into broader or related categories partially based on the taxonomy employed by researchers of that time, predominantly from Yugoslavia. Wherever possible, I aligned these categories with the taxonomy used by Aleksej Kužljenko, the then-director of the Vrapče Psychiatric Hospital in Zagreb, in his comparative statistical analyses of mental diseases across Yugoslav hospitals conducted in 1934 and again in 1936 (Kužljenko, 1940).

Furthermore, it is necessary to consider the radical and extraordinary upheavals experienced by the hospital during World War II. Patients were relocated as parts of the hospital were repurposed as military prisons by the occupying forces. Under these challenging conditions, many patients died or fell ill, while others were intentionally misdiagnosed. Additionally, the number of admissions decreased significantly (Darovec, Milčinski & Skerbinek, 1991, 183–197).

Despite these methodological shortcomings, I hope that this approach to data processing and graphical representation, combined with qualitative analysis of the records, offers valuable insights into the specificities of psychiatric thinking in Ljubljana, which, like elsewhere, evolved significantly between 1911 and 1945.

Throughout the analyzed period, a consistent proportion of recorded diagnoses comprised chronic alcoholism or delirium tremens. For other diagnoses, however, significant fluctuations can be observed across different decades. Schizophrenia, as expected and consistent with trends in other Yugoslav psychiatric institutions of the time, was the most frequently diagnosed illness in all decades. However, its prominence varied, being less significant during the first and fourth decades (the periods of both world wars) compared to the 1920s and 1930s. Moreover, the proportion of schizophrenia diagnoses in Ljubljana's psychiatric hospital was notably lower compared to other Yugoslav hospitals. For example, in the 1931–40 period, schizophrenia accounted for twenty-eight percent of diagnoses in Ljubljana, compared to sixty-five percent at Vrapče Psychiatric Hospital in 1936, and sixty percent across all Yugoslav psychiatric institutions in 1934 (Kužljenko, 1940, 654).

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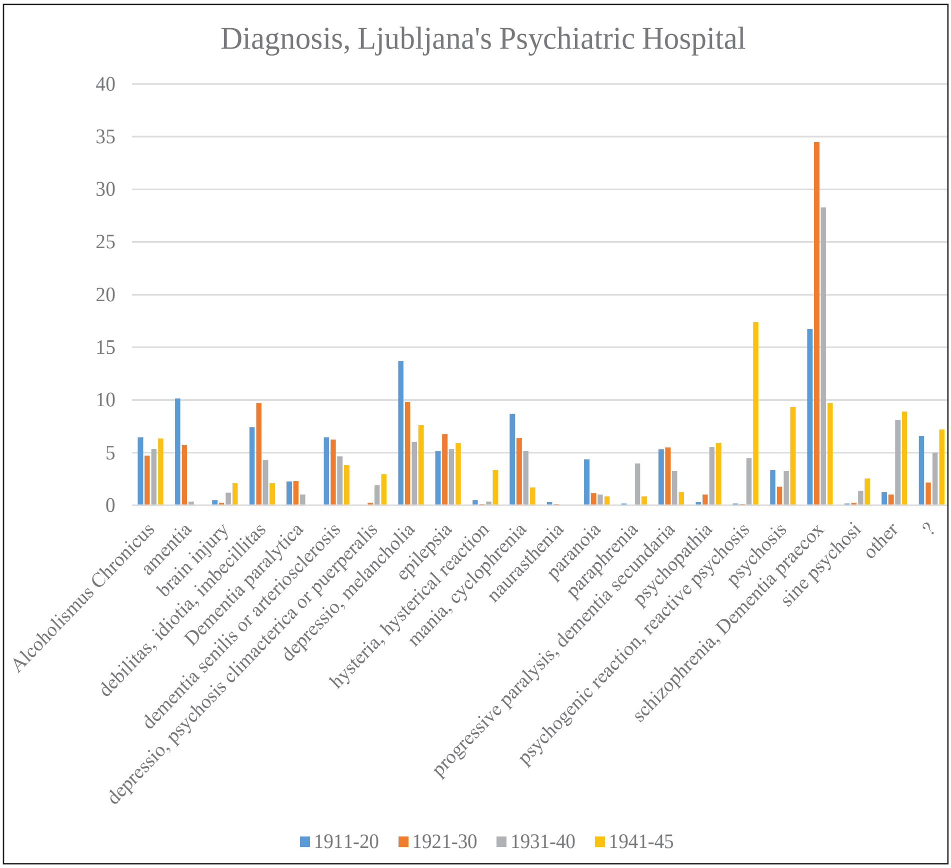
[9] It should be further clarified that this paragraph is not based on my own sources; rather, Darovec, Milčinski and Skerbinek (1991) relied on other hospital statistical data. Since my records are organized by dismissals, it is difficult to establish the exact number of admissions through individual patient files.

The proportion of patients diagnosed with depression/melancholia declined over the decades but rose again during World War II. Similarly, the proportion of diagnoses for mania/cyclophrenia and, predictably due to the introduction of antibiotics, progressive paralysis also decreased. Additionally, the once common and now seemingly outdated diagnosis of amentia, prevalent in the first decade, disappeared entirely from the records in later periods.

During World War II, there was a marked increase in the proportion of diagnoses for psychosis, hysterical reactions, and various other conditions suggesting a psychogenic origin or reactive element (Graph 1). These diagnoses placed greater emphasis on environmental factors in their pathogenesis rather than purely biological or organic predispositions for psychiatric illnesses.



Graph 1: Increase in the Proportion of Diagnoses Suggesting Psychogenic or Reactive Origins.

The relatively few patients explicitly recorded as soldiers in the files (a total of twenty- seven) were diagnosed with schizophrenia in more than fifty percent of cases for the period until 1940, aligning with findings by other historians for other Yugoslav hospitals. Karge interprets schizophrenia during World War I and right after as a diagnostic “loophole” into which difficult-to-diagnose cases were categorized, potentially to facilitate recognition of patients’ rights to military disability pensions. Direct diagnoses of war neuroses were, after all, disfavored by Yugoslav authorities (Karge, 2020).

Among the quite numerous other patients whose military service during World War I becomes apparent only through a detailed examination of their files, the majority were also diagnosed with schizophrenia, albeit less prominently (accounting for approximately one-third of such cases). A notable proportion was diagnosed with melancholia (one-sixth) and chronic alcoholism (one-ninth).

Patients identified in the records during World War II as soldiers, Partisans, or Home Guards (*domobranci*) were most frequently diagnosed with psychogenic reactions, hysteria, and other related conditions, comprising one-quarter of all such cases.

The shift in diagnostic practices is also documented in a 1991 study on the Ljubljana psychiatric hospital by Jože Darovec, Lev Milčinski, and Ladi Škerbinek:

> *During the still relatively calm period from March 5 to April 2, 1941, 42 patients were admitted, of whom twenty-six (sixty-two percent) were diagnosed with endogenous psychoses, while only three (seven point one percent) were diagnosed with psychosocial disorders (e.g., neuroses, psychogenic reactions, personality disorders). In the following month, this ratio (among a total of thirty-seven admissions) shifted to fifteen (forty point five percent) versus eight (twenty-one point six percent). Between April 6 and May 5, 1944, among twenty-seven admissions, nine (thirty-three point three percent) were diagnosed with endogenous psychoses, while eleven (forty point seven percent) were diagnosed with psychosocial disorders.* (Darovec, Milčinski & Skerbinek, 1991, 186–187)

Why did this shift in diagnostic practices emerge precisely at that time? On the one hand, it was undoubtedly shaped by the profound psychological impact and brutality of wartime events. On the other hand, it may reflect a broader paradigm shift within psychiatry in Yugoslavia and Slovenia that began in the late 1930s. Statistical data and diagnostic classifications compiled by Kužljenko (1940) suggest that Yugoslav psychiatrists in the 1930s recognized the role of psychogenic factors in mental health conditions, indicating a potentially significant evolution in the field’s theoretical framework.

Darovec, Milčinski, and Škerbinek offered two explanations for this diagnostic shift during World War II: “Exogenous factors gained greater significance during wartime, or, in cases of diagnostic uncertainty, it became easier to justify and present a neurotic disorder rather than a psychotic one” (Darovec, Milčinski & Skerbinek, 1991, 186–187). They further note that by the end of the war, there was an “epidemic-like” prevalence of traumatized Partisans, particularly among the *jurišanti* (assault troops) from the southern regions of Yugoslavia that often arrived in groups (Darovec, Miličinski & Skerbinek, 1991, 194).

Heike Karge and Ana Antić present differing conclusions regarding the acknowledgment and treatment of war neuroses (and related diagnoses) during and after World War II in Yugoslav psychiatric institutions. In her studies, Ana Antić argues that Yugoslav psychiatry of the time developed a heightened sensitivity to the psychological suffering caused by the war, particularly in relation to the Partisans (Antić, 2014; 2017). In contrast, Heike Karge contends that the psychological suffering of resistance movement members was largely marginalized toward the end of the war and in the immediate post-war period. According to Karge, traumatized Partisans were often diagnosed with conditions such as psychopathy or schizophrenia, diagnoses that emphasized constitutional predispositions over the impact of wartime experiences (Karge, 2020).

Patient records from the Ljubljana psychiatric hospital suggest an increased interest in the effects of traumatic experiences, not only among former Partisans but also across the broader patient population, at least until the end of 1945. However, it is crucial to interpret these records with an awareness of the close collaboration between psychiatric staff and the resistance movement. This collaboration may have influenced records and diagnoses in two significant ways.

First, beyond potential paradigm shifts within psychiatry itself, this collaboration could have spurred a desire to document the general suffering under occupation. The records from the Ljubljana psychiatric hospital might, therefore, served as a form of testimony to the violence perpetrated by the Italian and later German authorities. Second, as Marta Verginella (2026) highlights, the psychiatric staff’s alignment with the resistance movement may have motivated them to protect patients who had been Partisans. This could have been achieved by partially altering the narratives in the records—for instance, omitting details that explicitly revealed their involvement in the Partisan movement or reframing their experiences to shield them from possible repercussions.

AN OVERVIEW OF PATIENT FILES

More than the diagnoses themselves, the content of patient files reveals how thoroughly psychiatrists from Slovenia actually addressed and considered the consequences of both world wars—particularly the first—in their treatment of patients. The purpose of this chapter is to provide an initial panoramic view of the evolving approach to war psychological suffering in this region. Instead of offering a comprehensive description and analysis of a large number of patient files (a task undertaken in previous studies), this chapter will concentrate on those files that effectively illustrate the medical staff’s attitudes toward, and recognition of, war psychological effects, as well as the changes in these attitudes over time. As expected, psychological effects during World War I and immediately after are described significantly less explicitly in the records compared to the final period before 1945.

Reports on patients' life experiences are sparsely featured in the files from this period. The doctors' questions focus more on the physical development and, particularly in the case of women, sexual development of patients, on past infectious diseases (such as trachoma, malaria, syphilis, and Spanish influenza), or on their so-called "hereditary burden." Suicidal and alcohol problems of relatives are also documented. Additionally, patients' education and their success in school are noted, which, in the vast majority of cases, is described as extremely poor.

Heike Karge (2020) hypothesizes that the sparse descriptions of wartime experiences in the medical records of patients treated in Serbian and Croatian psychiatric hospitals are primarily due to the assumption that psychiatrists did not find it necessary to document such events, as they were considered self-evident. This reasoning partially challenges the idea that psychiatrists, adhering strictly to a biological paradigm, blindly dismissed the relevance of such experiences in the development of psychiatric disorders. This perspective is supported by patient files from World War I and its immediate aftermath from Croatian and Serbian environment, which include minimal references to wartime experiences but often explicitly note that affected soldiers were granted disability pensions based on psychiatric diagnoses—typically schizophrenia—that emerged during or as a result of the war (Karge, 2020).

The presumed self-evident nature of wartime atrocities might similarly have influenced the content of patient files in Ljubljana's psychiatric hospital. However, in contrast to Serbian and Croatian records, references to disability claims for psychological consequences of war are notably scarce in Ljubljana's files.

Were psychiatrists in Ljubljana more reluctant to recognize war-induced disabilities? One rare case mentioning disability involves an 18-year-old baker who voluntarily enlisted in 1915. Deployed to Russia, he was wounded and later, in 1919, was reenlisted. He was wounded again near Gornja Radgona, and from that point became extremely fearful. In February 1920, he was hospitalized with a diagnosis of dementia praecox (schizophrenia). After some improvement, he was discharged in October with a fifty percent work disability pension (EIPT, 57, 3852).

An even more illustrative case involves a man identified in the files as a landowner and discharged soldier. Drafted into active service with the artillery in July 1914, he fought in Italy, primarily around Trento. In May 1916, he deserted his unit near Trieste and arrived at a military hospital in a disheveled and distressed state, crying and lamenting that he had fled because "everyone had gone mad." He was subsequently transferred to the Ljubljana psychiatric hospital, where he expressed guilt for betraying Emperor Franz Joseph and was charged with desertion. A court-appointed medical examiner concluded that "due to hereditary predisposition and the strain of war, he suffers from melancholia," leading to his acquittal. He spent about two months in the psychiatric hospital before being discharged home under supervision.

He was readmitted in 1921, and his hospitalizations, likely intermittent, continued until 1939. Under provisions such as the 1920 Decree on Temporary Assistance and the 1921 Regulation on General Assessment of Disability, he was initially declared hundred percent permanently disabled due to melancholia. However, his disability status was reassessed in 1929, when Dr. Ivan Jurečko (1884–1964), a psychiatrist and court expert, attributed his mental health issues, including melancholic episodes, to hereditary predispositions rather than wartime experiences. Consequently, his hundred percent disability status was revoked (EIPT, 58, 3861).

A comparable shift in the recognition of war-related disability claims in Serbian and Croatian psychiatric hospitals during the late 1920s and early 1930s has been documented by Haike Karge (2020). This shift coincided with the enactment of the 1929 Invalid Law, which explicitly excluded psychiatric illnesses from the pension scheme for war invalids. In contrast, earlier laws and decrees had included psychiatric conditions (Kastelic, 2023; Karge, 2020). This policy change represented a significant turning point, highlighting broader socio-political attitudes toward the long-term psychological consequences of war.

The approach psychiatrists from Slovenia (and the state apparatus) took in treating patients who experienced psychological suffering during the war and sought state compensation, as noted by Janoš Kastelic, is also reflected in numerous complaints published in *Vojni Invalid* (*War Invalid*), a Slovenian newspaper dedicated to advocating for the rights of war invalids (Kastelic, 2023), as well as in the following patient file.

A 33-year-old man from Ljubljana was drafted into the army in 1914 as a regimental doctor. By 1915, he felt physically and mentally exhausted due to the demanding nature of his work. However, due to a shortage of doctors, he had to continue working until 1917, when he began to show clear signs of mental disease. He imagined that his colleagues and superiors were his enemies. He also began to handle weapons recklessly, which led to his admission to the psychiatric ward of the garrison hospital in Ljubljana in November 1917. As his condition worsened, he was transferred to the military department of the Steinhof mental hospital in Vienna, from which he was moved in 1923 to the mental hospital in Ljubljana.

Throughout this period, starting from 1915, he exhibited persecutory delusions and auditory hallucinations, according to the staff at the Ljubljana hospital. He was described as manically restless, “witty and annoying.” He still expected “that the Austro-Hungarian empire and he himself would be rehabilitated,” and he sent relevant orders to various world personalities. In his numerous letters, he described Slovenes as entirely incompetent and incapable of statehood, and he labeled all Slovenian psychiatrists as quacks. He was diagnosed with dementia praecox/schizophrenia paranoids, or schizophrenic psychosis. In the 1930s, he attempted to obtain a disability pension, but his requests were denied. For instance, in 1939, the medical commission provided the following explanation for the rejection:

> *Schizophrenia is a mental disease that arises from internal causes, with heredity being the most important factor. External factors are not significant for the onset of schizophrenia, meaning they are never causal, but at most, they may play a triggering role if the inherited predisposition is already present. Laypeople often attribute schizophrenia to external factors such as overexertion, deprivation, exhaustion, and others. However, psychiatry does not recognize this view as correct. Experiences from the World War have shown that the influence of social and physical factors is not substantial enough to cause severe and especially permanent mental disease like schizophrenia. It was observed that the number of schizophrenic psychoses did not increase at all after the World War, despite all its immense physical and mental strains and traumas.* (EIPT, 9, 596)

As mentioned, the abovementioned case originates from a later period when Croatian and Serbian psychiatrists also became more hesitant to recognize such claims.[10]

However, in the late 1930s, and especially during World War II, the deceptions in patient records, especially those signed by Kamin or Kanoni, generally changed. They were generally more detailed in terms of patients' life experiences and more frequently included also descriptions of socio-political events that affected these experiences. Moreover, narration and explanations from the part of relatives were included, while older records primarily focused on hereditary or familial histories and physical characteristics.

CONCLUSION

This study revisits the question of why psychiatrists from Slovenia discussed in this paper adhered so firmly to a biologically deterministic understanding of mental disease—not only in their scientific discourse but, distinctively, also in their

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[10] Interestingly, the mentioned patient was a doctor, an educated individual. This perhaps enabled him to at least attempt to link his illness to the consequences of the war and claim an invalidity pension. Educated patients were certainly a minority among the patients, although based on the data examined, urban residents were overrepresented among the patients. Given that, in the entire Drava Banovina, the interwar Yugoslav part of Slovenia, fifty percent of the population was still rural just before World War II, the sample shows that only about one-third of the population was exclusively engaged in agriculture. I was interested in whether patients from different social backgrounds received different psychiatric diagnoses at the Ljubljana psychiatric hospital. The differences are not pronounced. The most frequently diagnosed illness among all social classes is schizophrenia. However, it is diagnosed somewhat less frequently among the wealthier urban population compared to rural inhabitants and workers, whereas the proportion of psychopaths is higher among the urban population. Geographically, most hospitalized patients were born in smaller towns or villages in the region of Carniola. Many of those who lived in other countries lives were eventually repatriated to Carniola if they had *Heimatrecht* there, after shorter or longer periods of hospitalization elsewhere. In the 1920s, with the new state borders, the proportion of patients from Styria increased. Those born in parts of Carniola that were ceded to Italy or in the Austrian Littoral typically arrived in the Kingdom of Serbs, Croats, and Slovenians as immigrants or refugees before being hospitalized.

clinical practice. This approach contrasts with what we know of the praxis of their Croatian and Serbian counterparts (Karge, 2020), who were more open to recognizing war as a potential trigger for psychiatric disorders.

This strict adherence to biological determinism likely stemmed from more than just loyalty to the theories of their "Mitteleuropean" mentors. It may also reflect an internal drive to assert themselves as representatives of a nascent scientific field of psychiatry within Slovenian discourse. By adopting a "rigid" scientific perspective, they positioned themselves in opposition to other influential public figures of the time, including historians, literary authors, lawyers, and other educated elites, who were also contributing to the nation-building process with their explanation and interpretation about the origin, role and special character of the Slovenian nation. Such a stance may have helped legitimize psychiatry as a distinct and authoritative field and as a scientific discipline. Psychiatrists contributed to the process of nation-building by framing mental illness in ways that emphasized the perceived "otherness" of individuals with psychiatric conditions (Antić, 2017). Their diagnostic and theoretical approaches reinforced social boundaries, aligning notions of mental deviance with broader efforts to define and regulate the normative citizenry. They characterized these individuals not only by their temporary mental conditions but also by broader attributes, including family pedigree, physical traits, academic failures, alcoholism, suicidal tendencies, cultural backwardness, etc. This reinforced a dichotomy between the "normal" Slovenian (or Yugoslav) population, seen as resilient and capable of enduring war without psychological consequences, and those labeled as fundamentally different.

However, World War II may have marked a turning point in this perspective. Faced with the atrocities committed by the occupiers, psychiatrists were compelled—or perhaps inclined—to acknowledge that even the "normal" population could suffer under conditions of extreme psychological stress. This shift not only challenged earlier assumptions but also reflected the evolving socio-political context in which psychiatrists operated, reminding us that psychiatric categories themselves are historically contingent. As Shilpi Rajpal (2018) has shown in her study of colonial India, psychiatric and medical diagnoses are never neutral reflections of "objective" disease but are deeply shaped by cultural, political, and institutional contexts. For Rajpal, the boundaries between sickness and health were constantly negotiated, with diagnoses serving not just medical but also moral and social functions. In this sense, psychiatric knowledge simultaneously reflected prevailing anxieties and reinforced social hierarchies—an insight that resonates with the Slovenian psychiatrists' tendency to frame deviance in terms of broader cultural and national concerns.

BIOLOGIJA ALI OKOLJE? DIAGNOSTIČNI TRENDI V SLOVENSKI PSIHIATRIJI OD PRVE DO DRUGE SVETOVNE VOJNE

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POVZETEK

Študija raziskuje prakso psihiatrov, ki so delovali v slovenskem prostoru med prvo in drugo svetovno vojno, s poudarkom na njihovih pojmovanjih duševnih bolezni in spreminjajoči se vlogi psihiatričnih ustanov. Začne se s predstavitvijo vidnih strokovnjakov, kot sta Fran Göstl in Alfred Šerko, pri čemer izpostavi njuno izobraževanje v habsburški in širši srednjeevropski intelektualni tradiciji. Ta zgodovinska podlaga je usmerila njihovo naklonjenost biološkemu determinizmu, ki je v zgodnjem 20. stoletju določal psihiatrični diskurz in klinično prakso v Sloveniji. Na podlagi 2.220 kartotek pacientov in pacientk iz Ljubljanske psihiatrične bolnišnice študija analizira diagnostične vzorce in njihove premene skozi čas. V zgodnejših desetletjih so prevladovale diagnoze, kot sta shizofrenija in melanholija, medtem ko se je v času druge svetovne vojne povečalo število psihogenih in travmatičnih motenj. Kljub temu je pogosto prevladoval poudarek na dednih predispozicijah, ki je zasenčil prepoznavanje okoljskih in vojnih dejavnikov kot ključnih vzrokov duševnih stisk. Prispevek se ukvarja tudi s sociopolitičnimi vidiki psihiatrije, zlasti z njeno vlogo v procesu oblikovanja narodne identitete in v okviru odporniškega gibanja med drugo svetovno vojno. Študija zaključuje, da je druga svetovna vojna sprožila postopno premik v psihiatričnih praksah, pri čemer so zunanji (okoljski) dejavniki postopoma pridobivali večje priznanje – kar bi lahko bilo povezano tudi z vpletenostjo in naklonjenostjo nekaterih slovenskih psihiatrov do odporniškega gibanja.

Ključne besede: Slovenija, psihiatrija, vojna, psihično trpljenje, biološki determinizem, Ljubljanska psihiatrična bolnišnica, psihiatrična diagnostika, prva svetovna vojna, druga svetovna vojna

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CHILDREN WITH INTELLECTUAL DISABILITIES IN CROATIA: FROM PSYCHIATRY TO SPECIALIZED INSTITUTIONS (1897–1970s)

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ABSTRACT

In the period between the late nineteenth century and the 1970s, the treatment of children with intellectual disabilities (ID) in Croatia was predominantly shaped by medical paradigms and biologically deterministic perspectives. Initial steps toward educational inclusion emerged in the 1930s with the establishment of special classes and the implementation of standardized testing, although many children continued to be excluded from formal education. In the postwar period, institutional models gradually adapted to demographic changes and evolving diagnostic practices, yet in the absence of coherent policy frameworks. The study underscores the fragmented interplay between medical, social, and educational sectors, emphasizing that substantive reforms did not take shape until the early 1970s.

Key words: history of disability, Croatia, children with intellectual disabilities, institutional care, medical model, special education

BAMBINI CON DISABILITÀ INTELLETTIVE IN CROAZIA: DALLA PSICHIATRIA ALLE STRUTTURE SPECIALIZZATE (1897–ANNI ‘70)

SINTESI

Tra la fine del XIX secolo e gli anni Sessanta, il trattamento dei bambini con disabilità intellettive in Croazia fu prevalentemente orientato da paradigmi medici e da prospettive di tipo biologico-determinista. I primi passi verso l'inclusione scolastica si ebbero negli anni Trenta, con l'istituzione di classi speciali e l'introduzione di test standardizzati, sebbene molti bambini rimanessero esclusi dall'istruzione formale. Nel dopoguerra, i modelli istituzionali si adattarono gradualmente ai muta-menti demografici e alle pratiche diagnostiche in evoluzione, ma in assenza di un quadro politico coerente. Lo studio mette in luce l'intreccio frammentato tra ambiti medici, sociali ed educativi, sotto-lineando come riforme significative abbiano preso forma solo all'inizio degli anni Settanta.

Parole chiave: storia della disabilità, Croazia, bambini con disabilità intellettive, assistenza istituzionale, modello medico, istruzione speciale

INTRODUCTION[1]

In Croatia, the period between the late nineteenth century and the early 1970s was marked by institutional ambiguity and overlapping approaches to the care provided to children with disabilities. They were accommodated in various institutions, ranging from medical and educational to social facilities. Frequent transfers of these children from one type of facility to another demonstrated the uncertainty of the societal system about finding adequate solutions to their specific needs and conditions.

The first chapter explores early institutional responses to children with intellectual disabilities (ID) in the territory of the present-day Croatia, from the late nineteenth century to the interwar period, particularly the early 1930s. This period was marked by the dominance of the medical model in which ID were understood primarily as biological deviations (Kohler, 1928; Prebeg, 1939). In the absence of specialized institutions, children with ID were most often institutionalized in psychiatric hospitals (Seferović, 2019). Although formally medical institutions, these hospitals largely functioned as custodial facilities rather than therapeutic environments, a pattern observed in other countries as well (Goffman, 2011). The limited understanding of ID, not specific only to Croatia, both by professionals and the public, was partly a consequence of the scientific knowledge available at the time, and made worse by widespread poverty and limited institutional resources. The factors mentioned above marginalized these children in society, leading to their separation from the family and community and increasing their reliance on institutional care (McKearney & Zoanni, 2023).

The second chapter traces the shift from medical to educational approaches in the treatment of children with ID in interwar Croatia. A key milestone was the opening of the Institute and School for Mentally Deficient Children in Velika Gorica (*Zavod za duševnom manjkavu djecu u Velikoj Gorici*) (hereinafter "Velika Gorica") in 1934, the first institution in Croatia offering care and education for them (Jukić & Matijaca, 1999). A few years earlier, in 1930, the first special class had been established at the State National Boys' Elementary School in Krajiška Street in Zagreb (hereinafter "Krajiška").[2] Although limited in scope, these initiatives signaled a gradual shift from psychiatric care to educational support. The chapter also examines how access to these institutions was shaped by medical diagnoses, administrative decisions, and family circumstances, which often reinforced exclusion. Selected case records have illustrated how poverty and institutional regulations have influenced everyday lives of these children.

The third and final chapter traces the transformation of certain children's homes in Zagreb between the 1950s and early 1970s into residential institutions with integrated special schools. Following the end of the Second World War, socialist modernization

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[2] DAZG 163, Records of the establishment of the special class, 1930.

in Croatia introduced a series of changes that significantly affected the lives of children with ID. The urbanization process, the decline of agrarian lifestyle, and the expansion of the education system created new demands, while also opening up possibilities for their inclusion in public institutions. Care for this population was no longer limited to hospital-based or charitable models; instead, it gradually developed through specialized residential facilities that combined care and education (Klempić Bogadi & Podgorelec, 2021; Ivić-Hofman, 2021). Despite some efforts toward inclusion, such as vocational training and the establishment of specialized kindergartens, access to services remained selective, and full integration was limited (Zaviršek & Fischbach, 2023).

EXPERIENCES FROM PSYCHIATRIC HOSPITALS

In the late nineteenth and early twentieth century, in the territories under Austro-Hungarian rule, formal care and education for children with disabilities was developing in stages. The first specialized institutions were established for children with sensory disabilities (Dobaja, 2025).

In Croatia, Adalbert Lampe, a teacher educated in Vienna and himself hard of hearing, opened the first school for children with hearing and speech impairments in 1885 (Pribanić & Milković, 2016). The first Institute for Deaf Children was founded in Zagreb in 1891, followed by the Institute for Blind Children in 1895 (Juras, 1979). Nineteen years later, in 1900, the first Slovenian Institute for Deaf-Mute Children began operating in Ljubljana (Kvržić, 2023). In BiH, until the aftermath of the Second World War, there were no institutions for children with any form of disability (Seferović & Dujmović, 2025).

Between 1879 and 1930, state care for children and adolescents with ID in Croatia[3] was limited solely to their admission in two psychiatric hospitals: the Royal National Institute for the Insane in Stenjevec (hereinafter "Stenjevec")[4] and the Psychiatric Ward of the Royal Public Hospital in Pakrac (hereinafter "Pakrac")[5]. The opening of "Stenjevec" in 1879, as the first Croatian psychiatric hospital, marked the beginning of state-sanctioned institutionalization of children with ID.[6] The establishment of the first

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[3] For Slovenia and Bosnia and Herzegovina, it is not known which institutions, if any, accommodated children with ID during the Austro-Hungarian period. This topic has not been researched within the scope of this project.

[4] Stenjevec was a district in the western part of Zagreb, located about seven to eight kilometers from the city center.

[5] Located in central Slavonia, roughly 122 kilometers southeast of Zagreb, the psychiatric hospital in Pakrac was completed in 1910 and originally designed for around 200 patients (Herman Kaurić, 2014). It operated until 1991, when it was heavily damaged during the Homeland War and has remained non-functional since (Kovač & Matušin, 2005).

[6] Number of patients hospitalized in "Stenjevec" diagnosed with oligophrenia ranged from 88 to 122 between 1928 and 1932. Considering that the total number of patients during that period ranged from 778 to 821, it can be concluded that approximately ten to fifteen percent of the patients had intellectual disabilities (Kuljženko, 1933). The available data do not show the age or sex of patients diagnosed with oligophrenia. So far, no information has been found for earlier periods.

specialized class in “Krajiška” in the 1930s represented a preliminary move toward integrating these children into the formal education system. Although this milestone did not fully put an end to the segregation and custodial treatment of children with ID in psychiatric hospitals, it signaled a shift toward their gradual integration into the education system and broader community.

Even though specialized institutions for children with ID were established in neighboring crownlands such as Austria and Bohemia (from 1918 Czechia as part of Czechoslovakia) during the nineteenth and early twentieth century, the understanding of the complexity of their disabilities remained limited. This shows that having institutions did not necessarily mean there was a full understanding of the children’s actual needs (Kremsner, Koenig & Buchner, 2019; Mužáková & Strnadová, 2019; Goodey, 2011). The absence of adequate knowledge was not solely the result of insufficiently developed medical and pedagogical disciplines, but that it also stemmed from prevailing social conceptions of normativity, ability, and the social value of the individual. ID were most often interpreted through moral or biological categories of “deviation,” rather than as complex developmental and social phenomena. As a result, institutionalization and separation from the mainstream society became the dominant responses (Herzog, 2024).

The following example demonstrates the limited understanding of ID at the time, as well as the prevailing patterns of parental response to children with such difficulties. It is related to a twelve-year-old boy who was hospitalized in 1901 in “Stenjevec” and diagnosed with “idiocy,” a common medical term then used for individuals with ID. Shortly after admission, the boy passed away, though the cause of death was not recorded. Notes on his case are based primarily on statements from his mother, as the psychiatrist reported that, due to the boy’s speech difficulties and incoherence, no form of communication could be established.

> *The child was healthy from birth until the age of three, nothing abnormal could be observed in him, nor does the mother remember the child being ill. Only at the age of three did the child start to become fearful at night* […] *Now he is scared of everything. There is no chance of raising him. Older children used to take him with them to pasture. Of course, the parents would beat him when he behaved so unreasonably, and other children would tease him. He never attended school because there was no way to convince him to do so.*[7]

This psychiatric observation is one of the examples that shows how behavioral deviations in children with intellectual disabilities were understood and treated

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[7] *Diete je bilo od poroda pa sve do svoje treće godine zdravo, nije se moglo na njemu ništa abnormalno opaziti, niti se sjeća majka, da bi diete bilo kakvih bolesti trpilo. Tek sa tri godine počelo se diete u noći plašiti* […] *Sada se svakog boji. O kakvom odgoju ne može u obće biti govora. Starija djeca uzimala ga sobom na pašu. Domari su ga da bome i tukli kada se je ovako nerazumno ponašao, a i druga djeca bi ga znala dražiti. U školu nije nikada išao jer ga se nije moglo nikako na to nagovoriti* (AKPV, Patient File, 1901).

within the medical context and within the family in the early twentieth century. The boy's expressions of fear, withdrawal, and refusal to attend school were not recognized as potential signs of ID. Rather, they were seen as "unreasonable" behavior, reflecting the widespread assumption at the time that he was deliberately resisting or refusing to cooperate. As a result of his behavior, he faced physical punishment from his parents and social ridicule from his peers. The fact that he never went to school because he could not be persuaded to attend highlights the gap between the prevailing stereotypical expectations of children in general and the actual abilities of children with ID. At that time, biological determinism dominated, the belief that such differences were innate and unchangeable. This left very little room for the possibility of development or progress. Therefore, these children, widely misunderstood, were often "lost" to their communities, both physically through institutionalization, and socially through invisibility, neglect, and marginalization (Dobaja, 2022; Wright & Digby, 1996; Campbell & Oliver, 2013).

Another limiting factor in the understanding and care of children with ID in rural Croatia in the early twentieth century was the harsh economic reality of daily life. Chronic poverty and the constant struggle for survival where every able-bodied member of the household was expected to contribute offered minimal opportunity for consistent or specialized family care (Leček, 2003). Children with ID, unable to participate in agricultural or domestic labor, were often seen as an added strain on the already struggling households, which contributed to their peripheral positioning within both family life and the broader social environment. This could be supported by the case of a twenty-six-year-old woman who was first hospitalized at "Stenjevec" in 1932, where she was diagnosed with *imbecillitas*. Later that same year, she was transferred to "Pakrac," where she died after six months.[8] It is difficult to attribute her psychiatric hospitalization solely to "pathologization." Instead, it may also be understood as a response to genuine socioeconomic pressures and a pragmatic survival strategy. The municipal authorities from her home village in Slavonia provided this information to the hospital, which could substantiate such an interpretation.

> *The patient with a sick mind, born in 1906, needs to be sent to the hospital for treatment, as is the wish of her mother and the wish of the municipal government, because the said patient is in a completely destitute condition, as is her mother. The mother has no other means to keep her daughter out of the institution because she must go to work every day in order to sustain herself during this difficult crisis.*[9]

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[8] This patient underwent multiple hospitalizations at "Stenjevec"with the first occurring in 1916 at the age of ten. This case exemplifies the ongoing challenges within family dynamics involving a member with intellectual disabilities.

[9] *Pacijentica bolesna uma, rođena 1906., treba biti poslana na liječenje, jer je to želja njezine majke i želja općinskih vlasti, obzirom da spomenuta pacijentica nije nikako pri zdravoj pameti, kako navodi njezina majka. Majka nema drugi način da za svoju kćer sačuva od ustanove, jer mora svaki dan raditi da bi u ovoj teškoj krizi preživila.* (MGP, Patient File, 1932)

The mother's wish for her daughter with ID to be placed in an institution, a wish that coincided with the interests of the local authorities, does not necessarily indicate outright rejection, but may have arisen from a sense of powerlessness: her labor was essential for her own survival. Thus, the responsibility of care was shifted to the medical system, effectively removing her from the daily life of the family. In this process, she ceased to be seen as a full member of the household and instead became someone whose absence was necessary for the family's functioning to continue without disruption. In this way, she became doubly invisible, both as an individual perceived as unproductive and as a body that needed to be excluded in order to preserve everyday stability. This case demonstrates a common dynamic in times of crisis, when economic pressures, institutional authority, and notions of moral obligation often intersect, blurring the line between care for individuals with intellectual disabilities and their social exclusion (Vann & Šiška, 2006; Brantlinger, 2001; Pokempner & Roberts, 2001).

In the tension between what society sought to regulate and what it lacked the capacity to support, children with ID found themselves caught between medical diagnosis and everyday personal life. Depending on the context, they were at times treated solely as medical cases and at others institutionalized out of necessity. Thus, they were generally positioned at the intersection of biological, moral, and economic frameworks (Mauldin & Brown, 2021; Seferović, 2024). Their social status depended less on their own agency and more on societal perceptions, specifically, on how society delineated the boundaries of childhood, value, and worthiness of care. Ultimately, what was often framed as an act of protection functioned as a means of distancing. Beneath the layers of needs, definitions, and institutional structures, there remained an individual who was not recognized as a whole person but rather perceived as a problem to be managed, or as a burden to be transferred to others (Kuljženko, 1931; Danforth, 2009; Prindle, 2025).

THE INTRODUCTION OF SPECIAL CLASSES

In Croatia, an initial step away from a purely medical approach to children with ID was taken in 1930 with the establishment of a special class at the "Krajiška". Simultaneously, in Northern Macedonia, then part of the Kingdom of Yugoslavia, two primary schools for children with ID were founded in Skopje ("Gjura Jakšiky" and "Holy Mother of God"), alongside another one in Kumanovo (Savikj, 2006). These early, albeit limited, initiatives within the Yugoslav context signaled a gradual repositioning of children with ID as subjects capable of being educated rather than solely medical cases. During the interwar period, approaches toward them in the neighboring countries such as Austria, Hungary, and Bulgaria ranged from medical pathologization and charitable care under religious institutions to sporadic and inconsistent efforts at educational integration (Czech, 2022; Turnpenny, 2019; Attavar, 2024). However, none of these countries, including those within the Kingdom of Yugoslavia, developed a coherent or unified paradigm of care or education for this population.

The example below points to a broader uncertainty and inconsistency within the educational and care system of the time, as well as the likely confusion experienced by children with ID and their families in navigating it. This is evident in the case of a ten-year-old girl from a village in Gorski Kotar, diagnosed with *imbecillitas*. She was initially hospitalized at "Stenjevec" and subsequently transferred in June 1934 to its newly established branch "Velika Gorica,"[10] located on the premises of the former public hospital. The institution officially functioned as a residential home with an attached school for children with ID (Buljevac, 2025). In 1941, "Velika Gorica" requested her patient file from Vrapče Hospital for Nervous and Mental Diseases (hereinafter "Vrapče"), formerly known as "Stenjevec."[11] Among the documents was a letter dating from 1933, written by a physician from her hometown, stating:

> *She ran away from school saying that children were teasing her. On the street, she attacked passers-by more frequently with stones and curses using the most vulgar expressions (which she was taught by malicious adults). She is now looking forward to going to a special school where she will not be teased. It is my opinion that admission to an institution for less gifted or intellectually impaired children is possible and necessary, all the more so as she has an almost absolute prospect for success within a few years.*[12]

This case reveals how mechanisms of social stigma can produce outcomes that appear as individual choice but reflect deeper societal dysfunction. Her hospitalization was a response to the abusive and unjust conditions she had experienced within her social environment, which included persistent teasing, a practice that was not uncommon in such institutions (Goffman, 1963). Given these circumstances, her stated wish to transfer to a school for children with ID might be interpreted less as a freely made decision and more as a form of self-segregation.

Although cultural, social, economic, and political conditions in the 1930s and 1940s limited the development of care and education systems for children with ID in Croatia, some state initiatives were still present. This is especially clear in the case of

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[10] Today, Velika Gorica is a town located south of Zagreb, about fifteen kilometers from the city center.

[11] The hospital's name changed over time. Stenjevec was the city district where the institution was located, although it was physically situated in the neighborhood of Vrapče, which was part of that district.

[12] *Pobjegla je iz škole govoreći da joj se djeca rugaju. Na cesti napada, češće prolaznike kamenjem i psujući najprostijim izrazima (a nato su je naučili zlobni odrasli ljudi). Sada se veseli da će ići u posebnu školu, gdje joj se neće rugati. Mišljenja sam, da je primitak u zavod za manje nadarenu ili slaboumnu djecu moguć i potreban tim više, što ima gotovo apsolutni izgled za uspjeh već kroz nekoliko godina* (AKPV, Patient File, 1934).

“Krajiška,” which operated even during the difficult pre-war and wartime periods. In 1941, “Vrapče” opened its second branch, named Stančić-Štakorovec.[13] Around one hundred patients, mostly individuals with ID, were relocated there (Jukić, 2015, 91).[14]

“Krajiška” underwent several relocations. First, pupils with ID were transferred to the State Coeducational School in Nova Cesta (hereinafter “Nova Cesta”) in the Trešnjevka district. There, a special school, consisting of four classes for these pupils, was established, operating from 1940 to 1945.[15] Olga Franulović was one of the first headmistresses.[16]

Enrollment at “Nova Cesta” was determined through psychological assessments utilizing the standardized Binet-Simon tests. Due to numerous complaints from parents, teachers, and others regarding the placement of children who appeared either too advanced or who appeared to possess typical abilities into special classes, the school subsequently mandated that all psychological assessments be conducted exclusively by the Chamber of Commerce in Zagreb.[17] The Binet-Simon test was developed by French psychologists Alfred Binet and Théodore Simon in 1905. It was initially created to assess children’s mental functioning relative to their chronological age. Later on, it was adapted for employee selection and military use. The test was introduced during a period without clear scientific consensus on the accurate and objective measurement of intelligence (Binet & Simon, 1916). It included tasks assessing attention, memory, naming familiar objects, copying geometric shapes, repeating sentences and number sequences, logical reasoning, recognizing similarities and differences, motor skills, and handling everyday situations (Doll, 1917). The original test was not intended to provide a single numerical intelligence score. The concept of the intelligence quotient (IQ) was later introduced by German psychologist William Stern, who defined it as the ratio of mental age to chronological age, multiplied by hundred (Hardesty, 1976).

“Nova Cesta,” as mentioned, had four classes with adapted educational programs. Each class had its own teacher, while Eva Smolčić observed lessons as part of her preparation for the certification exam to become a specialized teacher for children with ID. Due to the large number of pupils, especially in the third and fourth grades, the teaching process became demanding. For example, pupils

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[13] Stančić is a small settlement located approximately thirty-seven kilometers east of Zagreb. Today, it is administratively part of the town of Dugo Selo.

[14] Since 1955, “Stančić” has been an independent institution for persons with ID. It still operates today as the Stančić Rehabilitation Center for different age groups with intellectual and mental disabilities.

[15] From 1945 to 1949, the school was located at Selska 5. In the academic year 1949/50, it moved to 40 Krajiška Street, where it operated under various names until 1980. After that, it relocated to a new building at 13/1 Nad Lipom Street, specially built for children with ID. Since then, it has been known as Nad Lipom Elementary School. Throughout its history, the school has always been located near the center of Zagreb (DAZG-165, State National Primary School, Nova Cesta, Zagreb, Examination of the intellect of secondary school children, February 6, 1941).

[16] DAZG-165, Examination of the intellect of secondary school children, February 6, 1941.

[17] DAZG-165, Request to the Education Department of the Ban’s Authorities for Opening a New Department, 1940.

in the fourth grade attended classes in two separate classrooms. Thus, the school submitted a request to the Education Department of the Banovina authorities to establish an additional class and appoint Mrs. Smolčić as a supervising teacher. According to the school leadership, this fifth class would enable the enrolment of a greater number of children with ID from mainstream primary schools into classes with adapted educational programs.[18]

Many children with ID attending "Nova Cesta" traveled long distances, as it was the only school in Croatia at the time offering adapted educational programs. Most of them lived in very poor conditions, and in many cases, their parents worked on farms or held other jobs, requiring these children to find accommodation in shelters. However, shelters often refused to admit them due to city regulations. Since many children arrived at "Nova Cesta" hungry, the school asked the provincial Red Cross Committee on November 14, 1940, to provide milk each morning for twenty-two of the poorest pupils.[19] Two days earlier, on November 12, 1940, the school director had written about a plan to build a separate, additional school facility with a shelter. The new school would be run by staff specially trained to work with children with ID.[20] Four months later, in March 1941, the management of "Nova Cesta" asked the Croatian National Theater to organize a performance of Mato Lovrak's play *Micek, Mucek, and Dedek*, in which these children would perform under the theater's supervision, in order to raise funds and support their education.[21]

In the early 1940s, a charitable and paternalistic approach toward individuals with disabilities prevailed. They were not recognized as potentially active participants in society but were seen solely as objects of care (Braddock & Parish, 2001). Nonetheless, some forms of institutional solidarity "from below" remain visible, with stakeholders like schools, the Red Cross, and cultural institutions working to address gaps in care and education for children with ID. Although city regulations prohibited these children from staying in shelters alongside their peers, the administration of the "Nova Cesta" institution showed willingness to foster social inclusion by proposing their participation in a theatrical performance. This example from the 1940s shows a small but meaningful step beyond the dominant paternalistic approach, hinting at early efforts toward social inclusion.[22]

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[18] DAZG-165, Request to the Education Department of the Ban's Authorities for Opening a New Department, March 12, 1941.

[19] DAZG-165, Request for Milk to the Banovina Committee of the Red Cross in Zagreb, Derenčinova Street, November 14, 1940.

[20] DAZG-165, Address by the school director at Nova Cesta to the municipal government's social department in Zagreb, November 12, 1940.

[21] DAZG-165, Request for the use of the play to the Management of the Croatian National Theater addressed to the Director of Drama in Zagreb, March 7, 1941.

[22] For the period of the Second World War, specifically the time of the Independent State of Croatia (NDH), no explicit records concerning the treatment of children with intellectual disabilities in psychiatric institutions have so far been found in the examined archival material. Further research is recommended, particularly a more detailed analysis of the archives of the Psychiatric Hospital in Pakrac, which was located in close proximity to the Jasenovac concentration camp.

However, during the interwar period, progress remained limited. The effects of the Great Depression and reduced public investment in education (Gnjatović, 2017; Ahtik, Erent-Sunko & Pilipović, 2010; Gjedia, 2013), along with the influence of eugenic ideas, which, although largely theoretical in the Croatian context, were nonetheless present (Kuhar & Fatović-Ferenčić, 2012), posed barriers to care and education for individuals with ID. According to eugenic theories, they were viewed as genetically "defective" and socially undesirable, often linked to poverty, immorality, and social decline. In the interwar period, intellectual disabilities were not categorized as a condition as they are today, but were treated as an illness that needed to be cured (Nicholson & Cooper 2013). During the interwar period in Croatia, eugenic ideas were primarily present within the framework of public health discourse and preventive measures, such as premarital health examinations, marriage restrictions, and hygiene campaigns. Nevertheless, unlike in some other European countries, these ideas did not result in formal legislation or widespread institutional policies (Kuhar, 2015; 2022). For instance, in Austria and Hungary, eugenic principles had a stronger influence on policies concerning children with ID, including laws permitting forced sterilizations and institutionalization. These measures reflected more aggressive approaches to social control and systematic exclusion (Bucur, 2010; David, Fleischhacker & Höhn, 1988).

A specific form of differentiation and internal selection was also applied within the category of children with ID. Institutions such as "Velika Gorica" and "Krajiška" admitted only those children who were capable of following an adapted educational program. Children with more severe disabilities, whose parents were unable to care for them, continued to be institutionalized in psychiatric hospitals. One example that illustrates this practice is the case of a fourteen-year-old boy, born in 1927 in a village near the Croatian-Slovenian border, who was denied admission to the "Velika Gorica" hospital. He was diagnosed with idiocy and epilepsy, and subsequently hospitalized in the Psychiatric Hospital Moslavina-Popovača (hereinafter referred to as "Popovača")[23] during 1941. A letter from his mother to the authorities of the Banovina of Croatia reveals the following:

> *My son has been receiving treatment for eight years already. I am a pauper with four more small children, living on a very small property of only one and a half acres of arable and non-arable land. I am not able to afford hospital treatment for my son, so I am kindly requesting that the authorities of the Banovina of Croatia allow his*

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[23] DASK 161.2, Files of the Royal State Estate Moslavina – Disability Estate in Popovača, General Files, 1923–1934 (56, 2418). The Psychiatric Hospital Moslavina-Popovača began operating in 1934 as a branch of the State Hospital for Mental Illnesses in Belgrade. It was established on the grounds of the Erdődy Castle estate in the town of Popovača, located approximately sixty-five kilometers (about fourty miles) from Zagreb. Its first director was Dr. Ivan Barbot, after whom the hospital was later named. Today, the institution operates under the name Neuropsychiatric Hospital Dr. Ivan Barbot Popovača.

> *treatment in "Velika Gorica" at their expense. I was told that my son had been treated for the same illness at the Hospital of Merciful Sisters in Zagreb three years earlier, for three weeks. However, he had not been cured when they sent him home and not considered a patient for that hospital. Please help me and support me in getting my child cured so that I don't have to suffer so much at home with him.*[24]

However, the response from the Department of Social Policy of the Banovina of Croatia, dated January 9, 1941, clearly stated that the boy's psychophysical condition had not been suitable for placement in the educational institution for "feeble-minded children" in "Velika Gorica." According to the institution's authorities, only children able to learn a trade were admitted. Since there was no place for him, he was sent to "Popovača," where he died in late 1941 from an epileptic seizure.

The mother's plea clearly demonstrates how poverty, medical classification, and institutional inaccessibility jointly affect access to support. The son's diagnosis determined not only his access to treatment but also how he was perceived by society, while bureaucratic obstacles and a lack of resources further hindered access to institutions. As the mother lacked economic capital (poverty) and cultural capital (limited education, simple language), she relied on recognition from bureaucratic and professional authorities, which operated through mechanisms of symbolic violence (Bourdieu, 1996). Her suffering remained institutionally unacknowledged, shaped by the unequal distribution of recognizability and its dependence on normative frames of intelligibility (Butler, 2009). The mother's request reveals how the interconnected influences of poverty, medical diagnoses, and social norms formed a "triangle" that acted as a framework that regulated belonging within the social fabric.

The transition of children with ID from the medical system to the systems of social care and education in Croatia began to accelerate after the Second World War. The paradigmatic shift in the understanding of ability and disability in Yugoslavia resulted from a convergence of socialist ideology, post-war practical needs, and state modernization. The war, in this sense, "democratized" disability: it was no longer seen solely as a stigma or medical issue but also as a consequence of sacrifice and participation in the struggle, reshaping public perception and opening the way for the institutional inclusion of individuals with disabilities (Mladenov, 2017; Newman & Lendák-Kabók, 2024). Just two years after the war ended, in 1947, a

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[24] *Moj sin se već osam godina liječi. Sirota sam, s još četvero male djece, živim na malom imanju od svega jedne i pol jutra zemlje. Ne mogu platiti sinu liječenje, zato molim da vlasti Banovine Hrvatske dozvole njegov smještaj u »Velikoj Gorici« o njihovome trošku. Rečeno mi je da je moj sin bio liječen za istu bolest u Bolnici Milosrdnih sestara u Zagrebu prije tri godine, tri tjedna. Međutim, nije bio izliječen, pa su ga poslali kući i više ga ne smatraju pacijentom te bolnice. Molim da mi se pomogne u liječenju djeteta, da ne trpim tako mnogo doma s njime* (DASK 161.2, Patient files; Mother's plea to the authorities of the Banovina of Croatia, December 1940, 16, 1941).

residential home with an integrated special school for children with ID was opened in the convent of the Sisters of the Society of Jesus in Antunovac, in Maksimirska Street in Zagreb. Of the ten nuns, four worked as teachers, while the others were responsible for technical and support tasks. The only layperson employed at the institution was its director, Adela Teodorović (Center for Rehabilitation Zagreb, s. d.). Under socialism, religious communities remained involved as staff but lost their authoritative control. Disability was no longer approached solely with pity; instead, it was addressed through education, labor, and social integration, reflecting a shift toward a state-driven model emphasizing both productivity and equality. Children with ID became both subjects of care and objects of regulation, targeted at producing the "socially useful" citizen.

THE DEVELOPMENT OF RESIDENTIAL HOMES WITH INTEGRATED SPECIAL SCHOOLS

In the 1950s, numerous children with ID moved to Zagreb from rural areas as part of the broader post-war integration of the agricultural population into urban society. This movement reflected a widespread trend across the former Yugoslavia, where a large-scale rural-to-urban migration reshaped the demographic and social fabric of the country. A wave of rural population left agricultural employment during this period, seeking opportunities in urban centers for work and education. Over time, education became the primary channel through which rural children entered urban life. The shift away from agrarian society, marked by the transition of the peasant population from agricultural to non-agrarian occupations, transformed both the geographical distribution and professional structure of rural communities. Within this framework, the school system played a key role in facilitating urban integration, creating pathways for the inclusion of various marginalized children, including those with ID (Puljiz, 1972).

While living in rural communities, the intellectual capacities of children had often been overlooked. However, this aspect became significant after their relocation to Zagreb, due to stricter educational standards and different living conditions. In rural areas, ID were in most cases neither diagnosed nor categorized, as the prevailing social framework did not require their formal identification (Leček, 1997). Functionality was primarily based on an individual's ability to work the land, contribute to household tasks, or care for livestock, rather than on educational achievement or developmental norms typical of urban environments (Župančić, 2000; Leček, 1999). With migration to cities such as Zagreb, children and adolescents with ID became integrated into systems of education, medicine, psychology, and the labor market, within which they began to be placed into narrowly defined diagnostic categories.[25] This development was ambivalent: on the one hand, it enabled access to specialized forms of care; on the other, it

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[25] DAZG-163, Report on the work of the school, 1950.

reinforced mechanisms of social control and normative ideologies of productivity and normalcy (Conrad, 2007). Research conducted by the Institute for Child and Youth Development Issues estimated that in 1959, there were approximately 26,000 individuals classified as "mentally retarded" in the broader Zagreb region, with children and youth under eighteen accounting for twenty-three percent of this population.[26]

Although socialist ideology in Yugoslavia promoted equality for all citizens, including individuals with disabilities, the reality was often different. Despite state investments in education and social care, this did not always lead to greater social inclusion, as the medical model remained dominant (Puljiz, 2006). This reflected a broader trend observed beyond national borders, residential homes with integrated special schools, designed to provide specialized services for children with ID, often contributed to segregation, resulting in limited interaction between these children, their peers, and the wider community (Towell, 2012).

These types of institutions began to be established in the early 1960s under the Ministry of Social Care of the Socialist Republic of Croatia. They evolved from children's homes and followed a similar mode of operation. Depending on the emotional, health-related, practical, and financial capacities of their parents or guardians, children stayed there on a weekly, monthly, or full school-year basis, much like in children's homes (Sovar, 2015). In Zagreb, among such institutions were children's homes Gornje Prekrižje (hereinafter "Gornje Prekrižje") and Tuškanac (hereinafter "Tuškanac").[27] In the early 1960s, the Social Protection Council of the City of Zagreb (SPC) proposed that "Gornje Prekrižje" be repurposed as a residential institution with a special school for children with ID while a decade later, "Tuškanac" asked to be granted the same status.

In December 1972, "Tuškanac," then known as the Stjepan Sekulić Jucko Children's Home, formally submitted a request to the SPC for its renaming and a change in its operational activities. In explanation, they stated that "due to the insufficient capacity of the existing Special Social Institutions in Zagreb, the Home has been working predominantly with mildly mentally retarded residents for eight years and has adapted part of the program and organization to that category."[28] It is evident that as early as 1964, "Tuškanac" functioned as an institution that simultaneously admitted and educated both children with ID and those without. This practice points to a transitional period in the system of care and education for this population marked by ambiguities on the one hand, and efforts toward clearer categorization of user groups on the other. These statements highlight the challenges these institutions had faced in defining their identity and role during a

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[26] DAZG-37, Report on the work of the Institute for Child and Youth Development Issues, 1959.

[27] Gornje Prekrižje" and "Tuškanac" are located only a few kilometers apart, both within Zagreb's wider central area. Today, they operate as a single institution under the name Tuškanac Center.

[28] DAZG-948, Address of the Children's Home Stjepan Sekulić Jucko to the Council for Social Protection of the City of Zagreb, 1973.

time of societal change, reflecting broader uncertainty about the residents' identities, needs, and appropriate societal responses to their vulnerability.

The case of "Gornje Prekrižje" further illustrates the confusion within the system at the time: on May 22, 1972, the institution's council submitted a request to the Urban Planning Institute of the City of Zagreb (UPI) for the issuance of a planning permit to build the Center for the Rehabilitation of Mentally Retarded Children at 48 Gornje Prekrižje. In its response, the UPI stated that during the review of the request, it had become clear that the land previously reserved for social welfare institutions did not match the building dimensions specified in the application. The UPI also noted that the current practice, addressing individual requests without a defined work program, created several difficulties regarding the quality of solutions provided. They stated that they expected the SPC to initiate the development of a long-term program for building social institutions in Zagreb. A key reason for the divide between the proposals from individuals working within state social policy institutions and the actual needs of residents, employees, and institution heads was the lack of direct involvement or consultation with the residents during policy formulation and decision-making.[29] The lack of coordination between state and municipal authorities, the SPC and the UPI, was not merely administrative in nature, but pointed to broader shortcomings in the coordination and dialogue between the institutions sharing responsibility for the care of children with ID. Nevertheless, despite this lack of alignment, the support system for individuals with different types of disabilities and across different age groups in Croatia during the 1950s and the 1960s began to develop in various ways.

In the early 1950s, the first non-governmental organizations providing psychosocial support started operating in Zagreb, including the Society for Helping Mentally Underdeveloped Persons and the Counselling Center for Children and Youth. Its team of psychologists, psychiatrists, and special education teachers assessed children and adolescents, including those with ID. A decade later, in 1963, the Federal Committee of the Association of Societies for Helping Underdeveloped Persons was established there, along with the founding of today's Faculty of Special Education. At the same time, adolescents with ID over the age of fourteen were included in vocational training for various trades and industrial sectors through three-year secondary education programs. For example, in 1963, seventy of them were employed, with modest financial compensation, by the Municipal Social Security Institute at the company Autokaroserija Zagreb in Dubrava, an eastern suburb of Zagreb.[30] These initiatives were part of a broader socialist state vision of "productive participation," aimed at ensuring a certain degree of social inclusion through employment. In contrast to later rights-based approaches and full integration models promoted by the disability rights movement, the models of that time emphasized participation mainly through work,

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[29] DAZG-948, Assembly of the City of Zagreb, Request for Planning Permit for the Center for the Rehabilitation of Mentally Retarded Children at 48 Gornje Prekrižje, May 22, 1972.

[30] DAZG-948, Assembly of the City of Zagreb, Report on the Work of Rehabilitation Institutions, 1964.

reflecting the dominant ideological view of employment as the foundation of social value and belonging (Jelača, Kolanović & Lugarić, 2017; Dinu, 2022). However, this form of integration was limited and selective. Individuals with ID, as was similarly the case elsewhere, were employed exclusively in low-paid jobs, clearly highlighting the gap between the ideal of equality and the reality that kept them on the margins of society (Rasell & Iarskaia-Smirnova, 2011; Mladenov & Petri, 2020).

Thus, in the late 1950s, the idea of opening specialized kindergartens for children with developmental disabilities began to take shape. In a five-year development plan for social institutions in the Zagreb district, it was emphasized that during the period from 1957 to 1961, a kindergarten specializing in care for children with visual and hearing disabilities, as well as children with ID, should be established. It was planned that the kindergarten would have a capacity for eighty to one hundred children. Very soon, this idea was legally regulated by the Law on Kindergartens.[31]

The decision to open kindergartens for children with developmental disabilities in Zagreb in the late 1950s was not an isolated case but part of the broader framework of planned actions by the socialist state. In its early stages, Yugoslav policies on school and preschool education were influenced by the Soviet model of institutional care. However, following the political and ideological split with the Eastern Bloc in 1948, and especially from the mid-1950s, Yugoslavia gradually developed its own approach, combining principles of social responsibility and collective solidarity with decentralization and a greater reliance on local initiatives (Simić & Simić, 2019).

In the 1960s, the social model of disability had not yet been clearly developed. It began to take shape in the 1970s, when Yugoslavia started to reform special education. Although ideas about including children with disabilities in mainstream schools and communities had entered professional discussions, putting them into practice depended on whether schools were ready in terms of space, staff, and curriculum and whether families and children were willing to participate. Still, the education system was not yet prepared for such an inclusive shift, and awareness of the importance of social participation for children with disabilities had not yet become widely accepted (Zovko, 1972; Stančić, Sabol & Zovko, 1979; Alison, 2003).

CONCLUSION

At the turn of the twentieth century, approaches to children with ID were marked by limited professional knowledge and an insufficient understanding of the complexity of their conditions. Intellectual disabilities were primarily interpreted through the medical model and biological determinism, where deviations from developmental

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[31] DAZG-948, Assembly of the City of Zagreb, Proposal for the Development of Social Institutions in Zagreb, 1957.

norms were considered an illness or a deviation. The social model of disability had not yet been articulated, and ideas about establishing specialized institutions and gradually integrating children into the educational system in Croatia began to emerge only in the early 1930s. Until then, institutionalization in psychiatric hospitals was often the only option—frequently driven by social necessity and a lack of community-based support, especially in rural areas. Early attempts at educational integration during the interwar period represent the first steps away from a purely medicalized approach, introducing special classes and the use of standardized tests. Nevertheless, children with more severe forms of ID remained excluded from education. Although schools and humanitarian organizations occasionally worked to mitigate the effects of marginalization, a systematic approach to social integration had yet to be developed. These initiatives, however, marked an important transition from a charitable and paternalistic model toward more professionalized—and partially more inclusive forms of care, which would develop more substantially after the Second World War within the framework of the socialist modernization project. The period from the 1950s to the early 1970s represents a transitional phase in the institutionalization of children with ID in Croatia. In this context, children's homes gradually transformed into specialized institutions that combined upbringing, education, and care. However, this transformation was not guided by a clearly defined strategy but was instead primarily a response to demographic changes, urban migration, and the pressure of standardized diagnostic and educational frameworks. Given that this was a transitional period, institutions such as "Gornje Prekrižje" and "Tuškanac" had an unclear identity, shifting from children's homes to residential-educational institutions without a clear plan. It was only in the early 1970s that more systematic attempts to reform special education began. Until then, the period had been marked by uncertainty in categorization—who these children were, what their needs were, and where they belonged in society.

OTROCI Z INTELEKTUALNIMI MOTNJAMI NA HRVAŠKEM: OD PSIHIATRIJE DO SPECIALIZIRANIH INSTITUCIJ (1897–1970.)

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POVZETEK

V obdobju med poznim 19. stoletjem in 70. leti 20. stoletja je na Hrvaškem zdravljenje otrok z intelektualnimi motnjami (ID) potekalo v senci medicinske paradigme in biološkodeterminističnih pogledov. Do prvih korakov k vključevanju teh otrok v izobraževalni sistem je prišlo v 30. letih z vzpostavitvijo posebnih razredov in uvedbo standardiziranih testov, pri čemer je potrebno izpostaviti, da je bila številnim otrokom formalna izobrazba še naprej nedosegljiva. V povojnem obdobju so se institucionalni modeli postopoma prilagajali demografskim spremembam in razvoju diagnostičnih praks, vendar ob odsotnosti koherentnih političnih okvirov. Študija poudarja fragmentirano prepletanje medicinskega, socialnega in izobraževalnega sektorja ter izpostavlja, da so se vsebinske reforme oblikovale šele v zgodnjih 70. letih 20. stoletja.

Ključne besede: zgodovina invalidnosti, Hrvaška, otroci z intelektualnimi motnjami, institucionalna oskrba, medicinski model, posebna vzgoja

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