

Values and Structure in the German Health Care Systems

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IN THE EXTENSIVE LITERATURE ON POLITICAL values and health care, no work addresses the divided Germany that was forced into existence following the conclusion of World War II. The omission is surprising since the resultant individualistic West and the Communist East provide the researcher with a "natural experiment" in history, one in which a third of the world's oldest and perhaps most sophisticated health care system itself became an experiment in the application of Marxist/socialist ideology.

Examining this experiment has distinct advantages over other comparisons of health care under Communist versus non-Communist governments. If one compares health care services before and after a Communist takeover, one is unable to examine how the former society and its health care system would have evolved over time had a political upheaval not taken place. Alternately, if one compares a Communist and a non-Communist system in two countries during the same period, the problem of periodicity is solved but the problem of comparability is increased. Inevitably, there are differences of language, culture, history, medical institutions, forms of insurance, and other relevant variables. Happily, the German experience comes as close as is humanly possible to what Campbell (1969) calls a quasi experiment, in which

most of the relevant variables are held constant and an identifiable "treatment" randomly occurs (Teune 1978). In comparative systems analysis, this is a "most similar systems" design and allows one to examine the impact of a policy intervention on a society which is as nearly identical in pertinent characteristics and institutions as possible (Przeworski and Teune 1979; Marmor 1983, chaps. 2, 5, 9). In Germany, the resulting two systems continued to evolve side by side.

Laying the Foundations

The comparative study of East and West Germany must start with origins, the political, social, and institutional context out of which the two postwar health systems emerged. This story has been told before, but not in the context of the two German systems that exist today. When reexamined from that perspective, the development of the German health care system takes on a different shading. One discovers that it is a compromise between competing models or visions of what health care should be, so that elements of the early history are relevant to both the Communist and social-democratic systems that emerged from it. Of these, it appears that political values were paramount, even in the formative years.

In 1883 the world's first national health insurance program became German law. It was part of a series of social insurance programs initiated by Chancellor Otto Eduard von Bismarck to quell socialist sentiments among the burgeoning ranks of workers pouring into the factories as the industrial revolution came to Germany (Rosenberg 1969; Rimlinger 1971; Stone 1980). Away from their families and villages where relatives and neighbors helped out in times of sickness, these workers were unprotected by their corporate employers when accidents and illness struck. Bismarck's goal, therefore, was to establish a health care system run by the government so that workers would look to the state for their welfare and thus be less attached to trade unions and less attracted to the Social Democratic Party. To a lesser degree, Bismarck's proposal echoed a Prussian tradition of governmental responsibility for citizens' health and the long tradition of social medicine in Germany. In 1766, Johann Peter Frank had conceived a plan for the protection of individual and group health by government that remains today among the most comprehensive (Rosen 1979). He

outlined programs for protecting the health of pregnant women, for keeping infants healthy, for health education in schools, for minimizing dangerous conditions in the workplace, and for health care through the stages of life. Like other German writers, Frank assumed an authoritarian government, and called his plan *Medicinishe Polizey* or Medical Police. In the revolutionary years around 1848, Frank's work was joined by such German medical leaders as Salomon Neumann, Rudolf Leubuscher, and Rudolf Virchow, who also emphasized the obligation of the state to assure the health of its people (Virchow 1849). Although the defeat of the 1848 revolution quelled enthusiasm for these ideas, a more limited focus on sanitation and on compulsory health insurance for civil servants took hold (Peters 1959; Abel-Smith 1976). By the early nineteenth century, Prussia had laws regulating provisions for the health care of miners and domestic servants as well. Thus, while Bismarck was primarily concerned with meeting the health needs of a new industrial working class in such a way as to prevent socialism, his ideas also built on a paternalistic, conservative version of medical police and social medicine.

Bismarck's program was primarily rooted in the German tradition of a strong state (Craig 1978). Hegel argued that individual identity and reality only come through the state. "The state is the true embodiment of mind and spirit, and only as its member does the individual share in truth, real existence and ethical status" (quoted in Kohn 1946, 111). This view is found in many other German writers and philosophers, and it is reflected in Bismarck's dominance over the German state. In conclusion, Bismarck wanted a health care system that increased the power of the state, engendered loyalty to the state, and promoted the health of the new working class that was the backbone of German industrialization. From these values followed his proposal for a national system of financing, a state-administered program of services, a hierarchical power structure, and an image of the citizen as a subject of the state (Abel-Smith 1976; Rimlinger 1971; Stone 1980).

Opposing Bismarck's plans were legislators who did not want to give up their role in new programs for social welfare, employers who did not want more government, and mutual aid societies which sought a major role in running the system (Peters 1959; Rosenberg 1969; Stone 1980; Horst 1959). As the term implies, these societies were groups of workers who banded together, collected dues from each

other, and organized medical services for illness or accidents that befell their members. During the eighteenth and nineteenth centuries, mutual aid or "friendly" societies sprang up in a number of countries among the guilds and later among the unions that developed with industrialization (Abel-Smith 1976). Again, values seem key to the mutual-aid approach to health care. What evolved was a system of paying for care through subscription among members and running health care programs themselves on a local basis. Power was therefore collegial and local. Implicitly, members of the societies were seen as actively responsible for their own health and the health of fellow members.

The compromise which emerged out of the legislative debates of 1883 reflected both state-welfare and mutual-aid approaches to health care. Bismarck succeeded in getting a national health insurance program, but he failed in having the state administer it. Instead, the new program would be run by "sickness funds" (*Krankenkassen*), administered jointly by employers and employees and modeled to a significant degree after the local, worker-based, mutual aid societies. However, by joining employers with employees, Bismarck "undermined any future effort of trade unions to capture social protection as an exclusive function of labor organizations" (Stone 1980, 23). Nevertheless, workers' mutual aid societies continued to function as an integral part of the national insurance program. Within it, sickness funds were financed through premiums, not unlike subscriptions in mutual aid societies, but paid by both employers and employees. (It is notable that national health insurance in Germany was based on premiums, not taxes.) Seats on the governing boards would be proportional to the percentage of premiums paid, and the unions quickly volunteered to pay two-thirds of the premiums. This majority of seats would have a profound impact in the years to come. Thus, the German system was not "socialist" in the common American sense of a state-run and state-financed system as was to emerge later in Great Britain.

The sickness-funds compromise represents Germany's unique contribution to the organization of health care, corporatism. As Deborah Stone (1980) explains, corporatism has two distinct characteristics. First, it is a set of institutions intermediate between citizens and the government, with compulsory membership for designated groups. In the case of Germany, these were primarily occupational groups. Second, these institutions are given statutory authority over relevant behavior of their members and over the administration of relevant government

programs. Corporatism is a quasi-public form of representative government over a specific program area. The role of the state is to oversee and coordinate the activities of the corporatist institutions and to assure that they act in the national interest. The state serves as rule-setter and umpire. Corporatism is also a way of bringing different parties together to run services, like a health care system. It is a form of managed conflict. When the state sees that the balance of power is becoming skewed or that the system is moving too far in one direction, it can step in and change the rules through legislation.

At first, the national health insurance program grew slowly in Germany. Membership was initially required only for manual laborers. But over the years, new legislation enlarged the circle of workers to which it applied from 11 percent of the population in 1888 to 17 percent in 1900 and 20 percent in 1910 (Stone 1980, 49). Since workers held two-thirds of the seats on the boards overseeing the sickness funds, and since employers did not show a great deal of interest in them, they became worker-managed. The "in-kind principle" (*Sachleistungsprinzip*) stipulated that the sickness funds had to take direct responsibility for delivering services and not just pay insurance claims to providers in the private market (Tennstedt 1977). Thus, thousands of local sickness funds run by workers were soon contracting with providers for services. There followed a period of experimentation in which socialist physicians worked with sickness funds to meet the health needs of the workers. They developed prototypes of health maintenance organizations, contracts with selected providers under terms similar to preferred provider organizations, programs in health education about problems facing the group of workers in specific funds, programs in prevention, and rehabilitative services (Leibfried and Tennstedt 1985). In many ways, these programs embodied the values and organization of the mutual aid societies for services that were locally run by fellow workers in order to keep workers healthy and keep costs down (Rosenberg 1985).

The Rise of the Medical Profession

As the circle of workers covered by national health insurance widened, physicians and their medical societies became increasingly concerned. Compared to the vast majority of private, fee-for-service physicians,

the services provided by the sickness funds had a number of what today would be called market advantages (Plaut 1913; Stone 1980; Leibfried and Tennstedt 1985). Care was integrated and coordinated, and clinics kept convenient hours by being open after workers came home. By using capitation or fee schedules, sickness funds kept costs down through their contracts with cooperating physicians. Some of them also employed nonphysician providers as a way of controlling costs, and the law placed no restrictions on such providers. Finally, one suspects that services provided by the sickness funds eschewed the condescension and marked class difference that existed between working men and educated gentlemen-physicians in the nineteenth and early twentieth century. These may be some of the reasons why services provided by sickness funds were popular and efficient. For example, the four physicians hired by the fund in Bremerhaven treated about one-fourth of all the patients in the lower Weser region, while 45 private physicians treated the other three-quarters, even though this particular fund gave members a free choice between using private physicians or its clinics (Leibfried and Tennstedt 1985). Put another way, the fund took away a quarter of the private physicians' market so that the growing numbers of groups covered by national health insurance became a serious economic threat to private physicians.

Private physicians and medical societies found the funds offensive. Politically, they were becoming the backbone of the revived Social Democratic Party that Bismarck had outlawed some years earlier (Rosenberg 1969, 1985). They served as the training ground for workers to learn organizational skills. They organized regional associations that lobbied for public health measures and developed programs in preventive medicine. Socialist physicians also coalesced around the funds, and a disproportionate number of them were Jews, making them a double irritant to many private physicians. These socialist physicians willingly worked for lower fees or salaries, because they believed in worker-based social medicine.

When the legislation for the sickness funds had been hammered out, physicians were hardly mentioned as a party to them (Stone 1980). Indeed, they were not even recognized under law as a profession and did not have the extensive legal privileges of a profession. The ever-growing funds frustrated the efforts of the medical societies to establish physicians as worthy of professional status (Stone 1980; Leibfried and Tennstedt 1985). The funds were free to hire nonphysician providers, and this hardly strengthened the case of physicians as a

profession with unique skills. Moreover, the capitation rates, fee schedules, or salaries (whichever a given fund used) were considered offensively low by most physicians except the few who were ideologically sympathetic. Physicians complained about being subject to administrative decisions made by semiliterate managers. Even grievances and quality review were carried out by member-dominated committees.

Resentment led to action when, in 1898, a new system of social medicine was advocated by sickness funds in the town of Barmen (Plaut 1913; Stone 1980). The socialist physician Dr. Landmann had developed a system for making medical care more efficient. It included features that are considered innovations today in the United States, such as limiting the number of referrals, prescriptions, and hospital admissions to the average rate over the previous three years, making drugs available directly through funds to their members at reduced costs, and organizing care along industrial lines with 24-hour, 7-day coverage using a rotating schedule. The funds asked the physicians to support the new plan. When they refused, they were fired and replaced by outside physicians. The doctors went on strike until the government intervened eight days later and negotiated a more favorable contract with the physicians. Here, for the first time, we see the government as umpire step in to redress an imbalance in the corporatist structure, and for the first time we see physicians entering the corporatist structure as a new party.

Other strikes followed in towns where the Landmann system was introduced, and they received wide publicity. A call was made in 1898 "for all physicians simultaneously to terminate their contracts with sickness funds and to treat all patients henceforth as private patients" (Stone 1980, 46). Soon thereafter, the Leipziger Verband (LV) was formed as a militant physicians' group. In 1903 it staged a series of successful and widely publicized strikes against various funds. By 1904 over 50 percent of all physicians in Germany had joined the LV. It organized about 200 strikes and boycotts a year against funds that were judged to impose unfair contracts or treat physicians unfairly. The LV developed strike funds, boycotted employers who tried to bring in "scab" physicians, formed a job-placement service much less expensive than commercial services, and set up a number of other funds with members' dues such as a credit union, a pension fund, and a burial fund. In 1913 the government stepped in again to mediate between the funds and the physicians and negotiated

the historic Berlin Treaty (Stone 1980). It attempted to replace strikes and boycotts with regular procedures for handling conflicts. Physicians were given equal representation on those committees which set the physician/member ratio, selected the physicians to be admitted to insurance practice, wrote the terms of physicians' contracts, and arbitrated conflicts. Membership in the LV grew to 90 percent of all physicians by 1919.

Relations became peaceful but then erupted again over fees, which were still negotiated with individual physicians. Again, the government stepped in and restructured the corporatist institutions through a series of orders in 1923, 1930, and 1931. Physicians' power was consolidated into regional associations which were given official sanction to negotiate contracts based on capitation with sickness funds. Physicians wishing to treat patients covered by national insurance were required to join. In essence, competitive contracting was eliminated, and the LV as a militant union of physicians was made into an official body with sole power for contracting with sickness funds for physicians' services. This account significantly alters the typically apolitical explanation of how the German system of sickness funds and physicians' bargaining units came to be (Glaser 1978, 97; Heidenheimer, Heclo, and Adams 1975, 16–19).

While these new arrangements were taking place, the sickness funds continued to expand and continued to develop clinics, physicians' networks, pharmaceutical dispensaries, hospital programs, and the like. They also continued to be run by members and influenced by sympathetic socialist physicians (Leibfried and Tennstedt 1985). Thus, adversarial relations, open conflicts, and court cases continued through the Weimar period (1919–1933) even though relations with physicians were now institutionalized and physicians had much more power. The central idea behind the corporatist approach to health care still remained to contain these conflicts and resolve them within an institutionalized structure.

The rise of Adolf Hitler in 1933 marked the beginning of a new phase in the changing balance of powers within the German corporatist structure for health care. The National Party had wooed physicians and other professionals during the period 1924–1930 (Kater 1983). Physicians' earnings had been falling, in part from the expansion of national insurance and socialized medicine. The Party stood for professional liberties, against all forms of socialism, and against "non-Aryans."

It is not well known that after 1933 physicians joined the Party in greater proportions and sooner than any other profession (Kater 1983). As early as April–June 1933, the Reich's Ministry of Labor issued two regulations which excluded "non-Aryans," Communists, and socialists from further activity in local sickness funds (Leibfried and Tennstedt 1979).

Physicians in local medical societies prosecuted sickness fund physicians with such reckless zeal that many of those charged as "socialist" or "Jewish" had their cases reversed by Hitler's Minister of Labor for lack of evidence (Leibfried 1982; Kirchberger 1985). By 1938 virtually all physicians sympathetic to autonomous sickness-fund delivery systems had been deported or killed. Meanwhile, parallel action was taken to weaken or eliminate unions as an independent center of power. Sickness-fund members who administered the health care programs were removed and replaced by "old fighters" who had been among the first 100,000 to join the National Socialist Party.

Besides taking over the administration of the sickness funds, the National Socialists closed the ambulatory clinics and centers that private physicians resented so much (Leibfried and Tennstedt 1985). A law passed in 1933 enabled them to be closed if they were uneconomical, with "uneconomical" being defined as taking business away from more private physicians than they replaced. For example, if one physician in an ambulatory center took away business from four other physicians, the center was deemed uneconomical. These actions belie the myth that, aside from inhuman experiments in concentration camps, the German health care system did not change during the Nazi period.

The National Socialists provided the medical societies with other benefits. National legislation was finally passed recognizing physicians as a profession under German law. The resolution was predicated to 1932 "in order to avoid the stigma of National Socialist ideas" (Kirchberger 1985, 39; Selpien 1947). Organizationally, regional associations of sickness-fund physicians were combined into the National Association of Sickness Fund Physicians of Germany. "Now the more than 600 sickness funds were faced with a bargaining partner that represented the total number of the physicians and their organized power" (Kirchberger 1985, 39). Moreover, the responsibility for ambulatory care was turned over from the sickness funds to this association, thereby depriving sickness funds of their essential role in structuring medical

services (Tennstedt 1977). They were reduced to administering members' premiums.

The National Socialists also made changes in occupational health programs. In agreement with the sickness-fund physicians, they eliminated industrial physicians paid by the government to reduce health-endangering conditions in factories and to promote programs in prevention. This left only factory physicians, whose job it was to advise (but not treat) workers with health problems. Under the Führer principle, these physicians worked for the factory manager. With the pressure of war, however, factory physicians were allowed to treat sick or injured workers, because sickness-fund physicians were becoming more scarce, and it took time away from work to travel to their offices and wait until they could see these workers. This change was explicitly identified as an exception to the legal monopoly that sickness-fund physicians had gained over ambulatory health care (Kirchberger 1985).

All of these gains for medical societies and private physicians had their price in eliminating patient-based care and democratic institutions. But soon the Faustian bargain turned on the physicians themselves. The Führer principle meant that trusted lieutenants of Hitler's government were placed in key positions to run sickness funds. A further price was the use of physicians to carry out a number of political tasks. As sociologists have long recognized, physicians are agents of social control. The National Socialists politicized and extended this role and made physicians gatekeepers of social security benefits, guardians of race laws, and experts for carrying out the laws to prevent "hereditary diseases." Physicians naturally played a central role in the policy of "breeding" and the development of "perfect human material." Such national policies, of course, required eliminating parliamentary legislation, self-government in sickness funds, left-wing elements, and "non-Aryan" health workers, replacing them with centralized decrees and administration.

The Development of the West German Health Care System

West German health care is taken by most observers to be a continuation of the corporatist system established under Bismarck and modified

during the Weimar period. Indeed, the West Germans kept the strict division between hospital and ambulatory care, the use of specialists by referral, the network of sickness funds, and other features of the prewar system. But in the context of the history just described, it would be misleading to conclude that little had changed since 1932. The medical profession, having forced major concessions from the sickness funds during the Weimar period through militant action and having outlawed its enemies with the help of the Nazis, continued its drive after World War II for control and autonomy within the corporatist structure. The Allied forces were intent on eliminating racial laws, eugenics programs designed to promote a master race, and the Führer principle. This form of de-Nazification led, in the case of the medical profession, to eliminating the National Association of Sickness Fund Physicians and even to questioning whether medical societies should continue to exist (Kirchberger 1985). On the whole, however, health care was not a significant issue for either the Allied administrations or for the regional state governments to whom much was delegated. The reticence of the Allied forces to impose any particular system on their vanquished enemy but to foster self-determination sounded evenhanded but, of course, favored those groups that had benefited from the Nazi period (Kirchberger 1985). As one of these groups, the German medical profession was not reticent to pursue its own priorities. In the postwar years, it pressed for and secured laws that locked in the gains of the Nazi period (Rosenberg 1985; Leibfried and Tennstedt 1985; Kirchberger 1985). Postwar laws included the following:

- Sickness funds could not deliver services or run clinics without the approval of the physicians' associations (which was never given);
- Physicians could not employ other physicians and thus form group practices without permission of the physicians' associations (which opposed groups);
- Measures were passed to strengthen the power of physicians' associations in prohibiting physicians from advertising, competing, or criticizing each others' work;
- Occupational and public health physicians could not treat patients (beyond immediate needs) and had to refer them to ambulatory physicians;

- The boards of sickness funds changed to half employees and half employers, and the scope of self-government decisions remained at its reduced range;
- The medical profession pressed hard to maximize their economic security by reducing the number of physicians trained and by controlling the number of practices licensed for treating sickness-fund patients (Kirchberger 1985).

These gains marked the culmination of what could be identified as a rather coherent professional approach to health care services that contrasts with the state model under Bismarck or the mutual-aid model described earlier. Again, political values seem paramount. Since at least 1900, the ambulatory wing of the medical profession, which is strictly separated from salaried physicians in hospitals, had vigorously pursued policies to increase its autonomy and increase its control over the conditions of work. Another theme running through 50 years of political action was to increase the power and wealth of the profession. Organizationally, these goals translated into wresting control of ambulatory services from competitors such as sickness funds, occupational physicians, and physicians in public health. Ambulatory physicians wanted to be the gatekeepers to the entire system, and by the 1950s they had succeeded. Because they finally attained the status of a profession under national law during the Nazi period, they gained exclusive power over their affairs.

The financial structure also changed under pressure from the profession to eliminate competition and to give physicians central power in negotiating capitation rates. Consistent with this analysis, the profession succeeded by the 1960s in replacing capitation with fees for service (Landsberger 1981). The profession also succeeded in eliminating the fixed doctor-subscriber ratio that had been used to limit costs and improve efficiency (Glaser 1978, 113). Each of these changes increased the wealth of the profession. Finally, the implicit image in the professional approach of the individual was that of a private citizen who chooses how to live and when to see a doctor. The emphasis on prevention and health promotion found in the state-welfare and mutual-aid approaches is missing.

The priorities of the profession's approach to health care do not reach as full expression in the highly structured context of a corporatist health care system as exists in the United States. Nevertheless, one

is impressed by the distance travelled from not even participating in the original legislation of 1883 to being the dominant member of the German health care system. These trends have continued. The ambulatory physicians thrived under the new fee system, and the hospital-based physicians began to expand rapidly in the 1960s (Schulenberg 1983). Fees plus increased hospital utilization escalated costs rapidly during the late 1970s. At this point, the government as referee of the corporatist system stepped in and added a system for total budget review in order to put a cap on health care expenses. The medical profession vigorously opposed the caps and then found a loophole once they were passed which allowed physicians to bypass the caps (Landsberger 1981; Schulenberg 1983). German physicians have almost complete freedom to decide what tests to order or treatments to use. They have shown themselves readily able to increase services and therefore fees. The fee schedule, moreover, favors technical procedures and pays the same even if an assistant does them. Both procedures and use of assistants have grown.

Such behavior has led observers to question whether the medical profession can restrain its self-interests and be concerned about society as a whole (Landsberger 1981; Schulenberg 1983; Glaser 1983; Freidson 1970). It would seem that even the organizational constraints and legal powers of corporatism cannot hold the medical profession in check. However, the corporatist structure provides a political arena in which employers, employees, and the government can restrain the profession if they resolve to control the profession.

The irony of professional dominance is that understandable and sincere motives and values lead to an imbalanced and self-serving health care system. Physicians believe they are best qualified, even uniquely qualified, to decide how medicine should be practiced. They alone know how to diagnose and treat. They also believe in the quality of their work, and they want no impediments to making the best possible diagnosis and providing the best possible care. If government officials or insurance funds tell them when and where to practice and how to do their work, they claim that health care will suffer.

The systemic results of this clinical position are another matter and were well-recognized long ago by pioneers of social medicine in Germany. Medicine becomes the preserve of doctors and hospitals with little connection to the workplace, the community, or the habits of everyday life. Prevention receives little attention. The press for the best care

leads to increased specialization and cost. From the patient's point of view, care becomes increasingly fragmented and uncoordinated, even as physicians are increasingly able to focus on the specialty they like. They practice where they like and treat patients who can pay, doing little about underserved areas or populations. Coordination is disrupted by the separation of hospital from ambulatory care, so that a patient's physician may have to wait several weeks before receiving a report from a hospital on a discharged patient. German rules and the insurance system turn physicians' practices into private enterprises that are almost completely protected from competition or market forces. Prices are fixed. Physicians can order just about whatever they want. Competitive bidding is prohibited. One can neither promote one's own practice nor subject another's to criticism. Access to the market is controlled so that it does not become overcrowded. Cost-effective approaches are not economically rewarding to implement.

The Creation of the East German Health Care System

Because the East German system is not well known to English readers, it will be described here in some detail. On July 9, 1945, the Soviet occupation forces established the Soviet Military Administration in Germany (SMAD). One of its fifteen departments was devoted solely to the health care system and reported directly to the Ministry of Health in the U.S.S.R. About sixty professionals worked in this department, mostly faculty from the medical faculties of the largest universities in the Soviet Union. They were thoroughly familiar with the great German figures in social medicine, dating back to Johann Peter Frank (Weiss 1957). The emphasis of these German pioneers on public health and preventive medicine through an integrated system of care had influenced Lenin when he created the Soviet health care system (Rosen 1979; Kohn 1946; Durant and Durant 1967, 1975; Riasanovsky 1967). Lenin said, "Comrades, all attention to this problem! Either socialism conquers the lice, or the lice will conquer socialism." At the Fifth All-Russian Congress of Soviets in 1918, six principles of health care policy were laid down:

1. Health care is a responsibility of the state.

2. Health care should be available to all citizens at no direct cost to the user.
3. The proletariat occupies a preferential position in the Soviet Union including its health care delivery system.
4. There should be centralized and unified administration of health care policy.
5. Public health depends upon active citizen involvement.
6. The primary substantive emphasis in Soviet health care is on prophylactic or preventive medicine (Leichter 1979, 211).

These principles echoed strongly the central ideas of socialized medicine and public health articulated by Frank, Neumann, and Virchow, and carried forward into the first part of the twentieth century by Alfred Grotjahn (who emphasized the importance of social factors in the etiology of diseases), Ludwig Teleky (who emphasized the pivotal role of social class and the need for reducing class differences), Adolf Gottstein, and others (Fischer 1932). A health care system built on them would be primarily focused not on promoting the medical profession and the finest in clinical intervention but on preventing disease and promoting health among the members of a society. This is not necessarily a Communist goal and is most familiar to us in Great Britain's National Health Service.

The Soviets and their East German comrades—Communists from the Weimar period—considered health care as an important area of reform and as a chance to put into practice ideas about an integrated system organized around prevention that had been discussed in German socialist circles for so many decades. By September the Zentralverwaltung für Gesundheitswesen (ZVG) (Central Health Administration) was organized, the first single authority in German history responsible for the entire health system. Its first president, Paul Konitzer (1946), outlined its responsibilities:

- Redressing the maldistribution of professionals;
- Planning and controlling the production and distribution of medications and pharmaceuticals;
- Regulating (in part) health education and social hygiene;
- Overseeing (in part) industrial health care;
- Orchestrating the treatment of venereal diseases and tuberculosis;
- Supervising the collection of statistics on diseases.

The SMAD and the ZVG also had to deal with, as had Lenin, extremely serious health problems. From 1943 onward, the production, storage, and distribution of food had deteriorated rapidly, and there was widespread malnutrition. Various local checkups found that nearly a third of the people had lost more than 20 percent of their body weight. Incidence of disease rose. Fatigue and malnutrition increased industrial accidents and doubled fatal injuries (Liebe 1947; Kirchberger 1985). While reports like these made to the British were discredited as exaggerated (Dorendorf 1953), they were taken seriously by the Soviets (Kirchberger 1985). The Soviet zone also faced significant threats of epidemics, caused in part by the hundreds of thousands of refugees passing through from Poland and points east. Large, temporary, and crowded camps had been quickly established for these populations. There were outbreaks of typhoid, spotted fever, malaria, and tuberculosis. The ZVG organized a systematic registration of cases and established a Central Office for Hygiene for each 20,000 to 30,000 inhabitants, staffed by a physician and a team of disinfectors. Large quantities of typhoid vaccine were produced. Although many hospitals had been destroyed, rough barracks were constructed to care for the seriously ill (Renthe 1948).

The character and spirit of these early efforts reflect the approach of the new health care system in the GDR: centralized, coordinated, focused, preventive. For example, to fight the proliferation of venereal disease after the war, the Soviets established "ambulatories" (ambulatory health care centers) for every 50,000 to 70,000 persons, provided the necessary equipment, had specialists train a certain number of general practitioners, and routed all cases to these centers and trained providers. For physicians, this was the beginning of the end of their exclusive control over ambulatory care. Moreover, VD cases were unpleasant, and some of the physicians conscripted to do it changed their hours, found substitutes, or made treatment unpleasant for the patient (Jahn 1949).

In the western zones, there was also great concern about VD. Proposals from the British for a system like the Soviet's, however, met with vigorous opposition from the physicians. Physicians also opposed having public health physicians treat VD cases, even though they themselves did not want to treat them. To do so, they claimed, would open the door to public health physicians treating patients and thus socialized medicine. Remuneration for services raised further

complications. Out of which pocket were to come the expenses for the large number of patients who could not pay? Training general physicians by venereologists retained by public health agencies was opposed by private specialists protecting their territory. In the end, little action was taken in the Allied zones (Kirchberger 1985).

Structural Changes

The broader structural changes in the GDR began symbolically with dissolving the German Physicians' Association (Reichsärztekammer) and prohibiting professional associations. The division between ambulatory and hospital care was removed by establishing a network of ambulatories and polyclinics affiliated to hospitals. This long-awaited change removed the central source of fragmentation in the old German health care system, whereby patients admitted to a hospital would be "lost" to their personal physician, who then would receive little information about their hospital stay. Besides integrating ambulatory with hospital care, the ZVG emphasized prevention and social hygiene as responsibilities of the clinics (Winter 1948). All care was organized at three levels—*Bezirke*, *Kreise*, and *Gemeinden*—which correspond roughly to states, counties, and municipalities. Primary care was organized at the *Kreis* level, with small ambulatories and larger polyclinics as well as community hospitals. Less common and more complex disorders were handled at the *Bezirk* level. In time, polyclinics were to have at least five specialties plus dentistry represented, while ambulatories were to have two specialties (internal medicine and pediatrics) plus a dental clinic (Winter 1948; Ludz and Kuppe 1975; Ridder 1985; Kirchberger 1985).

Besides this regional organization of health care that resembles Kerr White's famous model for a health care system (1973), the East Germans established ambulatories and polyclinics in factories and offices. About half of the polyclinics and less than 10 percent of the ambulatories are today administered by hospitals. In addition, small hospitals in rural areas have *Ambulanzen*, or outpatient clinics, which are run by the hospital physicians. To these state-designed facilities must be added the state-run medical and dental practices taken over in the 1950s after control was turned over to the East Germans. In the larger scheme, these practices are seen as transitional to a system in which all care is given through ambulatories and polyclinics, but they still provide about one-sixth of all care (Ridder 1985).

The history of private practitioners in this reconstruction of the health care system is one of pain and dislocation. The SMAD depended heavily at first on their staying to practice, but thousands of physicians fled to the West, and efforts to attract them into the new system (such as sharing half the revenues of the polyclinics [Winter 1948]) did not work well. After the Germans took control of the government and a more centralized atmosphere set in, most practices were taken over by the state. It is said that 6 percent of all physicians in the GDR still had private practices in 1975 and that they performed 35 percent of the outpatient services (Bourmer 1974).

Behind the emphasis on multispecialty centers as the backbone of the new health care system was (and is) a model of general practice. As Kurt Winter (1948), a key architect of the new East German system, observed, the devoted family doctor who worked without time constraints and became a true counselor to the family is an idyllic model which has passed with the scientific era of medicine. Medicine now consists of much more knowledge using much more technical equipment, Winter observed, which requires specialization. The polyclinic integrates specialists and their equipment so that the benefits of modern medicine are democratically available to the entire population. Winter (1948, 2) added that at the center of good medicine is prevention, which requires "the registration and social-medical care of the entire population from the cradle to the grave."

To these goals of integration and prevention must be added three others. One was eliminating class-specific morbidity and mortality differences in the overall class struggle for a Communist society. (It is interesting that the East Germans believe that the Hippocratic oath means that only a good socialist can be a good physician.) Therefore, medical students received intensive ideological training so that they could understand the purposes to which their technical skills were to be put (Ridder 1985; Bergmann-Krauss 1985). Another goal was to maximize the productivity of a workers' society (Peterhoff 1977; Beyme 1977). Physicians were to get workers back on the job. They could write a permission for sick leave of up to ten days, after which the patient was examined by a consulting physician, and then by a medical commission after another ten days (according to military order 234 published in *Deutsches Gesundheitswesen* 1947, 686–87). Finally, there was the overriding goal of political control. Confidentiality between doctor and patient was eliminated. The health care system became

state property. This follows from the central belief that health is a collectivist rather than an individual phenomenon. The East German system is therefore much more intrusive, especially when it comes to prevention, and consequently it has been more successful than West Germany in its preventive programs (Henning 1985).

The price of integration and prevention in the case of the GDR was bureaucracy. The tension, the internal contradiction of a centrally directed system that rests ultimately on the actions of people in local situations, is captured in Lenin's term "democratic centralism." Quantifiable goals, measures of service, and health indicators are issued from the center to the periphery, including regulations about how much discretion in making decisions is allowed at the Bezirk and Kreis levels. Studies have found a strong emphasis on bureaucratic relations and rules rather than a focus on the patients (Wiesenhutter 1976). Greatest pressure seems to be on the Kreis physician, caught like the foreman in a factory between directives from above and the daily frustrations of health workers in the clinics (Wiesenhutter 1976). One should note that bureaucratic pressures and authoritarian relations between doctors and nurses in West German hospitals are not unknown (Freyberger, Proschek, and Haan 1972). Nevertheless, other features set East Germany apart. For example, physicians tend to be transferred every few years so that they do not "warm up" to a place or form personal attachments with patients. Physicians should not get too friendly with local administrators. Otherwise, it will interfere with carrying out directives (Ridder 1985).

One success of the centralized East German approach to health care has been to consolidate hospital care into larger hospitals that can be better equipped, so that by the mid-1970s the average number of beds per hospital was 315 compared to 195 for West German hospitals (Ludz and Kuppe 1975). After the war, the number of hospitals and beds was increased to replace the many that had been destroyed and to provide hospitals in underserved areas. Since 1965, however, the central administration has been able to reduce the number of beds by over 1,500 per year. The ability of the East Germans first to increase and then decrease the number of beds clearly distinguishes them from the West Germans. To reduce hospitalization, the East Germans have not been above using incentives to reward physicians and nurses by making their salaries inversely proportional to the length of patients' stay (Walther, Neukirch, and Schiddel 1974; Tornar 1974).

One consequence of the East German system is a different division of labor from that in West Germany. While the number of personnel in each system per thousand population is about the same, there are proportionately fewer physicians, dentists, and pharmacists, and proportionately more nurses and medical assistants of various kinds in East Germany than in the West (Bergmann-Krauss 1985). East Germany also uses proportionately fewer specialists and more general practitioners among physicians than does the West. Finally, as is true of the work force in general, East Germany has a higher percentage of physicians of every category in health who are women than does West Germany. Even among physicians, women made up 36 percent of the total by 1975, compared to 20 percent in West Germany (Bergmann-Krauss 1985).

Training for the large number of middle-level personnel in East Germany is more centralized and more uniform than the many small schools scattered throughout West Germany. A national institute plans and distributes the curriculum. Likewise, continuing education is more uniform and systematic (Bergmann-Krauss 1985).

East German health workers have a broader range of responsibilities in keeping with the broader concept of illness and health care that contrasts with the somatic emphasis in West Germany. Every health worker in East Germany is also a health educator, and this means conveying the right political attitudes as an integral part of health behavior.

Infant, Mother, and Child Care

A notable part of the East German system concerns pregnant women, babies, and their mothers. Once again ideology and reality intermingled from the start. Both the Soviet Constitution and the Constitution of East Germany emphasize the complete legal, economic, and political equality of women. The promotion of women from their "oppressed" state in pre-Communist societies is an explicit ideological goal. At the same time, the realities of East Germany in the late 1940s almost dictated that every able-bodied woman of working age be mobilized, because two large sets of male cohorts had been thinned out by World Wars I and II. In addition, mass migration to the West had depleted East Germany of several million more people, many in their prime working years. East Germany needed, therefore, to be sure that biology did not obstruct ideology or need. The government needed to encourage

childbirth, encourage mothers to work, and ensure the health of babies who would become the next generation of workers (Henning 1985).

The provisions for attaining these goals form a multifaceted and integrated whole that was laid down in 1950 and expanded in the early 1960s and again in the mid-1970s. Under current provisions, a pregnant woman cannot be dismissed from the beginning of her third month to one year after delivery. She is guaranteed the same or an equivalent job when she returns. From the third month, she may not be subjected to any health risks, including night-shifts and overtime. If this means moving her to less strenuous work, then her pay may not be decreased.

Pregnancy leave begins six weeks before expected delivery and can continue up to a year after delivery, though the usual time is 20 weeks after delivery. Women receive their average income during this time. Nursing care may be provided for up to 6 months. Nursing mothers who return to work get 90 minutes of paid breaks a day. After delivery, mothers still at home on leave receive "mother's support" as income.

Financial incentives are used to encourage couples to have babies and to encourage their health. After the first child, a mother receives a one-time payment of 1,000 marks. Young couples in their first marriage can obtain up to the age of 26 an interest-free loan of 5,000 marks to buy household goods. They have 8 years to pay back the loan. One thousand of these marks is cancelled when a first child is born, 1,500 marks for a second child, and 2,500 marks for a third. In addition, mothers receive an allowance of 20 marks per month each for the first and second child, 50 for the third, 60 for the fourth, and 70 for every child thereafter. Of great importance is the 1,000 mark "birth aid" given to the mother in the following manner: 100 for the first visit to a maternity center if done within the first four months of pregnancy; 50 for the second; the balance except for 100 marks at birth; and the final 100 marks in four installments for each of the first four monthly checkups at the maternity center after birth. Because of this program the percentage of women who visited a maternity center in the first four months of pregnancy rose from 17 percent in 1958 to 84 percent in 1974. This program is credited with the steep drop in infant mortality and maternal mortality. Infant mortality, for example, decreased from 72.2 per thousand in 1950 to 12.1 in 1980, while West Germany's dropped from 55.6 to 12.6

(*Demographic Yearbook* 1958; 1984). Maternal mortality in East Germany was 14.7 in 1980 and 20.0 for the West (Henning 1985).

Framing these provisions is a national network of health institutions. There are maternity centers that provide comprehensive obstetrical, gynecological, and infant care from the first months of pregnancy through the third year of life. Directed by physicians, the centers use social workers and nurses to help and to educate the mother and child. Earlier vaccination campaigns have been replaced by a vaccination calendar enforced by law, encouraged by incentives, and executed by the centers. Many of these maternity centers are near or at places of work as are child-care centers and kindergartens which provide professionally supervised care for infants and children of working mothers. These child-care centers and kindergartens are tied directly to the health care system. Essentially, the East Germans concluded long ago that prevention in the first few years of life is among the best investments a health care system can make. Mandatory checkups continue through the schools in grades 3, 6, 8, and 10 (Henning 1985).

The provisions for maternal, infant, and child care in West Germany differ little today from those in East Germany, except that in West Germany they are a set of options and facilities to be used by choice rather than by requirement. The similarities have several roots, one being the competition between the two systems over the years as they coexisted side by side, with thousands of visitors going back and forth with reports on what each system offered. In addition, both Germanies have the same roots in the social hygiene movement of the 1920s, which was the source of major ideas taken up by Lenin and then by the East German government. One might say that East Germany has implemented the preventive measures of maternal and infant care more thoroughly. It is interesting to note that, while conditions after the war were better and infant mortality considerably lower in West Germany than in the East, today infant mortality is somewhat lower in the East than in the West. Although statistics in the two countries are not gathered in quite the same way, the gap has become even greater for maternal mortality (Henning 1985). The fact that clinics in West Germany have more sophisticated, modern equipment is apparently secondary to the significance of a comprehensive, centrally coordinated program in the East. At some point, however, further gains will probably require very sophisticated interventions for low birth-weight babies and other medically complex cases.

Occupational Health

Finally, the changes made by the East Germans in occupational health deserve review. While in West Germany a bloc of professional and business groups which had not been persecuted under the National Socialists lobbied intensely to minimize reforms in occupational health and other programs of social welfare, the Soviet powers repressed professional and business interests and forged a single cadre party that was centrally interested in workers and their health (Tennstedt 1977; Schmidt 1977; Rodenstein 1978). Communist ideology and the values of German social medicine joined with necessity as the Soviet Zone faced a work force twice depleted by war and a large stream of young workers leaving for the West. Over the next 15 years, until the country was walled in, this mass exodus would reduce the East German manpower pool by 2.6 million.

Under these circumstances, the Soviets and later the East German government set about establishing a national network of clinics in factories and offices as well as a system for carrying out preventive industrial medicine. Progress was made slowly over twenty years, with spurts and lags that reflected the fundamental issue of how health policy should be integrated with economic policy. Marxists presume that these two are in conflict under capitalism: exploitation and profit clash with worker fulfillment and social responsibility. Under Communism, they should complement each other. In the first few years, a program of industrial medicine was delegated to the states and counties. Some progress came quickly. For example, in 1947 there were 4 polyclinics in factories and 681 plant medical centers. Three years later, there were 36 polyclinics, 109 ambulatories, and 2,369 medical centers at industrial and commercial sites (*Statistisches Jahrbuch der Deutschen Demokratischen Republik* 1955). Company physicians became employees of state and county governments and were charged with assessing as independent professionals the working conditions of the people. Their independent status was enhanced by their powers to make changes, stop dangerous practices, and the like. The responsibilities of the industrial medical centers and clinics included implementing preventive measures, organizing accident prevention programs, dispensing first-aid, providing ambulatory treatment for the sick and injured, granting sick leaves, and analyzing patterns of accidents or illness among the personnel. These on-site programs were seen as

using limited health personnel more effectively and more efficiently than community physicians and clinics (Kirchberger 1985).

As this socialist industrial health program (Betriebsgesundheitswesen or BGW) unfolded, however, it clashed with the goals of economic recovery and growth. Many plant physicians used their newly won independence "to intervene against economically desirable investments in the name of prevention" (Kondratowitz 1985). With the increased centralization and emphasis on economic recovery during the 1950s under the new East German government, reorganization took place. Increasing emphasis was placed, not on trouble-shooting and being a watchdog, but on systematic information-gathering and monitoring of workers doing hazardous jobs (Holstein 1953; Amon 1953). Additional pressure came from the widespread dissatisfaction with working and living conditions. The BGW was made a mandatory part of the factory collective labor contracts after 1953. By 1956, systematic examinations were put in place as a means of organizing an epidemiological preventive program (Winter 1957). The pressure to increase productivity with a labor force that was not going to expand was ever present (Marcusson 1954, 1956; Erler 1954; Eitner 1959). Into the 1960s, work progressed so that stressful job conditions could be catalogued and assessed in relation to the health capacities of workers (Eitner 1964). By 1970, long and detailed research had produced systems for matching health stages, job phases, and employee worker capabilities (Eitner 1972). These kinds of advances could take place without threatening the production goals of industries and thus avoid conflicts between health policy and economic policy.

Another tension running through these developments that was not unique to them concerned the degree of central versus decentralized control. As with the rest of East Germany, centralization intensified during the Stalin years, and the demand for decentralization surfaced thereafter. It was argued that a good match between health programs and factory needs could only be carried out at the local level (Kondratowitz 1985).

In conclusion, the Soviets and the East Germans created a health care system that embodied basic goals of recognizing the social and collective nature of health problems. It might be characterized as a state model of health care, because it regarded health as a matter of state responsibility and as a national resource. The East Germans wanted to create a system that also would impress citizens and the

world with the accomplishments of their government. They wanted a system that was run by the state, provided comprehensive services oriented toward prevention, and that integrated all health-related institutions such as clinics, hospitals, schools, nurseries, and places of work. The resulting system was financed out of general taxes and centrally organized. It costs half the percentage of the gross national product that the West German system costs, and it has produced comparable health statistics.

The East German system began with considerably higher incidences of infectious diseases, and higher rates of mortality, a mass exodus of physicians, and an economic base weakened by the Russian dismantling of major factories as well as by war. By the 1970s, its reported statistics for infectious diseases and various mortalities were somewhat lower than those reported by West Germany. In recent years, the West Germans have made proportionately more progress, so that statistics today are nearly equal. Infant mortality, perhaps the best single index for the quality of life and health care in a nation, was about 12 percent for both countries in 1980. Life expectancy in both countries was nearly the same: 68.9 for males and 74.8 for females in East Germany, and 69.9 for males and 76.6 for females in West Germany in 1981 (*Demographic Yearbook* 1984). One must recognize, however, that such statistics are not exactly comparable because the data underlying them are assembled differently, and sometimes their calculations differ. For example, in West Germany stillborn infants and premature infants are included in the infant mortality rate, while in East Germany they are considered miscarriages and not included (Henning 1985). These and other statistics place both Germanies in the mid-range of western European countries and give no indication that their health care systems have taken such different forms.

Reflections

This study has been a unique opportunity to observe how two distinct health care systems evolved through time from a common background which "controlled for" cultural, organizational, economic, and political differences. In West Germany we learned that the old system did not stand still but rather continued to evolve as it had through most of the century toward increased professional control. Ironically, the West

German emphasis on individual free choice, combined with the dominance of the medical profession, led to abandoning the original impetus in 1883 to develop a health care system that attended to the health needs of the new industrial state. That spirit was carried out to some degree in the democratic localism of mutual aid societies and the subsequent local sickness funds but died as the medical profession pushed the system toward centralized bargaining. In East Germany, however, something quite different occurred. Its political regime restructured health care to embrace the much older German idea of the state taking responsibility for the health of its people. In essence, the old system has come to emphasize values that depart from its foundations, while the new system in East Germany represents a radical reaffirmation of paternalistic socialism.

The irony of this complex social history holds lessons for the theory of comparative politics and for the comparative study of health care systems. Concerning the former, the story of this most perfect of "natural experiments" suggests that the language of science—of "most similar" vs. "most different" comparative approaches, and of quasi experiments—is not too applicable to whole societies. One could come to this conclusion simply through an internal examination of the contradictions and limitations of the literature itself; but the German experience shows that more insight is obtained by appreciating the multiple values and political tendencies that struggled for articulation from the start than by considering the Communist takeover as experimental intervention in a "most similar" design. Consider how differently this essay might have read had it begun in 1945 rather than in the last quarter of the nineteenth century. The language of social history, of social and political culture, seems more insightful than the science of comparative politics.

This study also suggests that political values play a more central role in how systems behave than is presently appreciated. In Stone's "most similar" analysis (1980) of West Germany, undertaken in order to draw lessons for the United States, it is political values and the will behind them that ultimately explain the limits of power wielded by the medical profession. The West German government put its foot down in 1977 because at some point enough policy makers decided that cost escalations had gone "too far" and were "financially unsound." Public opinion shifted to believing doctors were earning "too much" and were "too greedy" when they went on strike against new gov-

ernmental restrictions. In Marmor's (1983) essays on the "most similar comparison" of Canada with the United States, he leaves unexplained why the Canadian system diverged from the American one and implemented a national health insurance program.

Returning to the German experience, the West German system emphasizes high-tech cures; protects the individual autonomy of ambulatory physicians as gatekeepers to the system; defends the free choice of patients; preserves the fragmenting turfs of specialists, hospital physicians, and general practitioners; and minimizes preventive and occupational medicine. The resulting system is expensive but popular. In effect, the West German system shifted its legitimacy from one based on the health needs of society to one based on the miracles of medical science and the supremacy of the physician as a figure of authority, expertise, and prestige—central values of the medical profession. In East Germany, however, the return to the legitimacy of meeting the health needs of a society led to integrating ambulatory with hospital care, outlawing an autonomous profession, installing extensive programs in prevention, emphasizing a centralized state system, and linking health with housing, the work place, and the schools as Johann Peter Frank first proposed so long ago.

At the same time that the two German systems made fundamentally different choices, there are some notable similarities in the ways they have evolved. Both have snuffed out mutual-aid, local delivery systems that were so influential in the early decades. In one case, the medical profession organized against this system and fought militantly for provisions that would force sickness funds to negotiate with large, powerful medical associations. In the other case, the Communist state (in the name of "workers' democracy") instituted a top-down national bureaucracy to run medical services. It seems as though neither state nor profession wants local, autonomous institutions.

One should pause to note two organizational changes that played a key role in reducing the function of localized programs to provide inexpensive care for workers. First was the fateful change of rules so that sickness funds could no longer provide services directly. Because insurers could no longer be providers, a gap was forged between citizens as premium payers and as patients. The second change was the elimination of direct negotiations by funds with doctors and their replacement of collective contracts with physicians' associations which in turn paid their members for services rendered. Both of these changes

were devastating blows to the concept of workers being in charge of their own health care, and both severely reduced competition.

Another similarity between the two systems is their increased neglect of patients as individuals. The West Germans have developed a system that prides itself in being curative and individualistic. The East Germans have developed a system that is preventive and collective. But some observers (Kirchberger 1985; Ridder 1985) wonder if both systems, despite their contrasting values, are not creating a mass society where patients are treated like numbers. The individualism of the West seems to apply less to patients than to physicians, who have altered the rules to maximize their autonomy and minimize competition. Nevertheless, Germans in both countries perceive the West German system as more individualistic and as offering more options.

The systemic similarities arise from the organizational tendencies of large national systems. The power groups running them want to be in charge and dislike countervailing centers of power. Like all organizations, they become preoccupied with their own organizational goals so that clients, consumers, or patients become pawns through which to pursue larger ends. There are, in such systems, constant efforts to correct for these tendencies, to decentralize, and to refocus on the individual. These efforts are spurred by a final similarity which the two systems share—the force of system competition. Each wants to match the achievements of the other while claiming its ideological superiority. This has led, for example, to West Germany building up its mother and child care program to match the East German one as much as it can within the confines of a system emphasizing free choice and physician autonomy. On the East German side, it has led to conceding the right of citizens to choose their personal physician, within the confines of a centralized system in which physicians are assigned and transferred. Each system plays off the other as it tries to reconcile its weaknesses with the other's strengths, both being part of a larger ideological heritage.

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