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Regression of Hard-Won Advances in Socialized Medicine: The Emergence of the Private Sector in Health Care in Serbia

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Abstract

Dual practice physicians are those who work in both the public and private sectors: for example, in the morning seeing patients in a state-run hospital, and in the afternoon seeing paying customers in a private facility. Dual practice is a legal but morally problematic practice that can lead to dual loyalty. In Serbia, dual practice has contributed to institutional corruption because physicians who work in both sectors siphon patients from public facilities into private ones and have little incentive to protect the public system. This problem is especially acute in the areas of psychiatry and the public mental health care sector. Private health care is unregulated, with no legal framework for psychotherapy, and there is widespread reliance on cheap anti-anxiety drugs in the population. All of this contributes to rising health care costs, poorer care in both the private and public sectors, overworked physicians, and the shortsighted complicity of the guilds. This is an attack on the right to health: the poor will often get insufficient care, while the patients who are financially better off are at risk of overtreatment and overdiagnosis.

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Introduction

This paper argues that dual practice among health care workers constitutes a form of institutional corruption. Dual practice—that is, the practice of working simultaneously at both private and public health facilities—differs from petty corruption and gifts because it is a legal and institutional opportunity for practitioners to steer their patients toward private practice due to real or perceived obstacles, shortages, long waiting lists, and poorer conditions in the public sector, thereby securing additional income. It also gives rise to a dual loyalty that may compromise physicians' commitment to the public sector, contributing to complacency toward its deterioration. Institutional corruption in health care is a human rights violation because it breaches equality and access to rights and services.

In Serbian public discourse, dual practice is justified as an antidiscriminatory measure (because it allows doctors to work after hours like any other profession) and as a demographic and human resources management strategy (because it increases doctors' income and reduces their motivation to migrate).[1] However, this topic is rarely framed in terms of equal access to rights, particularly how this arrangement deteriorates "the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health."[2]

Duality in health care has normalized the migration of patients between public and private practices. It enables patients to navigate between inefficient public health care, on the one hand, and supplementary private care, on the other, to achieve better health outcomes. However, it also means that they often end up paying for services that are covered by their insurance, resulting in significant out-of-pocket expenses. Consequently, dual practice leads to high health care costs and health inequalities. In the most extreme cases, it could lead desperate people to experience economic hardship, pushing them into poverty and undermining their ability to exercise basic human rights such as access to adequate living conditions, food, and health care.

Serbia's path: From universal public to universal public plus supplementary private health care

The spring of 1945 saw the communist party firmly in control of Serbia and, by the end of the war, the whole of Yugoslavia. In 1946, laws inspired by the idea of socialized medicine were introduced, establishing state medical coverage for certain professions, encompassing 12% of the population. Over the years, other professional groups were gradually included, and in 1959, farmers marked the last group to be added to the public health care scheme. A year earlier, private practice in medicine was banned (with rare exceptions), and for nearly five decades thereafter, state institutions were the only providers of health care services. With the fall of communism and the onset of the transition period, one of the first changes was the reinstatement of private practice. Legislative reforms in 1986 and 1989 allowed private practice, including both dental and medical practice. However, several factors contributed to its slow initial acceptance.

First, the war and sanctions of the 1990s led to an economic decline and to the impoverishment of large segments of the population. This happened while Serbia was already entering the transition process with relatively unfavorable indicators. For example, by the 1980s nearly one in four Serbian citizens lived in poverty, compared to 15% just a decade earlier.[3]

Second, the health care system established by the communists—especially in the area of specialty services—was still functioning relatively well and enjoyed high levels of public trust owing to its fairly effective operation over the preceding decades. Finally, the idea of private practice as a respectable alternative to publicly provided care was still unfamiliar to many people, particularly with regard to a profession such as medicine that is driven by altruism. Due to these factors, private practice played only a minor role until the start of the genuine capitalist transition in 2000.

The decades-long dominance of public health care shaped a network of prestigious public institutions that came to occupy a central place in the field

and in society. This prestige remains strong today, as all medical students and residents in Serbia continue to be educated within these institutions. There are no private medical schools due to, above all, the fact that medical education requires practical instruction that can be conducted only in large clinical centers offering all specialty services—centers that have existed solely within the public health sector since the communist era. The medical schools within these centers date back to pre-World War II; they are publicly run and technically state-owned, but with significant autonomy. Consequently, all professors who hold prestigious academic titles are necessarily employed in the public sector. This arrangement has helped preserve trust in the public system, even among wealthier members of society. The most complex procedures and conditions are still almost exclusively treated within the public sector.

In this regard, psychiatry remains even more closely rooted in the public system compared to most other specialties. Currently, there are no psychiatric wards in private medical centers, outside of addiction treatment. For all other types of psychiatric symptomatology, such as psychosis, bipolar disorder, suicidality, or depression, only outpatient care is available outside the public sector. Therefore, any patient who needs day-hospital or inpatient care must go to a government-run facility, even if they are financially well-off or their outpatient doctor is in the private sector. This has led to situations that are unimaginable in most Western countries: a famous movie star or a prominent politician in such a crisis could find themselves being treated in the same ward—or waiting in the same line for medication—as a factory worker, a farmer, or even a homeless person.

Currently, the Serbian health system's funding comes from multiple sources, including compulsory health insurance contributions, taxes, out-of-pocket expenditures, and supplemental health insurance. Of these, the main source is contributions to compulsory health insurance, which are collected from employees' salaries and employers' profits. Serbia's 2022 Law on Contributions for Compulsory Social Insurance specifies contribution from salaried incomes: 26% for pension and disability insurance, 10.3% for health insurance, and 0.75% for unemployment insurance.

Public financing in the health system has been steadily declining, accounting for only 59.4% of total health expenditures in 2018. Private expenditures—consisting mainly of out-of-pocket payments (96%)—made up the remaining 39.6%.[4] This share of out-of-pocket spending in Serbia is considerably higher than in most European Union countries (e.g., 24.5% in Hungary, 16.1% in Austria, and 12.9% in Slovenia).[5]

Theory: Transition, siphoning out, and the neoliberal push

Transition and corruption

Corruption is the misuse of entrusted power for personal gain, and it can manifest as both petty and grand corruption. Petty corruption involves small gifts, services, or modest financial contributions to low- to mid-level officials.[6] These acts are illegal but can be considered acceptable for some patients when there are no other ways to assert rights or access services. In this sense, petty corruption can help individuals cope with a failing public sector that regularly does not provide services. In contrast, grand corruption involves only a small group of high-level officials and is characterized by enabling a select group to amass wealth. Grand corruption is significant because it exacerbates and highlights perceived societal inequalities, making it widely regarded as unacceptable. People are less tolerant of it, and its existence often sparks moral condemnation and public outrage.[7]

Corruption, at its core, embodies the idea that officials and politicians prioritize personal interests over the common good and make decisions based on individual preferences rather than objective standards. This fundamentally violates the principle of equality before the law by giving certain citizens preferential treatment in their dealing with institutions and legal systems.[8] As a result, corruption prevents equal access to rights, services, and resources such as education, health care, employment, and administrative facilities.

Expanding on this idea, Balakrishna Rajagopal

argues that corruption can sometimes be the root cause of human rights violations, either by acting as a structural cause that allows such violations or by directly constituting human rights breaches.[9] As a structural enabler, corruption weakens the rule of law, which is essential for protecting human rights. This happens as bureaucracy disrupts the fair and efficient delivery of public goods vital for realizing human rights. Corruption also adds subjective elements and arbitrary practices to administrative decisions and law enforcement, leading to human rights violations. Additionally, it undermines the independence and impartiality of the judiciary—key factors in safeguarding human rights—and weakens representative institutions by injecting individual interests into democratic decision-making processes meant for collective well-being.

On the other hand, corruption can directly constitute violations of human rights. For example, the right to political participation is undermined by the unfair distribution of public goods that sideline citizens' interests; the right to freedom of speech is infringed when journalists are bribed to write or not write about specific topics or when bribes prevent access to information about government transactions with the private sector; and the right to equality before the law, including the right not to face discrimination, is violated when certain individuals or groups are given privileges because they paid a bribe.[10]

In all countries that underwent a post-socialist transition, privatization was a massive administrative, economic, and political effort that paved the way for the emergence of new economic and political elites.[11] Unfortunately, privatization also created opportunities for corruption.[12] As in many other countries of the Eastern bloc and the Balkans, such a transition and the rise in corruption have led many to believe that corruption is among the most pressing social and political issues in Serbia.[13]

Furthermore, the development of private firms across various sectors, including public services such as health care and education, began with limited financial resources. After the collapse of socialism, the new Serbian economic elite emerged mostly from the ranks of the former nomenklatura. During the 1990s, two-thirds—and by 2003, half—of those belonging to the economic elite were former members of the socialist political and economic elite or their descendants.[14] Since then, they have been siphoning off public resources to establish their private businesses, whether factories or hospitals. The first private medical facilities, as well as the first private medical schools, were established by professionals from the public sector who lacked the financial means for initial investments and therefore relied on their positional and social capital to start and sustain their businesses.

Corruption in health care

Small-scale corruption, in the form of bribes to public health workers, is widespread in Serbia. Although it is generally frowned on in private conversations, in real-world situations, people often perceive it as necessary. When health is at risk, morals tend to be lower on the list of priorities. Because of this, more than half the patients visiting public hospitals give small gifts or even money to physicians or nurses, and half of them expect to receive better treatment because of it.[15] In a survey, over two-fifths of people (41%) said that they believe it is necessary to give a bribe at a public health hospital if they need an operation, while just half as many (20%) believe that it is not necessary, and the rest are undecided.[16]

This is a direct and easily recognized form of corruption. However, other types also exist. One well-known example in the public sector is the siphoning of patients from public to private health care. This often results from the mixed work hours of many health care workers. Physicians who work in both the private and public sectors may encourage the patients they see in the public system to schedule their next appointment in the private sector, convincing them that they will receive more time and better conditions there—albeit for a fee. Anecdotally, the first author, a psychiatrist in a public hospital (who does not work part time in the private sector), finds that many patients expect the physician to suggest such a referral or even ask for

it themselves, believing it to be customary practice or a way to receive better care.

The neoliberal push

The opening of the first private practices, followed by small hospitals, and ultimately large private medical centers, was in line with "medical neoliberalism," an ideology that promotes treating health as a commodity and the patient as a consumer.[17] This reflects freedom of choice, one of the hallmarks of capitalism—for example, the right to choose the school we attend, the career we pursue, the products we use, and the services we receive, along with the responsibility for the choices made. The idea is that this freedom of choice will, in all areas where the free market is allowed to function, lead to greater autonomy for consumers (in medicine: patients), resulting in competition, which will in turn lead to better and more effective services.[18]

However, it is questionable whether the same concepts that work in other areas are equally applicable in medicine—specifically, because patients lack the knowledge to make informed decisions and there is an asymmetry of power, with patients depending on the physician.[19] Of course, the problem lies in the fact that in an economically unequal society, the question of choice is heavily influenced by a person's financial status. For example, a study from Vietnam on behavioral economics shows that consumer sensitivity to health care costs of screening varies depending on the socioeconomic capabilities of the individual.[20]

As a result, the ones choosing will be the ones with the means to choose, while the poor will be left with what is available. Compounding this, studies show that there is no solid proof that the neoliberal free-market approach in medicine improves the quality or effectiveness of health care services.[21] Studies also show that private medical institutions do not necessarily provide better medical care than public ones and that, in some cases, they might even deliver worse care.[22]

Dual practice

Issues arising from dual practice

Physicians have the right to work, and it would raise ethical concerns if the state were to determine what a person must do in their free time. Thus, if wanting to work is what a physician wants to do, that is their right. However, it is important to recognize that beyond a certain number of working hours, the focus and quality of one's work tend to decline.[23] This means that if a physician from a public hospital, after completing an eight-hour shift, proceeds to work in a private facility, their focus and quality of service are likely to be significantly diminished. Yet patients often feel that they receive better and more attentive care in the private sector, so much so that they are willing to switch from one setting to the other for the same doctor.[24] This is largely because physicians in the public sector tend to conserve energy in a stable job that does not closely measure their effectiveness, and where the number of consultations and the level of patient satisfaction have no impact on their salary.[25] Thus, the biological limitations of the human body and the financial incentives that exist create a fertile ground for institutional corruption. Three issues arise from this corruption.

Issue 1: Degradation of the quality of public services. The first is the *degradation of public health care quality* and the *passive siphoning of resources* from the public to the private sector. Even when a patient remains in the public sector, as mentioned above, they believe that additional payments or gifts to medical personnel or additional checkups in a private clinic are necessary to receive quality service.

A key part of work in the public sector should include not only routine tasks but also advocating for better working conditions for health workers and better care for patients. Health care expenditures per person in Serbia are near the bottom in Europe, lower only in Moldova.[26] In this light, it is reasonable to hypothesize that many workers who operate in both the private and public sector feel conflicted about the state's lack of support for public health care. If the quality of work in the public system were to improve significantly, the private sector might receive fewer patients, thereby leading

to less private work for which doctors are paid by the consultation. On the other hand, the public sector could experience a higher patient load, yet for the same salary. Although most physicians probably do not consciously think in these terms, it is evident that the current system has created a double loyalty and a clear financial incentive to (at least subconsciously) prioritize private work at the expense of public because the direct personal gains for the physician are greater when such a priority is made. This can lead to institutional corruption. In other words, a legal and publicly morally acceptable system exists in which the institution and individuals have a clear personal incentive that overrides the incentive the institution and individuals in it are meant to put in first place: the patient's well-being.

Issue 2: Overtreatment and overdiagnosis (as a human rights violation). Receiving direct payments for medical consultations in the private sector encourages physicians to communicate more carefully, leading to higher satisfaction among service users. However, it also creates financial incentives that are not always in the patient's best interest. Tests that otherwise would not be performed and could even cause harm are more readily ordered when the patient is paying. This is often understood by lay people to mean that private health care patients receive better care because they receive more tests and treatments, whereas the concepts of overtreatment and overdiagnosis are less prevalent in the public sphere. Considering that "the potential consequences of overdiagnosis and overtreatment may be significant and include such harms as the psychological and behavioral effects of disease labelling, physical harms and side effects of unnecessary tests or treatments, unnecessary treatment negatively affecting quality of life, increased financial costs to individuals and wasted resources and opportunity costs to the health system," a case can be made that it is just the opposite side of the same coin as undertreatment.[27] Further, as as Kanny Ooi points out:

> *doctors in private practice usually operate a fee-for-service model where they charge for each consultation conducted, and for each test and procedure performed. Although most doctors do not intentionally abuse or defraud the health system, operating a fee-for-service model essentially means earning more for doing more irrespective of what the outcome may be for the patient.*[28]

This means that overtreatment and overdiagnosis in the private sector are shaped, at least in part, by institutional corruption. In this sense, the overtreatment and overdiagnosis that stem from a private health care system that incentivizes the physician to almost always choose intervention whenever there is doubt could be viewed as a form of institutional corruption, which in turn may amount to a human rights violation. As noted by the Office of the United Nations High Commissioner for Human Rights and the World Health Organization in a fact sheet on the right to health, "All services, goods and facilities must be available, accessible, acceptable and of good quality … Finally, they must be scientifically and medically appropriate and of good quality."[29] In terms of health, it is recognized that "good quality" is absent not just when patients do not receive necessary care but also when they receive care that is unnecessary.[30] While this is not caused solely by financial interests in the private sector, these interests often exacerbate the problem.

Issue 3: Subjective satisfaction vs. quality of services. In line with the previous two issues, another factor related to dual practice is the massive influence of subjective feelings in valuing a service. Thus, even if a given service is measurably worse in one place compared to another, a patient might still prefer the worse option because of the simplicity of the process, the aesthetics of the room, or the decorum of the workers. A study from 2020 found that one of the three main problems in public health care in Serbia, as seen by citizens, is "insufficient motivation and dedication of the staff."[31] Another study, which examined how patients navigate between the private and public health care systems, quoted a patient as saying:

> *"What we are paying for is the human relationship. It is not like a hotel here, but they at least look you in the eyes and have patience with you, I know it is*

not easy for them, but they can at least introduce themselves. They can ask how we are feeling. Sometimes a single word means a lot, a single smile. We are paying for kindness."[32]

Of course, psychiatric patients are not spared from this need, and they are possibly the category of patients mostly influenced by the relationship with their psychiatrist.[33] Studies show that satisfaction with private health care in psychiatry is often greater precisely because of the difference in approach.[34]

It is similar to buying a coffee at a nice-looking café versus a café that is dirtier or has a rude cashier, even if the first place serves worse coffee. This effect might be even more pronounced in medicine, where the placebo effect has a major influence on the measurable metrics. Choosing a clinic is also influenced by aesthetic details that affect cost and subjective satisfaction, but not necessarily by the health outcomes experienced by its patients. However, satisfaction is an important factor for any consumer, and objective measures are nearly impossible to recognize on an individual basis in health care. As a result, people with means are increasingly opting for private practice over public health care. This shift affects not only their individual health care costs but also their attitude toward public health care and the perceived obligation to pay for it.[35] The sentiment of "if I don't use it, why should I pay for it" undermines solidarity and the sense of duty toward all members of society.[36] Thus, on a population level, these individual decisions affect the whole of society. They can even affect the public sector directly. The psychological effect of receiving direct payments from patients for work in the private sector could lead physicians to view their work in the public sector, and the patients they see there, as less important or less worthy of maximum attention—unless a gift or payment (i.e., a bribe) is given, which might explain at least part of the petty corruption in the public sector. This further diminishes trust and perpetuates a vicious cycle that is directly influenced by the institutional corruption of dual practice, which enables petty corruption and degrades the quality of care, which is a human rights violation.

Dual practice in Serbia

In Serbia, physicians working in the public sector have the right to also work in the private sector, and many do so to supplement their monthly income. Such physicians usually work in a public hospital in the morning and early afternoon (typically from 7 a.m. to 3 p.m.) and then move to a private clinic in the late afternoon. Some have their own small private practices, while others work for private medical centers that are eager to hire these physicians as part-time employees—both because of the prestige they carry from the public sector (especially if they also hold academic titles) and because of the expectation that they will attract patients from the public sector, thereby bringing business with them.

A 2020 study found that 27% of public sector physicians plan to work in both sectors simultaneously. This trend is even more common among physicians in their twenties, with 36% intending to do so. Only 7% plan to work full time in the private sector, while 45% intend to work exclusively in the public sector.[37]

Dual work has normalized the migration of patients between public and private practices. It allows patients to navigate inefficient public and supplementary private health care more effectively to achieve better outcomes. However, as a result, patients often end up paying for services that are covered by their public health insurance, which can lead to significant health expenses.[38] A quarter of physicians working in dual practice worldwide report that their motivation for working in the public sector is because it allows them to recruit patients to their private practice.[39] In Serbia, a 2020 study found that citizens perceive poor organization and long waiting lists as the primary problems with the country's public health system—problems that, in theory, could be addressed with relatively low financial investment, provided that a motivated workforce is in place.[40] In 2024, Serbia's then minister of health (a physician herself) claimed that the long waiting lists for surgeries were being intentionally created to steer patients toward private practice, where they would have to pay the same

surgeons who also work in the public sector.[41]

Moving to the private sector is often viewed as more practical, especially if it allows one to bypass the primary care setting. In today's world, where patients can check symptoms online, they often know upfront what type of specialist they need.[42] This further renders the primary care doctor even more redundant, turning them into an administrative obstacle, since in the current public health care model, the primary care doctor is meant to perform triage and give patients referrals to see specialists. In private health care, patients call directly and go straight to the specialist they believe they need, making the process simpler and more practical.

All of this leads to more health inequalities. Citizens with higher socioeconomic status are more likely to see specialized physicians, gynecologists, stomatologists, psychiatrists, and others.[43] Again, higher socioeconomic status is the main factor influencing the likelihood of using private health care options.[44] Because of this, although 27.7% of people nationwide use private health care, this figure rises to 42.8% among those with higher socioeconomic status. There has been a sharp rise in the use of private health care services in recent years: while 15.2% of citizens used private practice in 2013, this figure rose to 27.7% in 2019.[45] The public health care system's inability to provide necessary and effective care for everyone has resulted in the growth of the private sector.

The rise of the private sector and the marginalization of the public sector has not brought observable benefits for public health. While direct data on causality are hard to obtain, some indirect data may be interpreted to show that this phenomenon is negatively influencing health outcomes and health inequities. According to a World Bank and UNICEF report from 2023 on health care in Serbia:

> *Despite improvements over the last decades, Serbia does not compare well with peers and aspirational peers in health outcomes. Life expectancy at birth is lower than in several Western Balkan countries. At 12 per 100,000 live births, maternal mortality in 2017 was more than double the EU average. Serbia ranks second highest on mortality per 100,000 population among comparator countries, performing better than only Bulgaria.*[46]

The same report recognizes that Serbia is continually lowering the amount spent on public health care, eager to give ground to the private sector so that the money in the budget can be allocated elsewhere. At the same time, the state is reluctant to introduce stricter regulations on the private sector and dual work, which leads to an inefficient and expensive health care system that is especially damaging to those who are lower on the socioeconomic ladder. As the report finds:

> *Long-term trend shows a decline in the government's health spending, from 6.2 percent GDP during 2008–2010 to 5.1 percent in 2018. At the same time, private expenditure stayed at 3.7–4.1 percent of GDP. The health system relies heavily on OOP (out-of-pocket), which makes Serbia an outlier when compared with peers and aspirational peers … The system performs poorly on financial protection, relying on OOP payment for 42 percent of total health expenditure. Roughly 86 percent of OOP is spent in the private sector … Some 4–5 percent of the population suffers from "catastrophic" health expenditure each year (health expenditure that exceeds 25 percent of total household nonfood expenditure), a level that is higher than in all comparator countries except Albania … Private providers are a popular choice among the population due to their convenience and seemingly better facilities. However, except for a small number of selected services, private services are not contracted by the National Health Insurance Fund (NHIF) for the public benefit package, limiting the government's ability to regulate the private sector or helping to reduce OOP spending on private services.*[47]

This is a major problem for private mental health services, too, given that Serbian law currently recognizes only psychiatrists and psychologists—but not psychotherapists—as legal entities. This creates a substantial gray zone, allows the profession to self-regulate, and places the entire private psychotherapy sector—which has been rising quickly in the last decade—outside of any legal framework.[48] As a result, the official figures for out-of-pocket spending are probably underestimates, particularly as patient spending on psychotherapy has not been taken into account.

Just as the entire public health sector is being deprioritized, so is mental health. In 2019, the

state published an action plan highlighting the need for more community mental health centers, which are more accessible than hospitals and offer support to a broader array of people. At the time of the action plan's publication, there were five such centers in Serbia, and the aspiration was to have 20 by 2022. But as of today—the end of 2025—the total number is just six.[49]

Such neglect and lack of investment in the public health care sector have not produced any backlash among professionals working in this sector, likely due in part to general political apathy, but possibly also due to dual loyalty. This lack of support for mental health in the public sector—as well as the unregulated, non-insured, and expensive private mental health sector—has contributed to the widespread use of cheap anti-anxiety drugs. These drugs are being overprescribed by physicians, but also sold illegally by private pharmacies to patients without a doctor's prescription.[50] A recent comparative study that analyzed the use of psychiatric drugs across countries found that Serbia ranks first in tranquilizer use in the world.[51]

The unregulated landscape of dual practice in Serbia

Public framing of the problems: From patients' to doctors' rights

Although the public has long been aware of the direct ways in which corruption exists in the public health sector, the government has only recently taken steps to address the issue. In 2022, the newly appointed minister of health, Danica Grujičić, who is a physician herself, publicly stated that "physicians shouldn't be able to work in both the private and public sectors because it is a generator of corruption."[52] This triggered an immediate backlash from physicians, who defended their "right to work" and labeled her statement hypocritical, since she had worked in both the private and public sectors before taking office. In one response, an opposition member and physician engaged in dual practice argued that any alleged siphoning of patients should be proven; he also stated that he does most of his laboratory and imaging analyses in the private sector because these services are either unavailable or have long waiting lists in the public sector. Interestingly, he also claimed that patients in the private sector have "90% unnecessary tests done to them."[53]

This interaction highlights the ambivalence and institutional corruption at the core of the Serbian health care system and the physicians who are a part of it. On one hand, the minister of health correctly recognizes the corruption arising from the current model—but only after assuming a political role and ceasing to work as a physician. On the other, the physician defending his right to work in both the public and private health care systems correctly acknowledges that this duality results in unnecessary tests and that he himself experiences poorer service in the public sector partly because of this. He also calls for legal proof of corruption in cases of siphoning, probably aware that such proof is nearly impossible to obtain.

Under the current system, decision-makers are arguably the primary beneficiaries because they can keep medical professionals politically passive. Although public sector physicians in Serbia earn the lowest salaries in the profession across Southeast Europe, they manage to supplement their income through additional work in the private sector.[54] As the above interaction demonstrates, everyone is aware of these systemic problems, yet there is little motivation to remedy them. Consequently, while no one is genuinely satisfied, short-term incentives encourage the preservation of the status quo. But this dynamic results in fatigue among physicians: according to a 2020 study, feeling overworked was physicians' top complaint, cited by 50% of respondents.[55] Meanwhile, decision-makers can divert increasing funds from the public sector, confident that there will be little to no backlash from workers or patients.

Defining policies and framing the public discourse

Medical doctors have led Serbia's public health care system for decades. Typically, health ministers, state secretaries, and other high-level public officials are selected from the ranks of doctors and university

professors. Medical doctors have served as ministers of health for 23 of the last 25 years. This is part of the explanation for the pervasiveness of dual practice, along with all its negative consequences: the governance structures in the public health care system have been dominated by medical doctors who have no interest in restricting dual practice. Resistance to the status quo is rare, as illustrated by the cases of the association Doctors Against Corruption and former minister of health Grujičić; although both were highly critical of corruption in health care, their voices remained marginal.[56]

Serbia's legislation is also conducive to dual practice and its potential for corruption. The accreditation of health institutions is conducted in accordance with established quality standards. The quality standards for primary, secondary, and tertiary health care institutions do not specify the structure or legal status of employees; in particular, they do not establish specific requirements regarding the number of full-time employees that an institution must have.[57] This leaves an open door for dual practice in the public and private sectors.

The first and only serious attempt to regulate this problem happened in 2005, when dual practice was effectively banned by the Law on Health Care. The ban was supposed to take effect after a three-year period. However, in 2008, when the prohibition was due to be enforced, the Medical Chamber filed a case before the Constitutional Court, and in 2010, the court effectively annulled the restriction. Interestingly, the public discussion was framed around antidiscrimination issues, while the issue of access to rights and health care services played a marginal role.[58]

Over time, the private sector became stronger, but it was not until 2013 that a major investment in private health care occurred, marked by the acquisition and merger of several private practices. This process has gradually established the first large private medical network comprising primary and secondary health care facilities. Despite its size and foreign investments that followed, it still relies on the part-time or full-time work of doctors from the public sector. In essence, dual practice has become a part of the business model of both private and public health care institutions, which partly explains its persistence.

The other part of the explanation lies in the health care system's governance structures. To shed additional light on the issue, we will make a parallel between health care and education. Governance structures in both fields are controlled by professional elites who are able to influence public policies. In both cases, these policies primarily protect the interests of doctors and teachers, rather than the broader public. Thus, the primary beneficiaries of the two systems are university professors (in higher education) and specialist doctors who are also university teachers (in health care).[59]

However, there are significant differences between the two systems. Unlike in the health care system, dual practice in higher education has been regulated. The accreditation system for higher education institutions clearly prescribes the number and structure of employees, as well as the ratio of permanent and temporary employees.[60] This makes it practically impossible for a private educational institution to rely on the work of teachers from state universities whom it hires on a part-time basis.

Moreover, the education system is shaped by external pressures and incentives—mechanisms that are largely absent in health care. The European Union maintains a relatively unified policy in the field of higher education. The Bologna Process, which seeks to ensure compatibility in higher education systems across Europe, has helped regulate Serbia's previously deregulated higher education system. By contrast, the health care system lacks a similar external incentive to limit dual practice or protect patients' rights and interests.

Conclusion

Patients in Serbia's public health care sector are receiving constantly deteriorating care. Those who have money are switching to the private sector. Moreover, patients in the private sector are receiving care that is often detrimental because it uses unnecessary resources and includes unnecessary tests. Nonetheless, the guild and physicians within it are seemingly satisfied with the status quo be-

cause they believe that it provides the best of both worlds: stability, prestige, and low expectations in public health care, combined with higher financial returns in the private sector.

If the state were to abolish or more closely control dual practice while also increasing investment in public health care, it would reduce profits in the private sector—and with key actors "sitting in both camps," their incentive to pursue such reforms is limited. In our view, this inertia is likely to be detrimental to physicians in the long term: fighting for a better public health sector—with better conditions for patients and better salaries for workers—would increase the quality of life of physicians and nurses by allowing them more free time, giving them more respect, and reducing the likelihood of being overworked by long work days.

Serbia's current health care system is a product of historical conditions and compromises made to appease everyone. Unfortunately, it has predictably failed to do so, and in a way that harms all sides. Public health is receiving less funding and patients seem to experience poor-quality care. Private health care users are getting more care, which often is not better and can lead to overtreatment and overdiagnosis. Physicians are often pulled by both the security of a public sector job and the additional income from private practice. This mix causes them to be overworked and further damages the public health care system, ultimately compromising the right to health for Serbian residents. Addressing this issue is hindered by institutional corruption embedded in the way the system is built.

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