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DISTINCTIVE FEATURES OF THE ORGANIZATION OF HEALTHCARE MANAGEMENT IN THE BSSR AND WESTERN BELARUS (1919–1939)[1]

The article describes the process of organization of healthcare management bodies in the BSSR and Western Belarus in the interwar period. It is shown that, unlike Soviet Belarus, where a centralized model of healthcare was initially built, a stratified model of healthcare with a division into several separate sectors has developed in Western Belarus. The structure, competencies and features of the personnel of the senior management of healthcare in the conditions of the interwar period are shown.

Keywords: *Socialist Soviet Republic of Belarus, Western Belarus, medicine, healthcare, doctors.*

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ОТЛИЧИТЕЛЬНЫЕ ОСОБЕННОСТИ ОРГАНИЗАЦИИ УПРАВЛЕНИЯ ЗДРАВООХРАНЕНИЕМ В БССР И ЗАПАДНОЙ БЕЛАРУСИ (1919–1939)

В статье охарактеризован процесс организации органов управления здравоохранением в БССР и Западной Беларуси в межвоенный период. Показано, что в отличие от Советской Беларуси, где изначально внедрялась централизованная модель здравоохранения, в Западной Беларуси сложилась стратифицированная модель здравоохранения с разделением на ряд обособленных секторов. Показаны структура, компетенции и особенности кадрового состава руководящего звена здравоохранения в условиях межвоенного периода.

Ключевые слова: *Социалистическая Советская Республика Беларуси, Западная Беларусь, медицина, здравоохранение, врачи.*

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Introduction. The current COVID-19 pandemic crisis revealed not only the importance of maintaining a proper number of hospital beds and medical personnel but also the need to maintain prompt and effective interaction between various branches of the medical organization, making timely decisions at the highest level of healthcare management and their strict compliance by subordinate structures. The foundation of the modern model of healthcare management of the Republic of Belarus was laid in the interwar period when the Soviet model of medicine was established in the BSSR, but at the same time, there was a separate vertical of medical administrative bodies on the territory of Western Belarus, which was incorporated into Poland following the results of the Polish-Soviet war of 1919–1921. The distinctive features of these two systems were partly studied in historiography. In the articles of G. Krjuchok, the superiority of soviet healthcare was shown only, while the medicine of Western Belarus was described as weak and ineffective. Such conclusions were typical for the rest of the soviet scientists [1, 2]. In the post-soviet historiography, the basic features of soviet and polish healthcare were highlighted in the studies of M. Abramenko and E. Tishchenko, however mainly separately and without any attempts of comparison [3, 4, 5, 6]. In the studies of modern polish researchers (E. Więckowska, W. Noszczyk, J. Supady etc.), the peculiarities of the organization of healthcare management during the interwar period were considered mainly in the central regions of interwar Poland, without taking into account the peculiarities of Western Belarus [7, 8]. This article analyses the key features of healthcare management system in Soviet and Western Belarus during the interwar period.

Main part. After the October revolution, the medicine in Belarus began to develop on the example of the RSFSR, where at the First All-Russian Congress of Medical and Sanitary Departments on June 15–18, 1918, the theoretical foundation of Soviet healthcare based on the principles of accessibility, qualification and free medical care was laid. It was concluded, that it is necessary to destroy the interdepartmental framework and unite medicine under the authority of the People's Commissariat for healthcare of the Russian Socialist Federative Soviet Republic (RSFSR). On the provincial level (oblast, county, city, volost), local medicine departments were created, that were simultaneously subordinate either to People`s Commissariat for Healthcare or to local authorities (Executive Committees of Soviets) as their integral parts. The first steps of the new government in the field of healthcare became the widespread nationalization of medical institutions (hospitals, outpatient clinics, infirmaries) and pharmacies, as well as the mobilization of medical personnel to serve the state [9, p. 96].

However, in the conditions of the German occupation of Belarus in 1918, no significant healthcare management body was created, and local healthcare departments were organized in the unoccupied territories only. Their activity was complicated by the shortage of personnel, hospital beds, medicines and funds [10, p. 2].

After the retreat of the German armies and the proclamation of the Socialist Soviet Republic of Belarus (SSRB, later the BSSR), the creation of the Commissariat for Healthcare (later the People's Commissariat) as part of its government took place only on January 20, 1919 [11, p. 11–11 rev.]. The Commissariat had several subdivisions, that reflected the main directions of the new government body's activity: therapeutic; sanitary and epidemic; social diseases; statistical; forensic medicine; pharmaceutical; school-sanitary [12, p. 36].

In the regions, the provincial, city and county healthcare departments were formed in the Soviet troops controlled lands and directly managed the medical network and had a number of branch sub-departments for this. The number of sub-departments could vary depending on the specifics of the locality, for example, in 1920 the Mozyr county healthcare department had only four sub-departments: medical, pharmaceutical, sanitary-epidemiological, and children's health [13, p. 139–140]. Local health departments had a double subordination – to their local executive committees since they were part of them, and along the departmental line – to the Commissariat of Health of the SSRB. The new commissariat was supposed to combine the efforts of local health departments to combat infections and restore the medical network [14, p. 15].

Allocating the competencies of local administrative healthcare authorities, the SSRB government was guided by the standards developed by the People's Commissariat for Internal Af-

fairs of the RSFSR. So, according to the instructions on the organization of local councils and their departments, healthcare departments had to deal with the following range of tasks:

1) organization of medical care to the local population;

2) management of the local medical network: hospitals, sanatoriums, reception rooms, outpatient clinics;

3) creation of new medical institutions;

4) carrying out measures for sanitary improvement;

5) the fight against epidemics, including the organization of so-called volatile sanitary disinfection detachments;

6) management of nationalized pharmacies;

7) accounting of all medical products and medicines;

8) accounting of medical personnel;

9) organization of medical courses, sanitary education of the population through public readings;

10) sanitary supervision of urban and rural settlements [15, p. 6–9 rev.].

The exclusively state character of Soviet medicine, its ideological significance as the most important social guarantee of a Soviet citizen in comparison with the population of «capitalist» countries, led to the total subordination of the healthcare sector to the government and the establishment of tight Soviet and party organs control. In this regard, it was not doctors who were nominated for the positions of heads of city and county (later – district) health departments, but primarily party and Soviet organizers, which was also due to the specific position of doctors in the structure of the Soviet intelligentsia [16, p. 5, 49].

It should be explained that, in fact, from the beginning of the formation of the Soviet system in Belarus, doctors were generally regarded as «unreliable» from the point of view of cooperation with the Bolsheviks, and suspected in the attraction to the «old order» in healthcare («zemstvo medicine») and therefore were considered a potential social support of counterrevolutionary forces [17, p. 61 rev.]. Despite the «proletarization» of medicine through the preferred recruitment of applicants of worker-peasant origin to medical faculties, a distrustful attitude towards medical personnel persisted. Thus, at a meeting at the Central Committee of the Communist Party of Bolsheviks of Belarus about labor and health issues on November 21, 1934, party officials noted: «...we must not forget that they [doctors] still have a petty-bourgeois touch, remnants of everything negative which was in the petty bourgeoisie» [18, p. 82]. Such an attitude led to additional ideological supervision of the medical sphere, which was carried out by nominating to the positions of heads of local healthcare departments not doctors themselves, but representatives of the party vertical who were loyal to the Soviet government.

Thus, at the above-mentioned meeting at the Central Committee of the Communist Party of Bolsheviks of Belarus, the following opinion was expressed regarding the management of district medical administrative bodies: «We think it is wrong when they say that the district healthcare authorities should be doctors... where a doctor sits on administrative work, he should be transferred to medical work, and party people, administrators, should be put on administrative work» [18, p. 80, 90]. It should be added that such decisions also had objective factors, since, despite the presence of more than 2,000 doctors in the BSSR in the mid-1930s, they were concentrated mainly in large cities, and their shortage was constantly felt locally: «The Bolshevik organizers should be the district healthcare chiefs, those who know how to heal must heal... We cannot afford the luxury of putting a doctor on administrative work» [18, p. 80, 90].

These circumstances predetermined the practice of appointing persons without medical education to the positions of heads of district healthcare departments. Due to such a personnel management, an effective (in theory) healthcare management system did not always work properly in practice. Thus, by the mid-1930s, an organization of healthcare at the regional level, was weak, especially in rural areas. For example, in 1935, in the Drisen district, it was noted that chief of local district healthcare department Bukhshtikov «... is not familiar with healthcare... he says that he does not know what a medical center or hospital should do» [19, p. 224].

The situation was aggravated by the frequent change of personnel of chiefs of healthcare departments due to both the general socio-political situation in the USSR and the difficulties of conditions of service in the rural regions. So, in 1939, in the Minsk region, 15 chiefs district

healthcare departments were replaced in 21 districts, and in Krasnaya Sloboda, Lyuban and Smolevichi, 4 heads of district healthcare departments were replaced in a year, as a result of which «neglect in the healthcare matters» was observed [20, p. 2]. By the end of 1939, from 21 vacancies of heads of healthcare departments only 11 positions were occupied. In general, in the report about the state of healthcare in the Minsk region in 1939 it was noted that «the positions of heads of healthcare departments are often occupied by people who did not justify themselves in another job, who do not have organizational experience, and not familiar with the Public Health, and most of them are formally considered to be a district health department, but actually perform the work of the district executive committee and the district party committee on various political and economic sectors, do not visit the district healthcare department for 3–4 months» [20, p. 2].

However, despite certain shortcomings, the centralized healthcare management system allowed to build a strong medical organization, which, on the one hand, took into account local health needs, and on the other hand, provided the center with the regions through the regular exchange of circulars and reports, which, together with tight state and party control, made it possible to implement a common course for building Soviet medicine is based on the principles of accessibility, qualification and free of charge.

In interwar Poland, which occupied the Western Belarusian lands in 1919, the organization of healthcare began simultaneously with the restoration of its independence. Even during the First World War, during the period of the Provisional State Council under the Austro-German occupation administration in Poland in 1917, a Public Health Section was created at the Department of Internal Affairs, which through a series of reorganizations at the end of 1918 was transformed into the Ministry of Public Health. Six sanitary districts with centers in Warsaw, Lodz, Kielce, Lomza, Lublin and Lviv were created for the territorial management of the healthcare business. Each district united from a dozen to several dozen counties, the centers of which became the residences of local healthcare departments and county doctors [21, p. 1].

Despite the formal spread of a similar medical organization in the occupied Belarusian lands, during the Polish-Soviet war of 1919–1921, in the conditions of a large-scale epidemic crisis associated with the spread of typhus and other diseases, the actual management of the development of medicine was carried out by a branch of the All-Polish Main Emergency Commissariat for Combating Epidemics, and most of the medical institutions were deployed and controlled by this very body [22, p. 675; 7, p. 210–211].

Despite the end of the «great typhus epidemic» in 1923, there was no special administrative body like the People's Commissariat of Healthcare in Western Belarus [23, p. 16]. Moreover, the Ministry of Public Health in Poland itself existed only until 1923, when it was liquidated (due to political transformations, as well as to save money), and its powers were transferred to the Ministry of Internal Affairs. Since 1932, the main functions of the former Ministry of Public Health have been transferred to the Ministry of Social Care [24, p. 26; 8, p. 8].

Such structural changes could not contribute to the organic development of medical care for the population of the Polish state. To some extent, the liquidation of the Ministry of Public Health in Poland was balanced by the stratification of healthcare into several sectors: state, municipal, insurance and private, each of which had its own medical institutions, the totality of which formed the country's medical network. Military medicine can also be singled out separately as the fifth branch of the development of healthcare in interwar Poland. However, in Western Belarus, due to the weakness of the insurance and private healthcare sectors (which had an autonomous status in the healthcare system), the maintenance of the medical network in financial and organizational aspects fell mainly on the state, as well as local magistrates and county sejmiks [25, p. 15 rev.].

The management of state and municipal medicine was represented by the voivodeship and county administrations departments of healthcare (later – health and social care, and since 1932 – labor, guardianship and health) as well as the positions of city doctors in the largest cities [26, p. 2 rev.]. These bodies were formally responsible for all the spheres of public health protection, however, they primarily dealt with sanitary issues and provided disease control (trachoma, tuberculosis, venereal diseases). Counties were divided into medical districts, each of

which was headed by a district doctor [23, p. 16 rev.]. However, due to the chronic shortage of doctors in Western Belarus (for example, in Novogrudok Voivodeship in 1923 there were only 50 doctors, in 1928 – only 120), in a large number of localities, especially in rural areas, their functions were performed by paramedics [27, p. 5–5 rev.; 28, p. 72].

The duties of the city doctor included:

1) sanitary supervision of food;

2) the fight against infectious diseases and the supervision of the sanitary condition of cities;

3) school sanitation;

4) providing free consultations to city employees;

5) expert participation in meetings of the city council on sanitary issues [28, p. 42–43].

Due to the limited number of responsible persons at the county level, the county doctor was responsible for numerous medical, sanitary and social aspects of county life:

1) health statistics;

2) accounting for mortality and fertility of the population;

3) supervision of the spread of social and sexually transmitted diseases;

4) control of the implementation of vaccinations to the population;

5) registration of prostitutes;

6) accounting for the movement of medical personnel;

7) report on the work of insurance medicine;

8) sanitary control of housing and animal husbandry;

9) drinking water intake for the analysis of suitability for use;

10) the fight against alcoholism and fines for it with referral to court [29, p. 1–9].

Despite the formal large number of accountable areas of activity, local administrative medical bodies were mainly active in three main areas: 1) administrative; 2) sanitary; 3) forensic. However, analyzing the competence of representatives of the state healthcare structure, it should be noted that their main attention was focused on sanitary and general preventive measures, and not on the direct provision of medical care to the population [30, p. 116].

Conclusion. The above shows that the result of the development of medical administrative bodies in the BSSR was the successful construction of the vertical of the People's Commissariat of Health and the regional healthcare departments subordinate to it, which made it possible to build a single state medical organization that, on the one hand, took into account local health needs, and on the other, provided the center's connection with the regions. At the same time, the exclusive state character of Soviet medicine and its ideological significance led to the complete subordination of healthcare to the state by nominating leaders for this sphere mainly from the party vertical. This was justified by the need to release all available trained doctors for direct medical work.

In Western Belarus, the liquidation of the centralized Polish Ministry of Public Health and the branching of medicine into the state, municipal, insurance, private and military in conditions of weak socio-economic development caused the lag of the medical organization in the Western Belarusian lands from the Polish proper and negatively affected the provision of medical care to the population. Unlike the BSSR, regional healthcare structures were supposed to be headed by doctors, but their total lack led to frequent replacement by paramedics.

Thus, despite the problems in qualification of chiefs of local healthcare departments, the organization of Soviet healthcare system was far more effective, then the self-government built medical organization in Western Belarus, which expressed in quality of medical provision for the population, efficiency of anti-epidemic struggle in respectively Soviet and Western Belarus.

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