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Not-So-Informal Relationships. Selective Unbundling of Maternal Care and the Reconfigurations of Patient–Provider Relations in Serbia

Abstract. Social practices, such as connections (*veze*) and gift giving, are often labelled as socialist legacies that lead to corruption and are contrary to the establishment of market practices in postsocialist societies. This paper investigates the effects of the selective opening of aspects of maternal care to market practices on patient–provider relationships. Ethnographic research indicates that doctors are navigating between the constraints and opportunities afforded by both sectors, private and public, to negotiate their daily interactions with patients. In the attempt to maintain both authority and trust with their patients in a very precarious economic and social context, doctors have to be both medical experts and entrepreneurs. This practice points towards the conclusion that it may not be the legacies of socialism that have created the need for finding new ways of forging connections between medical providers and their patients, but rather the unbundling of socialist healthcare into the market.

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Introduction

One morning I was in the delivery ward of one of the largest maternity hospitals in Serbia. By this point, the entire staff had grown accustomed to the anthropologist in yellow, the colour of student scrubs, following doctors around and taking notes in a small, black notebook. That morning started off relatively slowly for this busy hospital. Three women were in latent stages of labour, lying in beds next to each other, hooked up to cardiocartography machines (CTG) that monitor foetal heart rate.

All three beds are identical; all three machines are working the same. Each of the three women is in this maternity hospital because it is the only place in the entire city where they can give birth. Partners and family cannot enter the hospital: the main reason given is the lack of privacy, since there are no walls between delivery cubicles. The delivery room is on the second floor of the hos-

pital. It is a semi-circular shape, divided into five cubicles or boxes, to which these three women will walk once in the active stages of labour.

The ward resembles Bentham's panopticon, in that from the central position of the doctors' and nurses' main desk every woman in labour can be seen and monitored. The women's phones and other personal belongings are stored in lockers until after delivery. All they have with them are their nightgowns and a small, damp piece of gauze to wet their lips; food and water are not allowed. In the latent stages of labour, all they can do is lie in their beds, wait out their contractions, breathe, and listen to soft music playing on the radio in the background and the sound of the CTG machine. Each alone.

The beds are numbered one to three. Even though the doctors and other medical staff always try to address each woman by her name, when talking among themselves they use shorthand: bed one, bed two, and bed three. At this point in the early morning, the four nurse-midwives were about to start their shift and were asking the night shift nurses to fill them in.

> Nurse Ana:[1] All right, who have we got now?
> Nurse Bojana: One is Dr G.'s, three is Dr Z.'s, and the one in bed two is 'of the people' (*opšte narodna*).
> Me: Of the people?
> Nurse Bojana: Yeah, she belongs to all of us. (*sarcastically*) Lucky her.

The distinction between the women as either belonging to a specific doctor or being 'of the people' refers to the status they have based on where and with whom they managed their pregnancy up to this point—whether in the private sector or in a public primary-care centre. All three women delivered healthy babies, and none of them were ever mistreated or failed to be given adequate medical attention. All three women later told me they were happy with their birthing experience. There was a clear difference in the added emotional attention that was provided to the women who had their own doctors. Dr G. was with her patient almost the entire time, providing words of encouragement and comfort. Dr Z. called his patient's partner right after the baby was born, letting him know both mother and child were all right. I mentioned this observation to one of the volunteer student-nurses, and her response was: 'You know what the most crucial diagnosis is for a patient? The differentiating diagnosis is: "Whose patient, is she?" That is key. Whether you have a *veza* or not.'

Not-So-Informal Relationships

What was considered a *veza*, a connection, in this instance? It did not appear that the women in beds one and three were friends with Doctors G. and Z., but they did have a relationship that marked them as somehow different from

[1] All of the names used in this article are pseudonyms.

other patients. By finding ways to 'choose' their obstetrician during delivery, women have reported feeling more respected and less unsatisfied with their care in the public maternity wards.[2] Their relation with these doctors was not informal, and yet it was called a 'connection' in the ward.

One can frequently read descriptions of Eastern European healthcare as ill,[3] as having a mixed diagnosis,[4] and of informal payments as symptoms of deficiency in governance.[5] Usually, the prescribed cure for this illness of socialism is the magic bullet of the free market,[6] rather than assuming that informality is pathological, a legacy of socialism that must and will be rooted out through the transparency of the market.[7]

It is important to distinguish between the relationships forged in the private-medical sector—through varying articulations of gifts, connections, bribes, fees for services—from presumed, but rarely actually demonstrated, 'corruption'. I analyse forms of social relationships between patients and medical personnel that tend to be bundled into informality—relationships forged in the private-medical sector yet are in many ways beneficial to patients as well as to doctors—and letting doctors supplement their terribly low state salaries, thus giving them an incentive to remain in the country instead of going to work elsewhere. In sum, these relationships, which are open and not hidden, serve to improve medical services and patient experiences for many women while helping encourage doctors, who could easily emigrate, to remain working in Serbia. Even though the relationships created in the private sector are formalized in many ways, the anthropological literature on informality is useful to understand them.

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[2] Petra Baji et al., Informal Cash Payments for Birth in Hungary. Are Women Paying to Secure a Known Provider, Respect, or Quality of Care?, *Social Science and Medicine* 189 (September 2017), 86-95, DOI: 10.1016/j.socscimed.2017.07.015. All internet references were accessed on 7 July 2018.

[3] Dagmar Radin, Too Ill to Find the Cure? Corruption, Institutions, and Health Care Sector Performance in the New Democracies of Central and Eastern Europe and Former Soviet Union, *East European Politics and Societies and Cultures* 23, no. 1 (2009), 105-125, DOI: 10.1177/0888325408327850.

[4] Rob Hyde, Mixed Diagnosis for Serbian Health System, *The Lancet* 388, no. 10061 (2016), 2729-2730, DOI: 10.1016/s0140-6736(16)32460-6.

[5] Sofie Buch Mejsner / Leena Eklund Karlsson, Informal Payments and Health System Governance in Serbia. A Pilot Study, *SAGE Open* 7, no. 3 (2017), 1-13, DOI: 10.1177/2158244017728322.

[6] Jelena Arsenijevic / Milena Pavlova / Wim Groot, Shortcomings in Maternity Care in Serbia, *Birth-Issues in Perinatal Care* 41, no. 1 (2014), 14-25, DOI: 10.1111/birt.12096; János Kornai, Hidden in an Envelope. Gratitude Payments to Medical Doctors in Hungary, in: Lord Dahrendorf et al., eds, The Paradoxes of Unintended Consequences, Budapest, New York 2000, 195-215.

[7] Transparency International. 2015 Corruption Perception Index, *Africa Research Bulletin. Economic, Financial and Technical Series* 53, no. 1 (2016), 21131A-21131B, DOI: 10.1111/j.1467-6346.2016.06882.x.

Anthropology of Informality

An anthropological lens is crucial for seeing these phenomena in ways missed by most approaches in political science, public policy, public health, and naïve normative theorizing. Anthropological scholarship has drawn attention to the importance of distinguishing between the critical concepts of informality that tend to be clustered and used interchangeably in dominant research on informal exchange. There are significant distinctions to be made between informal relationships, such as *blat*[8], *štela/veza*[9] and *spaga*,[10] and relationships forged through gift exchange,[11] and all of these forms of relationships can be distinguished from bribery.[12] What anthropologists point out is the importance of looking at how these exchanges occur in practice, how they are performed, and in what broader political, economic, historical power configurations they are taking place.[13] Anthropologists who studied socialism and postsocialism have shown that in everyday practice, individuals have used various forms of social connections and social networks to establish access to social and health provision.[14]

Such works show that informal relations are neither simply legacies of a socialist past nor pathological, but political strategies used by patients and healthcare providers alike to navigate transforming political and economic landscapes. Informal exchanges are individual responses to ever-increasing inequalities, which are only exacerbated by the ongoing neoliberal transformations of the

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[8] Alena V. Ledeneva, Russia's Economy of Favours. *Blat*, Networking, and Informal Exchanges, Cambridge, Russian, Soviet and Post-Soviet Studies, Cambridge, New York 1998; Alena V. Ledeneva, How Russia Really Works. The Informal Practices That Shaped Post-Soviet Politics and Business, Ithaca/NY, London 2006.

[9] Čarna Brković, Managing Ambiguity. How Clientelism, Citizenship and Power Shapes Personhood in Bosnia and Herzegovina, New York, Oxford 2017; Čarna Brković, Flexibility of *Veze*/Štele. Negotiating Social Protection in Bijeljina, in: Stef Jansen / Čarna Brković / Vanja Čelebičić, eds, Negotiating Social Relations in Bosnia and Herzegovina. Semiperipheral Entanglements, London, New York 2017, 94-109.

[10] Sabina Stan, Neither Commodities nor Gifts. Post-Socialist Informal Exchanges in the Romanian Healthcare System, *The Journal of the Royal Anthropological Institute* 18, no. 1 (2012), 65-82, DOI: 10.1111/j.1467-9655.2011.01731.x.

[11] Marcel Mauss, The Gift. The Form and Reason for Exchange in Archaic Societies, London, New York 1990.

[12] Michele Rivkin-Fish, Bribes, Gifts and Unofficial Payments. Rethinking Corruption in Post-Soviet Russian Health Care, in: Dieter Haller / Cris Shore, eds, Corruption. Anthropological Perspectives, London, Ann Arbor/MI 2005, 47-64.

[13] Haller / Shore, eds, Corruption. Anthropological Perspectives.

[14] Brković, Managing Ambiguity; Pierre Sean Brotherton, Revolutionary Medicine. Health and the Body in Post-Soviet Cuba, Durham, London 2012; Michele Rivkin-Fish, Women's Health in Post-Soviet Russia. The Politics of Intervention, Bloomington/IN 2005; Brković, Flexibility of *Veze*/Štele Brković; Rivkin-Fish, Bribes, Gifts and Unofficial Payments; Stan, Neither Commodities nor Gifts.

states after socialism.[15] They are strategies for navigating and even managing ambiguities prevalent in the current sociopolitical landscape of Eastern Europe.[16]

The relationships forged in private practice and continued in the public hospital, cued as being seen as Dr. Z.'s patient, are not so informal in that sense.[17] These medical specialists are doing additional, paid labour in legally opened private-medical practices with transparent costs for services provided. The patient–provider relations forged in the private setting are expected to spill over and transfer into relations in the public-healthcare setting as well.

Understanding Not-So-Informal Relations in the Maternity Wards

After socialism, the public sector in Eastern Europe has been undergoing radical transformations that are affecting citizens' access to care.[18] Dental care in Serbia, for example, has been almost completely privatized and has become inaccessible to those who cannot afford it. I am interested in understanding the role of private practices in a healthcare sector that is explicitly guaranteed and entirely covered by the National Health Insurance Fund (NHIF)—maternal care.[19] Why do women opt for private prenatal care with doctors who also

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[15] Stan, Neither Commodities nor Gifts.

[16] Brković, Managing Ambiguity.

[17] Ljiljana Pantović, Buying a Connection. Private Practice in Public Health Care – the Case of a Serbian Maternity Hospital, *Anthropology of Eastern Europe Review*, Special Issue 34, no. 1 (2016), 25-38, https://scholarworks.iu.edu/journals/index.php/aeer/article/view/23052.

[18] Heath Cabot, 'Contagious' Solidarity. Reconfiguring Care and Citizenship in Greece's Social Clinics, *Social Anthropology* 24, no. 2 (2016), 152-166, DOI: 10.1111/1469-8676.12297; Alfio Cerami / Pieter Vanhuysse, Post-Communist Welfare Pathways. Theorizing Social Policy Transformations in Central and Eastern Europe, Basingstoke 2009 ; Stephen J. Collier / Lucan Way, Beyond the Deficit Model. Social Welfare in Post-Soviet Georgia, *Post-Soviet Affairs* 20, no. 3 (2004), 258-284, DOI: 10.2747/1060-586X.20.3.258; Kristen Ghodsee, Lost in Transition. Ethnographies of Everyday Life after Communism, Durham 2011; Julie Hemment, Redefining Need, Reconfiguring Expectations. The Rise of State-Run Youth Voluntarism Programs in Russia, *Anthropological Quarterly* 85, no. 2 (2012), 519-554, https://www.jstor.org/stable/41857252; Maija Jäppinen / Meri Kulmala / Aino Saarinen, eds, Gazing at Welfare, Gender and Agency in Post-Socialist Countries, Newcastle upon Tyne 2011; Rosie Read / Tatjana Thelen, Introduction. Social Security and Care after Socialism. Reconfigurations of Public and Private, *Focaal* 50 (2007), 3-18, DOI: 10.3167/foc.2007.500102.

[19] During socialism, health care was an entitlement for all (Art.186 of *The Constitution of the Socialist Federal Republic of Yugoslavia* 1974). According to the Constitution of the Republic of Serbia only 'children, pregnant women, mothers on maternity leave, single parents with children under seven years of age and elderly persons' actually have a right to free healthcare provided by the state; everything else is to be covered through health insurance, providers not specified (Art.68 of *The Constitution of the Republic of Serbia* 2006). If anything, the assumption that healthcare is still free in Serbia is a socialist legacy.

work in state maternity hospitals in which they give birth, instead of the state-provided prenatal care in the primary-care sector?

As we have seen from the ethnographic vignette, women who paid for prenatal care establish a connection, *veza*, with the doctors in the state-run maternity hospital.[20] This is something not at all the same as the corruption narrative of doctors pushing patients from the public sector into their private practice.[21] In fact, it is the opposite—patients move from the private sector into the public sector interchangeably throughout pregnancy. For women, this is sometimes the only available avenue, when they do not have a usable network of informal relations and personal connections, to gain better maternality care and a better birthing experience in the public hospital. Because they do not have access to the 'classic' *veza*, women resort to paying for private prenatal care with the obstetrics-gynaecologists (OB/GYN) who are simultaneously employed in both the maternity hospital and private prenatal-care clinics. What they achieve through this strategy is providing for themselves continuity of care, a connection with the same physician from the beginning to the end of their pregnancy. What, though, do the doctors achieve through these not-so-informal relationships? A presumption has been that it is only money, but perhaps there is much more involved.

Shadowing the Doctors

My analysis is based on a year of ethnographic fieldwork conducted 2016-2017 in Novi Sad, the second largest city in Serbia, research aimed at understanding how various configurations of private practice impact on publicly provided maternality care in this city.[22] Novi Sad was chosen as the primary research site because, as in the majority of cities in Serbia, it has only one public medical institution in which women can give birth. For the purposes of conducting qualitative, long-term participant-observation research, a city with just one maternity ward provides a more reliable and complete representation of how maternal care is provided in the whole country, outside the capital.

The research consisted of two parts. The first was focused on semi-structured interviews[23] with women after giving birth in this hospital (n: 80) and with

[20] Pantović, Buying a Connection.

[21] N. Aralica, Korupcija U zdravstvu. Svaki četvrti pacijent se upućuje kod privatnika!, *Srbija Danas*, 22 September 2014, https://www.srbijadanas.com/clanak/korupcija-u-zdravstvu-svaki-cetvrti-pacijent-se-upucuje-kod-privatnika-19-09-2014.

[22] The research has institutional review board (IRB) approval from both the University of Pittsburgh and the Clinical Center of Vojvodina.

[23] The transcribed interviews and researcher's field notes were entered into qualitative research software for managing, analysing, and interpreting the data following the guidelines provided. Gery W. Ryan / Bernard H. Russell, Techniques to Identify Themes, *Field Methods* 15,

gynaecologists (n: 14) who were working (n: 10) or have worked (n: 4) in both the public and private-healthcare sector in Serbia. The women were asked to talk about their interactions with medical providers during pregnancy, birthing experience, and postnatal care. During the interviews, all interlocutors were given similar conversation prompts in order to increase the chances that all topics were covered in each interview in a similar fashion.[24] The gynaecologists were given prompts to discuss their career paths, impressions about the public and private-healthcare systems and their approach to patients. The second part of the research consisted of participant observation[25] in the maternity hospital. For four months I had shadowed various doctors, mostly residents, three to four times a week to learn what their typical work day was like.

In the maternity hospital where I conducted my fieldwork, the work day would start at 7:30 am with meetings and would go on officially until 2 pm with the end-of-the-day meeting. Little of this time is spent sitting at a desk. It is a very active and demanding eight-hour day, with up to fifteen deliveries and several surgeries all before 2 pm. Of course, in most cases people, especially junior staff, have to stay longer to follow up with a patient or catch up on paperwork. Some gynaecologists with whom I spoke would have to get up at 5 am because they lived several hours outside of the city where they worked. Moreover, after working two or three such days a week, at least twice a week the majority of these doctors spend another five or six hours working additionally as consultants in private gynaecological practices.

Why do some of the doctors choose to have 16-hour work days? Why do they not ultimately transition into the private sector, when they know that by working in both sectors they are always running the risk of being accused of corruption and coercing patients into their private practices for personal gain? What is the incentive for them to work in both when the salary in the private sector is potentially far higher than in the public system and requires less demanding work than in the public maternity hospitals and delivery wards?

This research points to one of the main reasons some of my interlocutors started to work in both industries related to the different constraints present in both sectors. In the private sector, they have no medical authority but do have the trust of their patients, while in the public sector they have the power but

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no. 1 (2003), 85-109, DOI: 10.1177/1525822X02239569. All qualitative data were uploaded and coded using Nvivo software. Codes were created both deductively and inductively using the constant-comparative approach proposed. Bernard H. Russell, ed, Research Methods in Anthropology. Qualitative and Quantitative Approaches, Lanham/MD 2011.

[24] Kathleen M. DeWalt / Billie R. DeWalt, eds, Participant Observation. A Guide for Fieldworkers, Lanham/MD 2010.

[25] Gitte Wind, Negotiated Interactive Observation. Doing Fieldwork in Hospital Settings, *Anthropology and Medicine* 15, no. 2 (2008), 79-89, DOI: 10.1080/13648470802127098; DeWalt / DeWalt, eds, Participant Observation.

do not have the patients' trust. For the doctors, thus, the incentive to work in both sectors is not just a matter of financial stability but a matter of regaining and maintaining authority. It is not just a matter of filling in the missing gaps of the state, nor is it a socialist, or rather postsocialist, exclusive phenomenon; it is a mechanism of negotiating and personalizing individual's interactions with public-healthcare institutions. Both patients and providers are using all of the resources available to them to attempt to manage neoliberal precarity. To understand how these constraints came about and how both patients and providers are negotiating their positions in both sectors, we need to understand how private-medical practice is taking shape in a previously exclusively public-healthcare landscape.

Selective Unbundling of Health Care

There are critical problems embedded in discourses around the transformations of postsocialist states into neoliberal states. The main issue is the notion of a clean and transparent restructuring of publicly provided services into services available through the market or civil-society organizations.[26] The restructuring of public services is indeed taking place, but I would caution against seeing it as a catch-all solution for decreasing health inequalities. It is essential to consider in greater detail exactly how market restructuring is taking place in a particular context.

Read and Thelen[27] have offered an innovative and useful view on welfare and the public and private provision of care in former socialist states. They acknowledge that everyday social security and care arrangements in these countries have fundamentally altered since 1989, change frequently experienced as a form of 'loss', but warn against interpreting this as 'withdrawal' of the state and an accompanying automatic increase in the dominance of private practice.[28] The presumed dichotomy between either an over-controlling, centralized socialist state or a market-centred system in which the state that has completely withdrawn from welfare and healthcare is problematic on both ends of the imagined binary. It is questionable not only because it is orientalizing but

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[26] Transparency International. 2015 Corruption Perception Index; Kornai, Hidden in an Envelope; Jeremy Morris / Abel Polese, eds, Informal Economies in Post-Socialist Spaces. Practices, Institutions and Networks, Basingstoke et al. 2015; Arsenijevic / Pavlova / Groot, Shortcomings in Maternity Care in Serbia.

[27] Read / Thelen, Introduction. Social Security and Care after Socialism.

[28] Rosie Read, Labour and Love. Competing Constructions of 'Care' in a Czech Nursing Home, *Critique of Anthropology* 27, no. 2 (2007), 203-222, DOI: 10.1177/0308275X07076798; Rosie Read, Images of Care, Boundaries of the State. Volunteering and Civil Society in Czech Health Care, *Social Analysis* 58, no. 3 (2014), 90-106, DOI: 10.3167/sa.2014.580307; Read / Thelen, Introduction. Social Security and Care after Socialism.

also because it does not encompass or do justice to the practice taking place in these ambiguous spaces of private within the public. Arsenijević et al., for example, state that to overcome shortcomings in maternal care in Serbia the state should consider 'the inclusion of private practitioners [to] create competition and decrease the need for informal payments and "connections"'. My research has taken up this challenge.

Private-medical practices were legally re-established in Serbia in 1989. The first doctors to open shop were specialists, whose numbers grew during the socialist period. According to the Association of Private Health Care Providers, there is no precise information as to how many private-healthcare institutions and practices exist in Serbia today. This organization was founded in the early 2000s with the idea of providing a platform for private providers. The Association surveyed to remedy this lack of information in 2015 and discovered that a total of 4,223 doctors were working in the private sector exclusively, while over 7,000 worked in both the private and public sectors.[29]

One problem is that vague references to private practice usually encompass only those working exclusively in the private sector and the patients who want to, and are able to, bypass the public sector altogether. The role of private healthcare thus defined has been seen as a practice of a small elite who can 'lift-off'[30] from the public-healthcare system. Over 7,000 specialists work in both sectors and, according to a 2017 study,[31] out of 44% of women who reported having special connections in maternity wards and felt they were better treated, more than half (64.5%) also stated that their prenatal care was provided in the private sector. Thus, private treatment is far from being accessed only by a small minority of elites. The largest number of pregnant women in Serbia to take advantage of private prenatal care not to 'lift-off' from the public sector but rather to be better grounded in it. Likewise, an ever-expanding number of gynaecologists[32] are working double shifts in the private and public sectors, doing so not only for financial stability but for status recognition in the healthcare landscape.

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[29] Asocijacija Privatnih Zdravstvenih Ustanova I Privatnih Praksi Srbije, Potpisan memorandum o saradnji izmedju Ministarstva Zdravlja i Asocijacije, Belgrade, 3 February 2016, http://privatnapraksa.org/2016/02/03/potpisan-memorandum-o-saradnji-izmedju-ministarstva-zdravlja-i-asocijacije/.

[30] Steven Sampson, Beyond Transition. Rethinking Elite Configurations in the Balkans, in: Chris M. Hann, ed, Postsocialism. Ideals, Ideologies and Practices in Eurasia, New York 2002, 297-316

[31] Biljana Stanković, Skočajić, Milica, Đorđević, Ana, Upravljanje porođajem u Srbiji. Medicinske intervencije i porođajna iskustva, *Limes Plus. Journal of Social Science and Humanities* 14, no. 2 (2017), 197-225, https://limesplus.rs/images/2017-2/Llimes---Rodne-politike-2-2017--za-tampu.9.pdf.

[32] Asocijacija Privatnih Zdravstvenih Ustanova I Privatnih Praksi Srbije, Potpisan memorandum o saradnji izmedju Ministarstva Zdravlja i Asocijacije.

Insisting on a binary framework of unreformed and reformed, corrupted and uncorrupted healthcare regimes thus prevents conceptualizing other frameworks that can provide a better understanding of how healthcare is delivered in post-socialist states. Collier and Way[33] argue that the way to 'get around' the dead-end bind of unreformed/reformed systems is to look at two regimes: that of distribution, to see the normative framework under which specific provisions are distributed, and that of access, to understand how things play out in everyday practice.

In regards to the regimes of distribution, in Serbia we see a 'selective unbundling' or, as Collier[34] puts it, 'selective interventions' of the market into existing public services. Within this normative framework, which has selectively opened up certain but not all aspects of maternal care to the private sector, we can understand how access is negotiated between providers and patients. This knowledge, in turn, is crucial to understanding why so many gynaecologists are working two jobs, and so many women are paying for care that is otherwise available to them free of charge through the NHIF. The main reason for selecting maternal care as the primary focus of the study is that this category of citizens (newborns and expecting mothers) are additionally protected by several laws and national strategies[35]—a special category and guaranteed access to health insurance regardless of previous health insurance status.

Regimes of Distribution in the Public Sector

Birth in Serbia, as in most parts of the world, is extensively medicalized. According to the official statistics of the Republic of Serbia from 2015, 99.1% of all births are in hospital settings.[36] Feminist scholars have for several decades written about embodied effects medicalized birth has on women.[37] Most recently there has been a growing scholarship in Serbia addressing the issues of women's subjectivity and how their birthing experience is shaped by medi-

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[33] Collier / Way, Beyond the Deficit Model.

[34] Stephen J. Collier, Post-Soviet Social Neoliberalism, Social Modernity, Biopolitics, Princeton/NJ 2011.

[35] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine, *Službeni Glasnik* 28 (2009), https://pravni-skener.org/pdf/sr/baza_propisa/43.pdf; Art. 68 of *The Constitution of the Republic of Serbia* 2006.

[36] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine.

[37] Carole H. Browner / Carolyn F. Sargent, eds, Reproduction, Globalization, and the State. New Theoretical and Ethnographic Perspectives, Durham 2011; Robbie Davis-Floyd, Birth as an American. Rite of Passage, Berkeley/CA, London, Los Angeles 2003; Robbie Davis-Floyd et al., eds, Birth Models That Work, Berkeley/CA, London, Los Angeles 2009; Robbie Davis-Floyd / Carolyn F. Sargent, eds, Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives, Berkeley/CA, London, Los Angeles 1997; Emily Martin, The Woman in the Body. A Cultural Analysis of Reproduction, Boston/MA 1987.

calization.[38] While these are important issues to address, my focus is centred on understanding the regimes of distribution and access to maternal care in economically emerging countries such as Serbia.

In the country, there is a total of fifty-eight public medical institutions in which women can give birth.[39] Four out of those fifty-eight public institutions are tertiary institutions dedicated exclusively to women's health. Two of the maternity hospitals are located in the capital, Belgrade, while the remaining two are in Novi Sad and Niš. According to official state documents, even though these four institutions make up around 10% of the medical institutions where women can deliver babies, over one-third of all births happen in these four institutions. Belgrade is the only city in the entire country that has private maternity wards as part of the only two large-scale private-healthcare providers, Medigroup and Belmedic. When it comes to maternal care, and healthcare more generally, Belgrade is the exception rather than the norm.

Aside from these two private-medical providers, the majority of private-medical care is provided on a much smaller scale. The average private gynaecological practice consists of one or two full-time employed specialists and one or two gynaecological nurses, with many gynaecologists working for them part-time as consultants. This pattern might explain why the number of medical providers working exclusively in the private sector is far lower than the number of those working as consultants.

A closer examination of the legislative and structural constraints in both sectors can provide more insight into why doctors would choose to work at two places at once. In the public sector, prenatal care is provided in the primary-care centres, the so-called *domovi zdravlja*. Primary care, in general, is provided at the municipal level. These primary-care centres offer a varied array of out-patient care. There is a total of 157 primary-care centres in the country.[40] According to the state legislature, places that are more than 30 km away from the nearest

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[38] Nada Sekulić, Drustveni status materinstva sa posebnim osvrtom na Srbiju danas, *Sociologija* 56, no. 4 (2014), 403-426, http://www.komunikacija.org.rs/komunikacija/casopisi/sociologija/LVI_4/02/show_download?stdlang=ser_lat; Nada Sekulić, O kulturi rađanja. Istraživanje o problemu nasilja nad ženama tokom porođaja, *Sociologija*, Special Issue 58 (2016), 259-286, http://www.komunikacija.org.rs/komunikacija/casopisi/sociologija/LVIII_poseban%20broj/05/show_download?stdlang=ser_lat; Biljana Stanković, Lone Mothers and Their Network Support. Sociodemographic Research of Nonmarital Parenthood in Serbia, *Stanovništvo* 52, no. 1 (2014), 55-76, http://www.doiserbia.nb.rs/img/doi/0038-982X/2014/0038-982X1401055S.pdf; Biljana Stanković, Women's Experiences of Childbirth in Serbian Public Healthcare Institutions. A Qualitative Study, *International Journal of Behavioral Medicine* 24, no. 6 (2017), 803-814, DOI: 10.1007/s12529-017-9672-1; Biljana Stanković, Situated Technology in Reproductive Health Care. Do We Need a New Theory of the Subject to Promote Person-Centred Care?, *Nursing Philosophy* 18, no. 1 (2017), e12159, DOI: 10.1111/nup.12159.

[39] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine.

[40] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine.

maternity ward in general hospitals can form small maternity wards in the primary centres (maximum of ten beds).[41] There were thirteen of these small maternity wards, but these numbers are decreasing. As of 2014, there are twelve maternity wards. Small maternity wards in the primary-care centres, such as the one in Ruma, were the first to be cut due to austerity measures and lack of funding from the NHIF.[42]

When it comes to prenatal care, and women's health more broadly, the state mandates one gynaecologist and one gynaecological nurse be in charge women's healthcare in the primary sector for 6,500 women older than fifteen in the primary-care sector.[43] This number of patients roughly translates to seeing and treating eighteen to twenty women during one 7-hour work day, or 20 minutes per patient. In reality, the numbers are much higher and the time dedicated to each patient is more in the realm of 10 to 15 minutes. According to the doctors I spoke to, and as other studies have pointed out,[44] this is barely enough time to complete an examination and not enough time for the patient and doctor to establish any relationship of trust and mutual understanding. The majority of doctors working in primary-care centres are general physicians. Most of the young residents whom I met at the maternity wards were employed in primary-care centres. One day as I was shadowing Vera, a young resident, she remarked on the way primary-care providers are treated today.

> '*Dom zdravlja* has now become a place just for paperwork, not an actual place of medicine. The general reputation of healthcare has deteriorated in Serbia. I do not understand how we can still call it free healthcare. It is not. It has not been for a while. The people are overworked and unappreciated. Our reputation is also terrible now. We get no respect from our patients. Today, patients, first of all, don't even come to the doctors; and when they do, they are rude. They come in and bring me a *brlja* [rakija, a form of schnapps] and an envelope with 20 euros and want to buy us! Those are bribes! There was a time when patients would dress up to visit the doctor, shave, smell nice, and treat us with respect and give you something as a gift, not as a bribe.'[45]

Vera's response corroborates the statements collected in previous studies about primary-care providers. Primary-care providers interviewed for a public-health study stated that they felt that the state was not providing them with adequate resources or incentives to conduct their work. The study allocates this too sparse resourcing in the primary sector: 'Citizens perceive primary-care doctors as

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[41] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine.

[42] S. Kostić, Ruma bez porodilišta, *Večernje Novosti*, Ruma, 9 May 2014, http://www.novosti.rs/vesti/srbija.73.html:490913-Ruma-bez-porodilista.

[43] Uredba o nacionalnom programu zdravstvene zaštite žena, dece i omladine.

[44] Mejsner / Karlsson, Informal Payments and Health System Governance in Serbia.

[45] All translations from Serbian to English are my own.

incompetent'.[46] In this study, the authors also argue that medical providers, such as Vera, lack the knowledge to distinguish bribes from gifts.[47] This is a rather paternalistic assumption. It is the lack of possibility of establishing relationships of trust that may explain why there is a lack of appreciation for primary-care providers. From Vera's response, it is the lack of trust and appreciation from the patients that is important. It is in this lack of sociality, mutual respect, and understanding that Vera sees the difference between *rakija* being a gift rather than a bribe.

Marcell Mauss, in his study on the practice of gift exchange, pointed out that what distinguishes gifts from other forms of economic transactions is the establishing of social relations by gifts and their accompanying obligations on the recipient.[48] When creating a social relationship, gifts are treated as symbols of respect. When Vera says that 'there was a time when patients would dress up to visit the doctor, shave, smell nice, and treat us with respect and give you something as a gift', she is alluding to a practice of establishing a social relationship based on mutual respect between a patient and their doctor. With the shortening of the time spent between patients and providers because of understaffing and poor resources it is clear why she now sees any items brought to her as symbolic markers of mutual distrust between the patient and doctor. 'Now patients, first of all, don't even come to the doctors; and when they do they are rude. They come in and bring me a *brlja* and an envelope with 20 euros and want to buy us! Those are bribes!' Even though the objects of the exchange are still present in this interaction—the *rakija* and the envelope—what is lacking is the lasting social relationship. Without this relationship, objects that could have been received as gifts become perceived as bribes.

These ideals, of being respected and treated as an authority, are now more and more being questioned by specialists who work only in the public sector, as being pushed out, as feeling unappreciated. These feelings of under-appreciation and constrained agency played a crucial role in decisions to leave the country or to start working in the private sector. As Vera said: '*Dom zdravlja* has now become a place just for paperwork, not an actual place of medicine'.

Upon a closer examination of the regimes of distribution set in place, when it comes to the normative framework of maternal care in Serbia, we can see why the question of constraints is not only a concern in the public sector. As noted above, birth is a medical event. As a medical issue, it also follows the protocols of the referral system.[49] The referral system can be understood as a regime of

[46] Mejsner / Karlsson, Informal Payments and Health System Governance in Serbia.
[47] Mejsner / Karlsson, Informal Payments and Health System Governance in Serbia, 10.
[48] Mauss, The Gift.
[49] Arsenijevic / Pavlova / Groot, Shortcomings in Maternity Care in Serbia.

distribution of maternal care. One cannot avoid public prenatal care completely, simply because it is necessary to have adequate paperwork.

For a woman to be admitted into the maternity ward of a hospital or a maternity hospital, she has to have a referral document from her designated gynaecologist in the primary-care sector, which cannot more than three weeks old.[50] While from my own research experience in the maternity hospital no woman was turned away while in labour for not having a referral document or for having an expired certificate, the bureaucratic aspect to accessing care is a complex constraint on both women and medical providers. The gynaecologists working in the primary-care sector are not only in charge of providing women with the referrals for the hospital but are also their primary gatekeepers for accessing other benefits guaranteed by law, such as medical leave from work and paid maternity leave.

The general idea behind this distributive framework is not to be malicious or constraining; the assumption is that the gynaecologist working in the primary-care centre is the leading specialist in charge of a woman's reproductive health from the age of 15, and that both the patient and provider have an established a long-term relationship over the course of the woman's reproductive life, with mutual respect and trust built through such a relationship. This model is very similar to the model of family doctors in Cuba[51] and highlights the ideal of long-term treatment and prevention that should be at the heart of primary care.[52] While some women who I have spoken to had established such long-term relationships with their primary-care gynaecologists in the public sector, the majority had not. Thus, when it comes to regimes of access, how things play out in everyday practice, we can see that it usually does not line up with the distributive framework for care in the public sector.

Regimes of Distribution and Access in Private Prenatal Care

For various reasons, women either do not regularly go for gynaecological checkups[53] or chose to pay for their reproductive care in the private sector. One potential explanation as to why women, who can afford it, are going to private practice is again the issue of trust and establishing a relationship with their pro-

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[50] Arsenijevic / Pavlova / Groot, Shortcomings in Maternity Care in Serbia.

[51] Brotherton, Revolutionary Medicine.

[52] Mejsner / Karlsson, Informal Payments and Health System Governance in Serbia.

[53] Arsenijevic / Pavlova / Groot, Shortcomings in Maternity Care in Serbia; Elina Miteniece et al., Barriers to Accessing Adequate Maternal Care in Central and Eastern European Countries. A Systematic Literature Review, *Social Science Medicine* 177 (March 2017), 1-8, DOI: 10.1016/j.socscimed.2017.01.049; Sekulić, Drustveni status materinstva sa posebnim osvrtom na Srbiju danas; Sekulić, O kulturi rađanja.

vider. With maternal care, this reliance on private gynaecological care becomes an obstacle for some but an enabling strategy for others. As one gynaecologist, who has recently opened his private practice pointed out:

> 'People are unhappy with the public system, and you can see that. At the core the issue is trust. There are doctors in the public system who don't have the trust of their patients. A pregnant woman will see me every time. If she trusts me she is not bothered by the administrative stuff, for her getting the paper for maternity leave is a technical matter. She will endure the waiting in lines, the verbal abuse (*šikaniranje*) from the nurses and the doctors. Usually, the comments are: Why did you come here now?! (*Šta si sad došla ovde*) Don't you have your doctor? Why don't you go privately now (*što ne ideš sad privatno*) instead of coming here? And yet all of them also work as consultants somewhere privately. So those who treat women bad, usually what they mean by it is why did you go to that private practice and not my own. They will endure all of that (*sve će to da istrpe*) and will not deter them from coming to see me.'

Private practice has existed in Serbia since the late 1980s,[54] but it is outside of the National Health Insurance system. When citizens do go to these private practices, they have to pay out of their own pocket because the state health insurance does not recognize their services. The doctors working in the private sector do not have the authority to write referrals or prescriptions for their patients. This means that in order to receive the needed referral for the maternity hospital or for working women to get the documentation needed for parental leave, they have to, at least once, 'endure it all' in the public sector. This sporadic encounter between the pregnant patient and the gynaecologist working in the public sector, solely for the purpose of documentation and not actual care, could be the reason why most public primary-care providers stated that they felt as though they were not doing medicine but paperwork.

In general, private-healthcare practitioners are not recognized by the state as medical practitioners, but as *preduzetnici* (entrepreneurs).[55] It is a constraint in the regimes of distribution and access to maternal care that has emerged with the opening up to the market of one particular aspect of healthcare provision but not others. The selective interventions of the market into state-provided maternal care has left doctors working exclusively in the private sector at a disadvantaged position when it comes to providing care. From the perspective of the state, they are entrepreneurs whose status depends on how well their practices do in the market, which is heavily constrained and inflexible when it comes to health.

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[54] Donna E. Parmelee, Yugoslav Health Care. Is the Cup Half Empty or Half Full?, in: Frederick Bernard Singleton et al., eds, Yugoslavia in Transition. Choices and Constraints. Essays in Honour of Fred Singleton, New York, Oxford, Berg 1992, 297-336.

[55] Azra Hromadžić, Affective Labor. Work, Love and Care for the Elderly in Bihać, in: Jansen / Brković / Čelebičić, eds, Negotiating Social Relations in Bosnia and Herzegovina, 79-94.

> 'I am lumped in that category of *preduzetnik* (entrepreneur). Me and the shoemaker and the baker, we are all entrepreneurs. I think that is the wrong way to go about it and, yes, it is more than a technical issue. For example, when I went to the bank to ask for a loan to buy some equipment, they told me that it would have been easier for me to lease a new car than new medical equipment. Because for the car, in the case I default, they can always find a new buyer, but for medical equipment, which is specialized, it is hard, and even the loaning system is not well equipped to deal with it. And this is nothing new—it's been like this for 20 years, so no change has happened.'

In the case of physicians working exclusively in the private sector, they are riddled with constraints. They are not able to provide referrals, write prescriptions, or provide valid medical documentation for their clients–patients when they need to take medical leave from their jobs or, as was the case for my research, provide pregnancy leave for employed pregnant women. It is because there are two conflicting regimes of distribution, two different normative frameworks are in play. The normative context of healthcare distribution is centrally structured around the NHIF. The normative framework of privatization is centred around a market logic that does not distinguish between different forms of private practice. Essentially, the state has ceased to view medical providers working in the private sector as healthcare providers and has denied them all the privileges and authority that came with that role.

> 'The state allowed for the opening of private practice but there is no mechanism of inclusion, or actually a better word would be the integration, of that private practice in the entire healthcare system. That is paradoxical. It shows you how uneven it is. You cannot from your private practice write a referral (*uput*) directly to the institution where you think the patient should go. No, instead it has to be verified by someone else in the public sector. Usually by someone who is much less educated than that person. We cannot open sick leave, maternity leave, pregnancy leave for our patients. And I can tell you from talking to my friends in the primary-care sector how much of an administrative burden that is for them.'

This gynaecologist's experience speaks to the image of disenfranchised physicians who feel as if they have lost their authority. It is also a clear example of selective interventions of the market into the healthcare sector. The legal possibility of creating a framework for the re-emergence of the private sector in Yugoslavia in the late 1980s was seen as a solution for combating high rates of unemployment among medical specialists.[56] But this inclusion was by no means complete or integrated and it has been left to patients and providers to seek out their own ways of navigating these constraints. The same legislative framework governs private-medical practices as for all other private entrepreneurs, hence, my interlocutors' comparison with shoemakers and bakers. This lumping of

[56] Parmelee, Yugoslav Health Care.

medical providers with other small private businesses points to a sense of loss of social status more broadly. Aside from the more psychological aspects, this constraining normative framework means that they are faced with everyday obstacles in running their businesses. One gynaecologist explained his situation like this: 'I went to the bank to ask for a loan to buy some equipment they told me that it would have been easier for me to lease a new car than new medical equipment.'

One of the founders of the Association of Private Care providers described the everyday obstacles the private-care physicians are faced with as a form of *preduzetničke akrobatike* (entrepreneurial acrobatics) when she was giving a talk at a conference of private-medical practitioners in 2016. It is a good way of describing the daily navigation and negotiation that is required from medical providers in the private sector. This lack of regulation on behalf of the state would appear to be in line with the central tenets of neoliberalism: deregulation, decentralization, and privatization.

Doctors and Entrepreneurs. Negotiating the Constraints

Legally, a physician cannot be fully employed in both the private and public sector. Private practices are usually (on paper) owned and operated by retired physicians, while a physician employed in the public-healthcare sector is classified as a 'guest' or 'visiting' physician, working an additional 30% per week in someone's private practice. This would mean that they are there two days a week, usually in the afternoon hours. Through this dual or supplemental labour in private practice, doctors are trying to navigate varied constraints and negotiate their positions of power and authority. Thus, the decision to work in both is, of course, financial as the monthly pay check for a medical specialist is very low in the public sector, but it is also a question of status—both of which are lost if they do not work simultaneously in the private and public sectors.

Physicians who are working simultaneously in the public and private sectors are acting as flexible, rational, and innovative actors. They are straddling two different distributive regimes, medical and entrepreneurial. They are trying to manage their own precarious, underpaid, and unappreciated status as state employees by taking advantage of their ambiguous position as both (state) medical practitioners and private entrepreneurs as potentially the only way to regain some semblance of both economic stability and medical authority. If we look closer rather than merely label these practices as possibly corrupt, we can understand how through this double labour physicians are acting as flexible, responsible agents with the goal of (re-)establishing both their social and economic positions in a very precarious context.

Rather than labelling these relations as yet another example of failed postsocialist transition, or as examples of clientelism and corruption, we can construe the flexibility of these doctors as a mode of gaining of power through managing ambiguity.[57] By working in both the public and private arenas, doctors can increase their influence and power. Brković points out that 'those who held multiple positions in public and private institutions could serve as a *veza/štela* to many people for various things'.[58] In the same sense, the physician working both in a public hospital and a private clinic can serve as a connection point for patients who wish to navigate their medical treatment in the public sector better. As one of my interlocutors phrased it: 'The problem with our healthcare sector is that women when they go to the public hospital to give birth, that is the first time they see that doctor.'

When a woman arrives at this hospital, her partner or other family members are not allowed into the hospital. Having someone other than the medical staff present at birth is not allowed in most public hospitals. It was undoubtedly the case in the maternity hospital where I conducted this research. For those few days prior and after giving birth, the women, the patients, are entirely separated from their families. The rationale for this separation is usually the infrastructural constraints of the hospitals to provide complete privacy for the women and their partners. If their partner or family wish to see the newborn and mother before being discharged from the hospital, they can only do so through video monitors and talking on their cell phones. This complete separation from loved ones, coupled with not knowing any of the medical staff in the hospital beforehand, created a sense of isolation for most of the women with whom I spoke. It is this lack of possibilities for establishing a long-term care relationship with the same medical staff that contributes profoundly to the sense of impersonality and coldness. We should not disregard the importance of establishing relations and the creation of kind and warm relations in institutions perceived as cold and faceless. I suggest that it is also important not to disregard these not-so-informal, alternative, institutionalized, privatized patient–provider relations as strategies for establishing a personalizing, closer, human relationship within the public-healthcare sector. The difference is that a personal connection denotes a previously established relationship that is not limited to the hospital setting—for example, a family friend who the woman has seen outside of the patient–provider setting.

In these situations, a patient–provider relationship established through payment for services in the private-healthcare setting is assumed to transition into the public-healthcare system as well, but not to continue outside of the medical context. Thus, the private visits and money paid to the doctors for prenatal care

[57] Brković, Managing Ambiguity.
[58] Brković, Flexibility of *Veze*/Štele, 95.

are not seen as merely economic transactions, but also have implications for solidifying social relations in the maternity hospital. The shift that is important to note is that money, in this case, does not equal impersonality—rather it is a buffer against it. It is not an economic transaction. If it were seen as economic, it would not be seen as morally acceptable by the women or by the doctors. Hence, as the apparent distinction Vera made between gifts and bribes as a question of trust and mutual respect, here too, we can see the importance of trust and sociality as the vital distinguisher between moral and immoral practice. It is the importance of establishing a trusting relationship, the notion of being heard and taken care of that women found most important when deciding which doctor to go to for their prenatal care.

Another crucial factor in their decision-making process is how well the doctor is connected to the specialist working in the public hospital. I had women tell me that they would change private prenatal providers a month before giving birth to doctors who worked simultaneously in the maternity hospitals in their town. While others, on the other hand, sought out those specific doctors for that very same reason.

Thus, it could be said that these women were making informed choices about their medical treatment, but these choices had more to do with the social connections—*veze*—these medical practitioners could provide in public healthcare than with their capabilities as physicians. I do not mean to say that their medical expertise was not a crucial factor, but that the possibility of better navigating their stay in the maternity hospital was something that would tip the scales in favour of one doctor over another. It meant that when they would eventually come into the maternity ward, they would be treated as 'someone's patient' and thus would be viewed and treated differently from the women who had no connections in the maternity hospital, women of the people. It is a different articulation of informality, neither a bribe nor a classic informal relation.

Conclusion

It is not the legacies of socialism that have placed medical providers and their patients in this precarious position, but rather the unbundling of socialist healthcare into the market. Instead of seeking the problem in past social practices by examining what regimes of access are used by both patients and providers, we can see that social practices, such as connections and gift giving, are not contrary to the establishment of market practices but have become an integral part. Connections, *veze*, have not disappeared with the introduction of the market into healthcare provisioning in Serbia. What has disappeared is the ideal that healthcare is free and a constitutional entitlement. Even in the specific cases where free public healthcare is still a guaranteed right, such as maternal

care, we can see that in practice it is far from free and inextricably linked with new strategies for establishing connections.

If anything, the possibilities for establishing connections in the public-healthcare sector have expanded since doctors started working in both sectors. By taking a closer look at the regimes of distribution of maternal care in Serbia, it becomes clear that working within either the public- or the private-healthcare sector poses real obstacles for gynaecologists. Publicly provided healthcare has very selectively and very problematically opened up to market practices. If a gynaecologist works exclusively in the public sector, especially in primary care, they do not have adequate resources, and they have great difficulty establishing trusting and long-term relationships with their patients. On the other hand, while by working in small, private practices gynaecologists are given more opportunity to form trusting relationships with pregnant women, they are unable to provide them complete continuity of care either.

To work around these constraints, they have to be at the same time both medical professionals and entrepreneurs. They are behaving as flexible, rational, neoliberal subjects trying to survive and thrive in times of precarity. On a daily basis, gynaecologists are walking on a tightrope and trying to juggle two constraining regimes of distribution. Using their entrepreneurial acrobatics, they want to avoid being labelled as corrupt extensions of the state—paperwork pushers or losing their expertise as doctors—lumped in with bakers and shoemakers.

Having corruption as the dominant narrative makes doctors' claims for recognition and respect in both the private sector and public sector an uphill battle, fostering distrust among patients. The purpose of this paper is not to deny the existence and persistence of corruption, especially petty corruption, in countries such as Serbia; rather it is to shed light on the problems of using the narrative of corruption as a cultural syndrome, a socialist legacy. The problem with this type of corruption narrative is that it shifts the focus away from analysing the current neoliberal, political economy and frames problems of access to healthcare as a question of cultural or mental (under)development. This framing does a great disservice to the already disenfranchised medical providers working in demanding jobs and searching out ways to maintain a semblance of social and economic status. It also does not present the complete picture of the strategies used by patients to better navigate through the public-healthcare sector. This is a response to the increasing inequalities, systemic cuts, and restructurings in the healthcare sector in Eastern Europe, leaving both doctors and patients no alternative but to seek out their own individual strategies of gaining access to care and social and economic security.

Untangling the practice of establishing a connection in the public-healthcare sector through the private sector, from both informality and corruption we gain insight into the core problems of selective interventions of the market into

healthcare. Problems of exclusion for both patients, who do not have the social and financial status to enable them access to care, and doctors, who do not have the means to flex between the private and public sector or to opt out of the healthcare system altogether. The question now remaining is if these strategies of negotiating patient–provider relations are visible in maternal care, the rare aspect of care that is completely covered by the national healthcare insurance system, how is the selective unbundling of the healthcare sector affecting other aspects of public healthcare?

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