Divide and Deal

Shapiro, Ian, Swenson, Peter, Donno Panayides, Daniela

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Chapter 9

Good Distribution, Bad Delivery, and Ugly Politics

The Traumatic Beginnings of Germany's Health Care System

Peter A. Swenson

"Will America copy Germany's mistakes?" asked Gustav Hartz, a noted German critic of his country's national health insurance system in a 1935 issue of the *New York State Medical Journal* (Hartz 1935). The answer was made public soon. By the time of publication, President Franklin Roosevelt had already decided against including health insurance in the Social Security Act. Medical leaders whom he summoned to advise him on the matter had vehemently advised against it; bad news from Germany was one reason. FDR's top medical adviser, the internationally renowned Yale neurosurgeon Harvey Cushing, had written to eminent German doctors for their views. They confirmed his suspicions. Surgeon and friend Friedrich Müller gave a mixed but overall discouraging picture and recommended that Cushing consult a highly popular book by the Leipzig surgeon Erwin Liek, the system's harshest critic and sometimes called the father of Nazi medicine (Müller to Cushing, 20 December 1934).

After reading Liek's *The Doctor and His Mission* (1926), Cushing wrote to the right-wing surgeon with high praise for his book, declaring in words that Liek himself could have penned that under national health insurance "the doctor will slowly and progressively deteriorate and . . . our beloved profession will come to be manned by an inferior type of people." Patients would suffer. To Cushing's relief, FDR quickly backpedaled on health insurance, and hence the surgeon expressed his wish to the president of the American Medical Association (AMA) that doctors

across America reward FDR with their votes in the 1936 presidential election (Cushing to Liek, 26 January 1935; Cushing to Bierring, 15 August 1936).

Calling it Bolshevik and worse—*German*, for example—organized medicine in America rudely rejected compulsory health insurance and therefore the offer of a massive new flow of fees. If European experience was any indication, some relief from the economic distress of the Depression was what they could have expected. British doctors did well after Lloyd George's legislation of 1911, and this contributed to the British Medical Association's sanguine views. In Germany, even though doctors' criticism was strident and their rhetoric raw, they had recently defended their income with more success than the vast majority of their fellow citizens. Nevertheless, the AMA dug in its heels, although American doctors' income had plummeted along with that of most other fellow citizens. Better than health insurance, Cushing's friend and AMA president Walter Bierring wrote in 1934, would be to reduce the number of graduating medical students by half. Do not increase demand; reduce supply, he counseled (Bierring 1934).

Raising demand through compulsory health insurance, many doctors thought, would jeopardize the quality of medical care in America. That message had already been coming through from the enemy land ever since America had girded for war with Germany in 1917. Speaking from personal experience abroad, prominent Chicago surgeon Edward Ochsner repeatedly confirmed American doctors' fears; his conclusions about Germany resonated with what they saw or heard about scattered capitalist-, labor-, and government-sponsored third-party payment arrangements in America. FDR adviser Cushing was one of Ochsner's appreciative readers (Ochsner 1920, 1934; Cushing to Ochsner, 30 November 1934). Then there was Metropolitan Life's formidable insurance expert Frederick Hoffman, who possibly did more than anyone to spread the bad word about Germany (Hoffman 1919; Numbers 1978, 78). In sum, these observers claimed, if the United States followed Germany, the intimate doctor-patient relationship, essential to good diagnosis and improvement, would be destroyed by compulsion and regimentation. The moral fiber of doctor and patient alike would fray. Partisan and patronage politics would hijack the medical system and poison it with rank incompetence. Government-provided health care would waste vast resources. Medical progress would slow. The health of Americans would, if anything, decline.

Health would be better served, the American reactionaries thought,

with public health measures and, above all, revived economic growth. They hastened to report morbidity and mortality statistics that showed Americans, with their higher standard of living, to be more robust than Germans and Britons. More money going into doctors' pockets would not buy better health. Part of the sentiment behind this view stemmed from elite doctors' assessment of the low quality of medicine practiced by many physicians across the country. As Cushing thought, and told FDR, insurance practices would attract and reward even worse (Cushing to Roosevelt, 1 February 1935).

Meanwhile, reports from German doctors indicated, the insurance system demoralized the profession and brought wholesale degradation of clinical practice. A system not of their own making—indeed a system thrust on them by German politicians in alliance with both capitalist and labor interests—was forcing doctors to deliver a high and rising volume of what they knew were often worthless services and medications to defend their income from economizing measures and competition from a surplus of doctors admitted into insurance practice. Despite insurance coverage, German citizens were turning increasingly to alternative medical practitioners, and paying out of pocket, dismayed as they were by the assembly-line treatment they received from regular practitioners working on a fee-for-service basis.

Leading American proponents of national health insurance could only feebly respond to doctors' warning signs about the quality of health care in Germany. For on the question of medical quality, the American medical establishment enjoyed close to a monopoly of certified expertise about what was good and bad medicine, especially now, after rapid turn-of-the-century advances in medical science and therapeutic practice had rescued the status of "regular" medicine from its nineteenth-century doldrums. To be sure, there was also a widely discussed crisis in American medicine, but unlike Germany's, it largely concerned providers' costs, not their quality and respect (Falk, Rorem, and Ring 1933).

Skirting the issue of what health insurance would do to the quality of medicine, liberal public health experts, economists, and other reformers directed attention to the economic devastation to individuals from the period's high and rising health costs, especially for chronic and acute ailments, and income loss from illness-related disability. Social insurance revenue, they hoped, was needed to redistribute resources from the healthy and gainfully employed to the sick; wealthier and therefore usually healthier citizens would subsidize the poor and infirm. But organized

medicine met these distributional arguments head on with cold denial, claiming (with rather feeble evidence) that low-income Americans got all the care that was medically necessary. Private practitioners who charged according to sliding fee scales, backed up by free public and charitable dispensaries, did the job that needed doing.

That was the state of things in Germany and the United States during a decisive formative passage in both their systems: venomous conflict in Germany about the perverse impact of compulsory health insurance on the medical system and an impasse in the United States caused by doctors fearing what they had heard about Germany. From the 1930s onward, organized medicine helped push America forth on a different track that would be hard to change: toward a mostly voluntary, private, employment-based, often collectively bargained group insurance system. Because of this, we can reasonably speculate that the flow of bad news from Germany in the 1920s and 1930s helps answer the frequently asked question, "Why is there no guaranteed health insurance in the United States?"

Capital, Labor, and Medicine in the Shaping of the German System

Historical knowledge about Germany's health care system also illuminates a larger question of the way conflicts over the distribution of the costs and benefits of health care play themselves out with complex and shifting relations among three major social forces: capital, labor, and medicine. Though locked in separate battles of their own, capital and labor could still join forces in politically brokered alliances against medicine. As one American medical critic of health insurance warned in 1920, "the Doctor" —if not vigilant—could become "a mere tool of Capital, Labor and the Politicians, to be used and cast aside as fits their fancy" (quoted in Rosen 1983, 112–13).

This critic may well have known something about Germany. From the beginning, Germany's system for organizing the public funding and delivery of health care gave capital and labor direct control over its operation. Likewise, they enjoyed direct influence over the system's evolution. German health care was, therefore, "corporatist" in the extreme. Over time it became even more so. Corporatism refers primarily to the official delegation of public policy making and administrative authority to organized

private interests. In European corporatist arrangements, the quasi-public officialdom of labor, employer, agricultural, and other interest associations often spend enormous state resources, all the while acting, as intended, with considerable autonomy from constitutionally and juridically regulated electoral, parliamentary, and bureaucratic processes.[1] Additionally, corporatism refers to quasi-governmental macroeconomic policymaking through collective bargaining of income distribution within and between classes—for example, in highly centralized and inclusive systems of collective bargaining between organized employers and the wage and salaried classes.

The German health care system was, and remains, highly corporatist in both senses: health policy making and administration by organized private interests and relatively encompassing collective bargaining over income determination by those same interests. For example, German labor unions and employers jointly manage the statutory health insurance funds that remunerate their members' providers for medical, dental, surgical, and hospital services. Capital and labor, through the funds, enjoy legally guaranteed representation on public bodies that make critical decisions about what medical, dental, and surgical services qualify for insurance reimbursement to providers. The corporatist system even metes out financial penalties to doctors who engage in what are regarded as excessive drug prescribing.

Also, through the health insurance funds they control, labor and capital must collectively bargain with organized providers over the terms of physicians' and hospitals' remuneration. Independent office-based physicians who wish to engage in insurance practice are required to join regional associations (*kassenärztliche Vereinigungen*) that perform legally prescribed roles, among them collective bargaining with the funds. Doctors cannot strike, and insurance funds cannot collectively lock out doctors. Instead, when intractable disputes occur, the state steps in to resolve them with compulsory arbitration.

These compulsory medical associations collectively bargain a fixed budget to reimburse all ambulatory services over a set period of time. Then the aggregate prospective payment is *transferred over to the regional medical association*. The association, in turn, undertakes the massive administrative task of processing and paying doctors' bills, on a fee-for-service basis, out of this budget for services rendered during the period (for details, see Stone 1980; Behagel 1994). In principle, by giving doctors' unions

the job of bill payment out of a limited budget, the law shifts an incentive onto doctors to establish what are unnecessary and uneconomical medical services and then to advocate ways of reducing them.

As we will see, organized medicine in Germany pushed for this unique and remarkable system—compulsory organization and bargaining, collective prospective reimbursement, administrative responsibility for individual fee disbursement, and assumption of economic risks that would create an incentive to control cost-ineffective doctoring—at a crucial turning point in German politics. They got what they wanted, in December 1931, in an unusual agreement with organized labor, brokered at the highest level of German parliamentary and bureaucratic politics. The agreement deeply antagonized big industry and agriculture, powerful social forces already at war with the last Weimar government, which enjoyed substantial parliamentary support. Indeed it gave these conservative forces one more reason to search for an authoritarian alternative and thereby pave the road to the Nazi dictatorship.

Through its telling, the evolution of the German health care system from 1883 into the 1930s illuminates how good health care distribution could generate bad (but expensive) delivery and give rise to some very ugly medical politics. The repercussions were great in Germany, of course, but also not insignificant across the Atlantic. Reformers in the United States, none of them highly respected clinicians and medical researchers, could not credibly extol the German system's results, while its manifest failures only stiffened the American reactionaries' resolve.

The Origins of "Bismarckian" Health Insurance

The core corporatist features of Germany's current health care system —introduced in 1931, drastically revised by the Nazi government, but in large part reinstated across all of West Germany by 1955—emerged within the framework of the health insurance law passed in 1883. Otto von Bismarck, the founder and first chancellor of the Wilhelmine Empire in 1871, normally gets credit for the law. The *Gesetz betreffend die Krankenversicherung der Arbeiter* was the world's first compulsory system of national health insurance, restricted however to industrial wage earners until middling-income groups were brought in against strong medical opposition during the 1920s. Bismarck, it is usually said, intended to construct a social insurance system to forge a bond of loyalty between the worker

and the authoritarian state, and thus intended to take the wind out of the rising socialist labor movement's sails.

Germany's leading capitalists did not oppose the legislation, and in fact their early support validates recent historiography that questions the primacy of Bismarck's antisocialist motives (Hennock 1998, 68–69; Kähler 1994, 455). Close to industrialists—an industrialist himself (lumber and paper)—Bismarck may have mouthed the argument mostly to persuade Emperor Wilhelm I, who was rattled by assassination attempts by socialists, of the need for social insurance. In fact, in 1883, industrialist Henry Axel Bueck did not believe that social insurance would do much to change the political mood of the working class. Twenty years later, Bueck, now the leader of Germany's most powerful capitalist organization, saw his prediction fully confirmed. Workers were as militant as ever. But that did not mean that Bueck thought the law to have been a mistake. On the contrary, he wrote that "with worker insurance the German Reich has with incomparable boldness and most tenacious endurance accomplished a work of civilization [*Kulturarbeit*] of the highest order, which will for all time . . . bring it renown" (Bueck 1905, 791).

Clearly German industrial capitalists had other reasons for support. Recent research on Germany's early social insurance concludes that because of their various managerial interests the leadership of German heavy industry supported early development of the modern welfare state in its first few decades, even though all its details did not come out to their satisfaction (Breger 1982, 1994; Kleeberg 2003, 108–11; Mares 2003). In the case of industrial accident insurance, industrialists were even out ahead of Bismarck. As one industrialist said, "Who was it after all that introduced the whole accident insurance idea? It was we, and without us the whole legislation would not have gotten underway!" (Breger 1994, 46).

Doctors could not have missed the fact that the design of health insurance was in part created for capitalists, if not directly by them. One aspect favorable to capitalists even disappointed Bismarck—because it conflicted with his simultaneous state-building objectives—moving him to scorn it as a "changeling" (*untergeschobenes Kind*) (Rothfels 1927, 55; Tennstedt 1977b, 23). For this and other reasons, the law's real father was the formidable civil servant and devout Lutheran social reformer Theodor Lohmann. Lohmann decidedly favored building big industrial employers' existing company sickness funds into the new system. Most notable was the arrangement at the steel and engineering colossus, Friedrich Krupp A.G., which dated from 1837. Later, in 1855, the Krupp fund introduced

limited "self-management" (*Selbstverwaltung*)—or at least co-management of company funds by workers. Lohmann, who took charge of crafting the legislation, saw in such arrangements the possibility, practiced by other industrialists with far greater sincerity than Krupp did, of forging a mutually beneficial corporate bond between capital and labor, and so to uplift as well as pacify capitalist society (Vossiek 1937, 16–18, 26–28; Lohmann, letter to Friedrichs 1874).

Bismarck, by contrast, had favored a more administratively centralized system, a more direct link between worker and state that largely bypassed the employer. In part because of his fiscal ambitions, he envisaged workers drawing tax-funded pensions and other entitlements from a single payer, the state. He did not have in mind payments from autonomously managed multiple payers handling payroll contributions that would not pass through the Reich treasury.

Bismarck's disappointment may well have contributed to his famous observation on the legislative process that "whoever knows how laws and sausages come into being can no longer sleep soundly at night." Many doctors lost sleep after getting a taste of the finished product, as well as subsequent amendments into the 1920s. The 1883 law allowed companies with over fifty workers to maintain their existing funds or start up new company funds (*Betriebskrankenkassen*). These funds were to enjoy complete freedom to contract as they pleased with individual doctors over their fees and other conditions of employment. The law did not spell out the role of doctors and thus failed to guarantee their status as solo practitioners against the economic might of big capitalists. Furthermore, the law did not guarantee collective bargaining with medical organizations and arbitration of conflicts so that medical interests might be protected.

The law required smaller firms, and those not wishing to form their own funds, to enroll their workers in multiemployer local funds (*Ortskrankenkassen*) that also contracted with doctors on terms dictated by the market and organizational clout. Large firms could elect to enlist their employees in these local funds, but they rarely chose to do so for managerial and economic reasons.[2] Mine operators retained their preexisting compulsory benefit funds (*Knappschaftskassen*), and small-scale artisanal trades could set up funds on a guild basis (*Innungskrankenkassen*). Agricultural funds (*Landkrankenkassen*) were set up in accordance with law passed in the 1920s.

In all cases, workers contributed two-thirds of the contributions to the funds in which they were enrolled, and employers contributed one-third.

Contributions were calculated as a proportion of a legislatively defined basic wage. Funds dispensed sick pay (*Krankengeld*) and paid providers for medical, dental, and other service benefits from doctors who contracted with the funds. The law set standard minimum service benefits (*Regelleistungen*), but the funds retained freedom to offer supplementary benefits (*Mehrleistungen*). Family coverage was the most important of the voluntary extras. Funds were free to set contributions higher than the statutory minimum if necessary to pay for supplemental benefits.

While the legislation created the theater for unending trench warfare between physicians and the insurance funds, it also pitted capital and labor against each other. Both company and local funds were, according to the 1883 law, to be co-managed by workers and employers. For their self-management councils, workers and employers elected representatives in proportion to their contributions, 2:1. However, in practice, big employers dominated the company funds in their relations with doctors. The law had reserved for them the chairmanship of co-management committees and therefore the routine administration of the company funds. Thus, workers played only a limited advisory role in the company funds.

In the case of the local funds, however, Lohmann had unintentionally made it possible for workers to establish labor union officials in executive positions, which occurred across the board as soon as the unions gave up their initial boycott around 1890. Because employers received only one-third minority representation—and probably because, as smaller enterprises, their interests differed somewhat from the interests of the big company funds—the company and local funds assumed dramatically different positions on important aspects of the system's evolution. That organized labor discovered it could dominate and therefore recruit large numbers of personnel into the local fund system is what, no doubt, caused the industrialist Bueck to criticize Lohmann in private, even though he praised compulsory social insurance in general.

The local funds intensely resented the fact that the larger companies' funds could usually offer better benefits and services (e.g., for dependents), even for lower contributions, than the local funds. The company funds' administrative costs were lower, in part because they did not have to construct new buildings or hire much extra executive and administrative staff. Also, for various reasons, they could hold necessary financial reserves at cheaper cost. But the local funds complained that the main advantage of the company funds lay in risk selection: larger employers hired healthier workers and discharged others (Hauptverband deutscher

Krankenkassen 1924, 8). Smaller firms tied to the local funds had less freedom to select for risks in hiring workers—and little interest anyway, because payment of benefits came out of a common pool. Thus, it became their long-run ambition to abolish the employer-controlled portion of the system so as to absorb their revenues and members into a more egalitarian and economical package.

The company funds fired back, however, that the local funds were more expensive largely because they were unable to monitor lax, abusive, and fraudulent behavior by members and the physicians they turned to. A severe problem, they reasonably claimed (see the Leipzig funds' experience in 1931, discussed later), was doctors' raking of fees with a high volume of unnecessary medical services—"overdoctoring," "busywork," and "mass production" (*Überarztung, Vielgeschäftigkeit, Massenbetrieb*). In the more intimate company arrangement, it was supposed, members were motivated and able to keep an eye on one another's waste and abuse, especially feigned illness and other malingering (*Simulantentum*). This monitoring apparently had been one of Lohmann's justifications for building company funds into the system (Schwenger 1934, 78–80). The company funds also were better able to keep matters under control through selective contract arrangements with physicians that the local funds proved unable to maintain against doctor strikes. But both systems suffered from politically fatal cost problems for which doctors, in the end, had to accept partial responsibility.

The Interests Organize

Conflict between capital and labor within the insurance fund system, as well as other rivalries in the non-medical camp, gave powerfully organized doctors significant leverage to influence developments over the years from the 1890s into the 1930s. Unified, doctors gained much of what they wanted against fragmented enemies.

Initially, however, there seemed to be little need to summon their resources for a fight. It took more than a decade and a half after passage of the health law before doctors mobilized on a national basis. What finally triggered national action was perceived abusive treatment they suffered at the hands of the local multiemployer funds once they became dominated in the 1890s by Social Democratic trade unionists. Organizational

escalation thus began in 1894 when socialists assembled the funds they controlled into a national organization, the *Hauptverband deutscher Krankenkassen*, to coordinate policies and strategies vis-à-vis relations with doctors, bureaucrats, and politicians.

One of the most prominent Social Democratic movers and shakers in medical politics during this phase was Friedrich Landmann, a doctor himself. In his 1898 publication, *The Solution to the Doctor Question*, Landmann announced his conviction that fellow physicians and chemical companies were massively swindling the insurance funds with useless treatments and medications. Considering the rudimentary state of therapeutic medical knowledge and the unprincipled concoction and marketing of drugs, Landmann had a respectable argument. For most illnesses, the best therapy was rest, good food and hygiene, clean air, and time for the body's natural healing power to take its course. Heavily influenced by nineteenth-century therapeutic skepticism—the break with heroic medicine of the past—Landmann thought patients were probably better served on the whole by homeopathic and natural healers than by the *Schulmediziner*, not because they were more effective but because they were cheaper. And less dangerous.

Furthermore, Landmann argued, workers were best cared for if the relatively few carefully selected doctors they could consult were hired on salaries—indeed *good* salaries—to serve on a restricted and exclusive panel (no private, independent practice on the side). Useless medical therapies were to be tightly controlled, thus making more funds available for sick leaves, bed rest, and rehabilitation on the therapeutic side and for public health and hygiene measures, including education, on the preventive side. Thereby, workers' meager salaries were also better taken care of (Landmann 1892, 1898; Möller 1910, 115–20, 127–50; Tennstedt 1977a, 15–19; Plaut 1913, 62, 80–90).

Landmann advanced therapeutic as well as economic reasoning for a restrictive form of what Americans called "contract practice," which was vilified by physicians on both sides of the Atlantic. Landmann was personally involved in two bitterly contested efforts in 1898, closely watched by German doctors across the country. Local funds in the towns of Barmen and Remscheid were trying to dissolve their current arrangements with physicians and set up restrictive contract practices. The tough resistance that local physicians summoned became a *cause célèbre* for doctors all across Germany. They had little doubt that if Landmann proved

successful locally, his therapeutic heterodoxy would hitch a ride around the rest of the country on the juggernaut of socialism, laying waste to doctors' prestige and careers.

Spurred by the Barmen and Remscheid conflicts, in the year 1900, German doctors organized themselves in the city of Leipzig under the leadership of Hermann Hartmann, in the *Verband der Ärzte Deutschlands zur Wahrung ihrer wirtschaftlichen Interessen*. By 1904, this "Leipziger Verband"—later (and here) called the "Hartmannbund," after its founder—had grown in leaps and bounds, taking the health insurance system by storm with well-coordinated strikes (Plaut 1913, 90–98; Neuhaus 1986, 299–313; Huerkamp 1985, 285–96). The doctors' main objectives were, first, "organized free choice of physician"—a closed-shop system in which insured patients could choose any area physician belonging to and agreeing to terms of employment approved by the Hartmannbund. Conflict over this near-holy principle continued into the Weimar period (Hayek 1927). Also, organized medicine demanded payment on a fee-for-service basis (*Einzelleistungshonorierung*), also a matter of deep significance to doctors and great consequence in political developments to come.

Members of the Hartmannbund were required to seek approval from the organization, on a case-by-case basis, before accepting contracts that were not already officially negotiated with a fund or association of funds. Costs of violations were fines, expulsion, and worst of all perhaps, professional and social ostracism. Doctors readily surrendered to this hierarchical authority no doubt in part because of the high-handed treatment they reportedly received from Social Democratic fund managers (Möller 1910). Doctors' relations with the labor-dominated local funds were of course far more status infected than their relations with the employer-dominated company funds. University-trained middle-class professionals found it galling to have to submit to the hierarchical authority of a man trained to be a machinist or carpenter, and perhaps taught manners by a father even lower down the scale. Quite possibly the insurance boss was a reader of Marx, certainly not of Virchow or Ehrlich.

The Hartmannbund's main tools of resistance were as militant as those of its class enemy in industrial conflict with their own bosses: strikes of blacklisted funds, centrally controlled strike benefits, and a national employment bureau. One primary goal was the same too: collective bargaining between the funds and local units of the Hartmannbund. The vast majority of strikes, sometimes citywide in scope, as in Cologne, Leipzig, Munich, and Gera, almost always achieved at least partial success (Neu-

haus 1986, 300). Very often success rode in with the arrival of state authorities demanding an end to hostilities.

By contrast, the silence of the historical record indicates that conflicts with the company funds were less dramatic, or at least less notorious for their smaller size, even if the employer funds pursued similar objectives. An all-out defensive mobilization against big business might well have been a tactical and strategic failure. Panel doctors working for big firms were generally paid well for good working conditions, and therefore they could probably not be pulled into a strike against their employers. Some even joined a separate organization friendly to their capitalist employers. Also, big employers were busy fighting their own propaganda battle with organized labor against efforts to unify and centralize the health system. They had little incentive to join forces with the local funds. For example, during the second big Cologne strike of 1909 against the local funds, the company funds offered no support. Doctors would have been unwise to attack the capitalist-controlled funds and give them reason to join forces with labor against them (Plaut 1913, 108; Neuhaus 1986, 296).

Even if doctors seem to have trod gingerly in their relations with the company funds, they nevertheless stimulated a capitalist counterorganization across Germany. Once again, Krupp was central. Its company health insurance fund had served as a model for the legislation; now it provided the core personnel for the organization of the some thirty-five hundred company funds across the country, making them a major political force in social policy for years to come (Schwenger 1934, 53). Key figures were Otto Heinemann and, notably, his son Gustav, the future Social Democratic Party (SPD) leader and president of the Federal Republic (1969–1974). Gustav served in the late 1920s as a key legal expert to the *Reichsverband* and, writing in that capacity in the organization's journal (*Die Betriebskrankenkasse*), brought on himself blistering and insulting criticism from Karl Haedenkamp of the doctors' Hartmannbund.[3]

The senior Heinemann took over the Krupp company fund in 1903 and the following year co-founded and directed a regional organization of large company funds in Rheinland-Westfalia (*Verband der rheinisch-westfälischen Betriebskrankenkassen*). The purpose was to coordinate neighboring funds in their purchasing relations with providers to bring costs under control ("25 Jahre Verband rheinisch-westfälischer Betriebskrankenkassen" 1929, 265–71). Hospitals were one part of the problem, but the more difficult task was to confront an increasingly well-organized and defiant medical profession. In short, they sought to defend their favored

solutions to the "doctor question." Broken down into its components, the *Arztfrage* posed three questions: whether to deal with doctors as employees or autonomous professionals; individually or collectively; and on a salary, capitation, or fee-for-service basis.

In the company fund view, doctors' demands for autonomy, collective bargaining, and fee-for-service payment were an intolerable intrusion on employers' managerial prerogatives to contract over terms of payment with a limited and exclusive panel of physicians on an individual basis (Thomsen 1996). What doctors called free choice by patients, *freie Arztwahl*, the funds called *Arztzwang,* or forced employment of doctors. Funds, not patients, should have unlimited free choice of doctors, employers thought; workers could then choose from among the ones the company fund recruited. Also, instead of fee-for-service medicine, the company funds favored payment by salary or per-patient capitation. Their capitalist managers believed that paying fee-for-service, like paying workers piece rates, made sense only if the goods or services delivered could be inspected and rejected when, made in great haste, they were of insufficient quality. But quality control was not possible for medical treatment. Quality in services was best assured through careful hiring of quality servants (Walther 1998; Thomsen 1996).

Within a short time after 1904, associations of company funds formed in other regions to deal with the doctors' Hartmannbund. These regional associations' need for coordination gave rise to the national organization in 1907, mainly to assert the separate and distinct interests of the company funds in legislative politics. At this level, however, the issues were not the ones that inflamed relations between company funds and doctors but rather conflicts between company funds and the socialist-dominated local funds. In short, it was about the political defense of the company fund system ("25 Jahre Betriebskrankenkassenverband" 1932, 305–17).

Until then, the national policy arena had been dominated by the local funds' national organizations, especially the *Hauptverband deutscher Krankenkassen*. Controlled by Social Democratic trade unionists, this national organization asserted many of the same interests as the company funds, like Krupp's. But the Social Democrats also aggressively pushed for centralization and unification of the social insurance system in general, and the health insurance system in particular. In other words, the *Hauptverband* called for the ultimate dissolution of the company funds and absorption or their members—a better risk pool—into the local funds. In

the meantime, the labor movement did all it could to promote regulations that hindered the formation of new company funds.

In 1907, to counter the socialists' centralizing designs, big employers put together a national confederation of company funds (*Verband zur Wahrung der Interessen der Deutschen Betriebskrankenkassen*, later renamed the *Reichsverband der Betriebskrankenkassen*). This organization, also headquartered in the Krupp company town of Essen, was directed of course by Krupp's Heinemann. Within a short time the *Reichsverband* succeeded in fully neutralizing all sympathies in the Reich bureaucracy for the idea of greater benefits equality and administrative efficiency through centralization. Their effective, aggressively distributed counterpropaganda proffered two related arguments. First, workers paid lower company fund contributions for better benefits. Second, even Social Democratic workers resisted their absorption into the larger multiemployer local funds.

In resisting centralization the capitalists' company funds allied with other key allies from the German working class. These were the Catholics' Center Party (*Zentrum*) and its closely allied organization of Christian trade unions. Although vastly outnumbered, these were still hardy competitors to the Social Democratic unions, with deep regional roots (for example in Bavaria), and as we will see, they were key players in medical politics. They in turn set up their own competing national association of local insurance funds that they managed to dominate, the *Zentralverband der deutschen Ortskrankenkassen*.

In short, organized medicine in Weimar Germany faced off against a complex array of divided opponents. On the burning *Arztfrage*—whether and how payers should exercise managerial control over medical professionals—their opponents were largely in agreement. All favored, on the whole, individual rather than collective contracting, reasonable limitations on patients' choice of physician, and payment by capitation or salary, not on a fee-for-service basis. But despite that unity, on most of these issues doctors firmly held their ground against capital and labor.

Because of doctors' success in collective bargaining, achieved with their aggressive strike and boycott tactics—and the *deus ex machina* of compulsory state arbitration—they only displaced conflict and strengthened the resolve of their opponents on another burning issue: *whether and how to control the number of new physicians allowed into insurance practice*. Too many doctors, performing too many services for fees, were bankrupting the system and degrading medical practice. Competing over patients,

doctors indulged them with unnecessary prescriptions for useless or even harmful and addictive drugs (*Gefälligkeitsverschreibungen*) and certifications of illnesses (*Gefälligkeitszeugnisse*) to qualify workers for days off with sick pay. For the extra fees they merrily applied electrical devices for all manner of expensive treatments that lacked evidence of efficacy from clinical testing: for example, Roentgen treatment of tuberculosis with obsolete machines that were weak and relatively harmless—or worse, up-to-date and strong, and therefore a threat to the very tissue that the tuberculosis was attacking ("Fragen der Zeit" 1930, 287).

Throughout much of the insurance system, fee-for-service prevailed, and fee reduction was not a viable option until well into the Depression. So "doctor reduction" (*Arztabbau*) to reduce competition over patients came to be a logical and for some of the players a preferred solution. The politics surrounding this burning issue played a key role in the shaping of the system imposed in 1931 and later reinstalled after the Nazi catastrophe was over.

Between Capital and Labor: Medicine's Answer to the Doctor Question

During the last three years of Weimar democracy, conflicts between the three main economic interest groups in German medical politics, and divisions within them, made unpredictability a certainty. Capital, labor, and medicine struggled with and against one another to reconcile quality, economy, and equality. The choices of electoral politicians, attempting to broker workable agreements among the interests, steered developments violently away from one imperfect solution toward the next. It so happened that a Catholic (Center Party) politician, Heinrich Brüning, came to dominate that process. In the end, he chose, for better or worse, to please the medical profession, satisfy labor, and antagonize capital.

At the center of Weimar democracy, and especially its social politics, was the Center Party (*Zentrum*), whose electoral constituency was both proletarian and bourgeois. Because of Catholic social reformism's independent position between capital and labor it was only logical that class antagonists in the Reichstag, attempting to work together in majority coalitions, could accept Heinrich Braun, leader of the Catholic's Center Party, to serve as Reich Minister of Labor between 1920 and 1928. The Social Democrat Rudolf Wissel interrupted the party's control of social

policy for about two years. Adam Stegerwald, leader of the Christian unions and Prussian minister of welfare, then took over the Ministry of Labor between 1930 and 1932.

At the helm in this period was Chancellor Brüning, who had served as executive director, Stegerwald's right-hand man, of the interconfessional Christian labor confederation between 1920 and 1930. In 1930, after dissolving the Reichstag, Reich president Paul von Hindenburg chose Brüning to serve as chancellor of the Reich. Now Stegerwald was Brüning's right-hand man.

These were fateful choices for the German health care system. First, in July 1930, Brüning and Stegerwald tried their hands at bringing capital and labor together against medicine to deal with the fiscal crisis of the health insurance system. When that failed miserably, they took a 180-degree turn and brokered a new alliance between labor and medicine. The deal, worked out in negotiations at the Imperial Labor Ministry in July and October 1931, met with the powerful capitalists' and agrarians' profound indignation. Passed into law in December 1931, it was soon abrogated by the Nazi regime, but it was resuscitated largely intact after World War II to become the basis of the German system today.

Capital and Labor against Medicine: The 1930 Presidential Emergency Decree

The Great Depression, with Brüning's political brokerage, brought capital together with both branches of the labor movement against the German medical profession. Brüning's predecessor government, the Grand Coalition led by Social Democrat Hermann Müller (with party colleague Wissel responsible for social insurance in the Ministry of Labor) had sought calmer relations with the doctors, and with their truce came a historical first: the Hartmannbund's first declaration of goodwill toward health insurance in 1929—almost half a century after Bismarck (Mayer 1929; "Sitzung des Verbandsausschusses" 1930, 98).

But because of the Depression, truculence quickly followed truce, and labor returned to what proved to be a futile war with medicine. Chancellor Brüning, facing crushing pressure from organized capitalists to trim social insurance charges, responded with emergency legislation perceived by doctors as a frontal assault on their profession (Neebe 1981, 78–89). Local sickness funds controlled by the socialist and Christian unions stood

side by side with the big industrialists' company funds behind a presidential decree of 26 July 1930, proposed to President Paul von Hindenburg by Brüning. Hindenburg signed the emergency legislation into law without a Reichstag vote; having been dissolved by him earlier, it would not have been able to challenge it, if so disposed, until after a new general election.

The Hartmannbund's Haedenkamp railed that Brüning's decree amounted to a declaration that doctors were unfit to fulfill their duties properly without external guardianship (*Entmündigung*). Nothing less than a total "system change" was under way, bringing with it a "narrowing of doctors' citizenship rights." While doctors bewailed injury to their "status honor," medicine's critics scorned the medical profession's "victim mentality" (Haedenkamp 1930, 661–62; Thomsen 1996, 98). Thus began a furious war of unified payers against unified providers over four main features of the decree: control of malingering by medical examiners, cost shifting onto patients, pressure for more cost-effective clinical practice, and reduction of the number of doctors admitted into insurance practice.

Control of Malingering. More of a symbolic than real immediate threat to doctors was a new legal requirement that the insurance funds hire medical examiners (*Vertrauensärzte*) to review all certifications by insurance practitioners' of their patients' inability to work and therefore qualification for sick pay. Postdiagnostic exams (*Nachuntersuchungen*), it was thought, would force many workers on "sick vacation" back to the workplace. The funds had already gathered compelling evidence of this malingering from various experiments: a great many workers simply returned to work rather than show up when ordered for reexamination.

Although many funds already had such examiners, and sometimes required routine reexamination, physicians' resistance to the practices rendered them less than systematic and effective. Now that they were to be compulsory, the Hartmannbund declared war on the measure and forbade members to apply for or accept examiner jobs without the association's permission ("Kampf der Aerzte gegen die Reichsnotverordnung" 1930, 214). The political impact, if not the medical one, of this action was clear. Along with doctors' individual and collective reactions to other aspects of the emergency decree, it helped persuade the reformers that the legislation was not going to work.

Cost Shifting. Another major economizing measure in Brüning's first decree targeted unhealthy workers, not doctors, for the biggest economic hit, a substantial cut in their sick pay. Furthermore, workers were now to pay a ten-Pfennig fee for each doctor visit and a fifty-Pfennig co-payment

for each prescription. Fewer patients, it was hoped, would seek medical attention and certifications of illness for trivial problems. In one way, the fees proved a great success. For example, the city of Leipzig watched its caseload sink from around 200,000 to 170,000 in the third quarter of 1930, and then to 130,000 in the fourth.

Among the organizations involved, only the Hartmannbund complained. Doctors blasted the legislation for sacrificing their own, not just patients', well-being. But the health funds noted very quickly the "astonishing result" that total expenditures on physicians' fees did not budge and that the financial health of the funds would not rebound. For example, Leipzig's consolidated local fund found that its doctors' fees remained flat at about one million Reichsmarks despite its steeply declining caseload. In other places, reportedly, expenses even went up ("Fragen der Zeit" 1931a, 59–60; "Fragen der Zeit" 1931b, 70). The conclusion: to make up for a declining caseload, doctors simply increased the services that they performed on remaining patients.

Capital joined with labor in bemoaning doctors' ability to rescue themselves economically at everyone else's expense with the rush to perform more services. By seeking "safety in numbers" (*Flucht in die Menge*) through "out-of-control doctoring" (*uferlose Verarztung*), the capitalists' company funds found, doctors were able to defend their incomes with enormous success ("Freie Arztwahl" 1930, 65; "Aerztetagung" 1931, 157; Wolff 1997, 129). Socialists agreed. But, according to Julius Moses, the most prominent of socialist doctors and, therefore, a defender of health insurance,

> Every doctor who sees reality as it is, and openly expresses it—namely that there is no academic profession that recovered economically so fast after the war and inflation . . . as the medical profession—is a "traitor" for saying the truth. . . . Whoever says it openly, whoever doesn't chime in with cries of woe that all doctors are suffering, they are "lacking in professional consciousness" and "undermine the prestige of the doctor"; they are ostracized and boycotted. . . . Not even in theology is such an unshakeable belief in dogma demanded as it is from certain medical circles regarding the belief in [protection of] economic interests as an ethical principle ("Fragen der Zeit" 1931b, 70).

Moses, a victim of Theresienstadt in 1942, was of course regarded by organized medicine as one of the worst traitors of all.[4]

Thus, with the fee-for-service remuneration system, which they had so successfully imposed, doctors were able to evade the laws of supply and demand, which normally enforce falling income on stable numbers of competitive suppliers in depressed markets. Notably, organized medicine's favored explanations for the perverse outcome blamed patients for their "demandingness" (*Begehrlichkeit*), the insurance system for cultivating this trait, and low fees for forcing doctors against their will to indulge them. Finally, feebly, they blamed a rising morbidity rate. Only rarely did doctors blame themselves. One exception blamed physicians' "lack of self-respect" for their softness toward pushy patients ("Reichsausschuß" 1931, 385; "Reform der Krankenversicherung" 1930, 163; Beierast 1931, 69). Outside critics of the medical profession of course charged doctors with what today might be called "supplier-induced demand." Greedy doctors, not needy patients, were the problem.

Cost-Effective Medicine. Defending themselves rather ably from economic privation through individual action, doctors also took collective action against other threatening aspects of Brüning's decree. One of these made it the legal obligation of insurance funds to monitor and enforce "economical treatment and prescription practices" (*wirtschaftliche Behandlungs- und Verordnungsweise*). This had only been vaguely exhorted before. Furthermore, cost-effective medicine was now more specifically defined to exclude "unnecessary" medical, dental, and surgical care.

Since passage of the insurance code in 1911—a first step in institutionalizing medical conflict resolution—doctors and funds had been called on in principle to pursue the economical practice of medicine. In 1923, the insurance funds, bureaucrats, and politicians attempted in vain to construct institutional means to develop guidelines for control of clinical practice. All it accomplished was an infuriated medical profession. Now, the threat of real enforcement was in the air. Individual physicians could now be sued for damages if found in violation of regulations—should they ever be formulated. Also, collective contracts could be abrogated if the contracting medical association resisted remedies to systemic problems. If doctors struck in response, the insurance bureaucracy could allow funds to substitute cash payments for service benefits, leaving patients to seek and pay any doctors they chose at any rate. This measure potentially doomed doctors' strikes over control issues to failure.

As in 1923, physicians vehemently rejected the idea that they should be held responsible for waste, even if there was no hiding the fact that their excessive and unnecessary practices were widespread. In 1926 Erwin

Liek had already confirmed for all, in lurid detail and purple prose, all the worst suspicions held by the insurance funds, labor ministry officials, and many doctors. But in his best-selling book, *The Doctor and His Mission,* and a subsequent one, *Social Insurance's Damages* (Liek 1926, 1928), Liek laid blame primarily at the feet of the insurance system for the moral degeneration of the profession and the German people alike.

Doctors probably worried too much about this humiliating aspect of the 1930 decree. More than anything else it proved to be a symbolic and therefore politically threatening challenge to their claim to status and power, based as it was on a putative monopoly of therapeutic knowledge. Just what exactly constituted economical and necessary clinical practice, of course, could hardly be legislated in the Reichstag. The insurance funds had no powerful incentive or resources to apply existing (shaky) therapeutic science, or to generate new knowledge about clinical efficacy, to that end. The law did propose the creation of an overarching corporatist agency to deliberate how to organize and pay for cost-effective medicine, but it never got off the ground.[5]

Controlling the Doctor Surplus. By far the most controversial measure in the emergency decree of July 1930 called for a slow but deliberate reduction, through attrition, in the number of physicians entitled to receive remuneration from the insurance funds. Since 1924, all funds were in principle required to hire or process the bills of no more than one registered contract physician for every one thousand members. Thus, for example, the 250,000 members of various local funds in a district were to have access to 250 regionally organized doctors. Companies that had not yet caved under medical pressure for "organized free choice" among doctors, and therefore still contracting with closed panels, operated under similar constraints. Hence, for example, a large company fund with twenty thousand members had to contract individually with at least twenty physicians.

In practice, efforts to slim down met with intense opposition from the Hartmannbund and achieved little success. Over the years, doctors even succeeded in preventing funds from gaining reductions with a decline of employment in a company or district. This problem became acute during the Depression, when firms suffered major drops in demand. In effect, physicians had achieved a system of permanent tenure for individual practitioners through manipulation of the complex negotiation and arbitration processes written into the insurance code. A kind of protective common law had evolved through negotiations in local admission and

contract committees consisting of physician and fund representatives and through state arbitration when the parties could not agree.

Especially in the Depression, this corporatist administrative law system guaranteed, from the insurance funds' standpoint, that too many doctors were chasing too few paying patients. For example, a company with twenty thousand workers could lay off five thousand of them but still be saddled with twenty doctors trying to maintain fee income through more intensive doctoring of fewer patients. Thus, the company funds were the most fervent advocates of "doctor reduction."

The 1930 decree now, decisively, called for bringing the system back into balance by requiring the funds to replace only two out of every three doctors who departed due to retirement, death, or other reason. Over time, funds were thereby allowed to bring their ratios back down to 1:1000. This was radical surgery even if it was slow. The Hartmannbund leadership sounded alarm at the prospect, over the long haul, of ten thousand fewer positions in insurance practice when, currently, there were no more than about thirty-five thousand registered. And there were more doctors on the march, because politicians, not doctors, controlled the universities. The numbers take one's breath away: between 1925 and 1932 the number of medical students *tripled*. In 1931 doctors in training numbered eighteen thousand or so, and twenty-five thousand more (!) were expecting entry into medical school in 1932 (Titze 1984, 104–7; Kater 1986, 56–60; Thomsen 1996, 129, 184). The system was drowning, nobody doubted, in a "glut of doctors" (*Aerzteschwemme*).

From a sheer economic standpoint, organized doctors already admitted into insurance practice should at least have loudly welcomed the new, more restrictive admission rules. And indeed, there was disagreement and vocal protest in response to the Hartmannbund's fight against restrictions (Jacobs 1929; Thomsen 1996, 32–33). Fewer doctors would mean less frenetic churning of fees for useless services to achieve a target income. They might even be able to get fees increased without economic damage to the funds. Indeed, it was not impossible to find doctors who would speak for shrinking the competition. One physician enlisted by the company funds declared that fewer prescriptions would be good for the health of their members—not just for the finances of the insurance funds. A problem, he noted, was the excessive prescription of pain relievers among other "more or less poisonous substances . . . whose effects over the long term we know very little" (Tröscher 1930, 273–74).

But although many insurance physicians saw a benefit in doctor reduction of the kind being proposed, official pronouncements belied that support. The Hartmannbund could not advocate that solution, even if it made economic and therapeutic sense. There were two reasons: organizational and political. First, in the 1920s, the Hartmannbund's leadership feared that endorsing restrictions would so antagonize and discourage unemployed doctors, many of whom were members, that they would break ranks and scab for the insurance funds. The funds would then be able to let collective contracts lapse, bust the doctors' unions, and return to restrictive contract practice. As Haedenkamp put it, young doctors would be driven into the arms of the socialist funds. Years of hard work would be destroyed (Thomsen 1996, 34). As we will soon see, Brüning's next major move, responding to Hartmannbund pressure, promised to rescue the medical leadership from this conundrum.

Over time, the reasoning became as much political as organizational. The politics of medicine in Weimar Germany was not just about how to organize the system to reconcile costs, coverage, and quality. It was also, pure and simple, about ideology, and increasingly the worst kind. By 1931, the cancer of Nazism had spread well into the medical profession where the immune response was weakest: among medical students and large numbers of young unemployed physicians. Indeed, because universities were continuing to hand out many thousands of new medical degrees every year, *a rising number of doctors were clamoring loudly for access to a declining caseload*. Though unemployed, the "young doctors" (*Jungärzte*) joined the Hartmannbund in large numbers and became an increasingly noxious and disruptive presence. Nazi MDs recently socialized in the poisonous politics of medical school, and organized in their special Nazi association, ferociously attacked the organization from within for its collaboration in a health insurance system controlled by capital—and, worse, labor—including its joint gate-keeping admission committees. This was a betrayal of all that Nazism stood for (Hubenstorf 2002/2003, 208–9).

The huge and growing doctor surplus made the 1930 answer to the doctor question politically untenable. Unemployed doctors had gained a powerful source of support: a small but influential number of radicalized doctors in the Reichstag. And these were gaining support within a parliament with a shrinking middle. Indeed, according to the Social Democratic funds, there was now a clear Reichstag majority sympathetic to overturning all restrictions on entry into insurance practice.

To moderate Weimar politicians like Brüning and Stegerwald, with their ears open to the local funds' complaints, doctors had proven themselves economically unsupportable and clinically irresponsible. Now many of them were proving to be a political menace to the shaky democracy by bankrupting the social security system. So Brüning sought a solution that might at least stave off disaster by enlisting organized medicine's support. In exchange, a few things had to give, including doctor reduction. Swept away with that ambition was capital's support.

Labor and Medicine against Capital: The 1931 Emergency Decree

Seeking a way out of the quagmire, Brüning changed course radically in 1931 and brought labor—Christian as well as Social Democratic—once again to a détente with medicine. By backpedaling on control of the doctor surplus, he moved forward toward reconciliation. In a deal brokered by Brüning and hammered out in the offices of the Reich Labor Ministry in October 1931, the labor fund officials and the Hartmannbund leadership agreed on a substantial loosening of the 1930 admission regulations. *From now on, funds had to lower their sights and permanently accept a doctor-member target ratio of 1:600*. This revision was incorporated into a new presidential emergency decree signed by President Hindenburg in December 1931.

On this revision, according to the *Deutsche Krankenkasse*, the mouthpiece of the Social Democratic local funds, labor sided with medicine because the burgeoning medical proletariat, "dynamite in the foundations of the state" (*Sprengpulver im Staatsgefüge*), was too dangerous to be ignited ("Der kassenärztliche Dienst" 1931, 1107). Ominous signals from the Reichstag, according to one Brüning supporter, probably Social Democratic local fund leader Helmut Lehmann, wrote of "a very strong majority in the Reichstag and in the current government for almost unlimited admission of the young doctors to insurance practice." In sum, the capitalists' passive wait-and-see approach, their gamble that no government would ever dare to throw open the admission gates, was "too flimsy (*billig*) to be taken seriously" ("Die Neuregelung" 1931, 1274; Tennstedt 1977b, 132n. 64).

In the deal, the Hartmannbund leadership accepted another major change: *a substantial across-the-board cut in the standard fee schedule*. But

in the bargain they hastened to gain something far more important—a radical restructuring of the system to the medical association's profound organizational advantage and an enormous threat to the capitalists' company funds. First of all, the reform introduced *compulsory membership of all insurance doctors in new regional associations that the Hartmannbund leadership could quickly dominate*. The company funds now had to give up all hope of working collaboratively with physicians through a separate medical association (Gibbon 1912, 35). More important, and also in line with principles adopted at the Hartmannbund's Cologne convention of June 1931, the legislation imposed on all insurance funds *a legal obligation to bargain collectively, on a regional basis, with these new medical associations*. The labor funds had already accepted collective bargaining with the doctors' associations in practice; now the capitalists' funds would have to negotiate with the doctors' unions, just as they did with labor unions.

It is logical to think that by getting agreement for compulsory collective bargaining and doctors' associations, Haedenkamp consciously and ingeniously maneuvered organized medicine into a position where it could pursue an economically rational admissions policy that was also consistent with organizational survival. From now on, if the medical associations agreed to the restrictive policy that the funds had been clamoring for, the funds could no longer simply turn around and legally exploit a reserve pool of unemployed young doctors now feeling betrayed by the Hartmannbund for accepting restrictions. That is to say, the funds would no longer have the potential to bust the regional doctors' unions because the unions enjoyed permanent legal status and an exclusive—corporatist—right to be negotiated with.

The emergency decree of 1931 brought one other and even more radical departure from current practice. *Collectively, doctors were now to shoulder official responsibility for pursuing cost-effective practices*. A collective incentive to do this was built into the compulsory bargaining process. Collective bargaining between doctors and funds was now to produce negotiated or arbitrated settlements on a district basis over fixed budgets for ambulatory services. In other words, the funds and medical associations were to settle on a collective prospective capitation fee (*Gesamtpauschale*)—calculated to fall or rise more or less in step with workers' income. The funds would then hand over the budget amount to the compulsory regional medical associations, which would then distribute fees for individual services performed by their members out of this budget (Ritter 1931, 603–5). The supposed genius of this arrangement—which made the rest

of the deal easy to swallow for the labor-dominated funds—was that if too many services were performed by their members, the doctors' associations would have to lower the fee per service. Reluctance to lower fees would give organized medicine an incentive to find ways to impose cost-effective clinical practice. Now it would be doctors' role alone to bring about a new, cost-effective medical order.

As early as 1900, German doctors had tossed around the rather intriguing idea of having their associations monitor and control members' unsound clinical practices to work within a budget. The Social Democratic local funds, having rejected the idea back then, had approved of the idea in principle in 1928 and formally adopted it at their Nuremberg convention in 1929. Now, in 1931, the politically pivotal Christian labor unionists, an increasingly radicalized constituency to which Brüning was tightly beholden (Neebe 1981, 243–44n. 44), agreed. Both saw the advantages of handing over to doctors themselves, on a collective basis, the responsibility for controlling the nature and volume of medical services billed for in insurance practice in order to stay within their budget. In Social Democratic insurance executive Helmut Lehmann's probably overoptimistic words, it would bring "a thoroughgoing protection of the funds against uneconomical treatment methods" (Lehmann 1932, 8, 16–18).

Capitalists protested loudly, and in vain, against the clever, complicated, and radical transformation of the health care system. Heinemann suspected a political and therefore more ominous motive behind this elaborate and radical transformation of the system. At work behind this "peculiar alliance of interests" (*eigenartige Interessenverbundenheit*) he saw the Social Democratic unionists' unshakeable long-term goal of absorbing company fund members into a unified system of local funds. Haedenkamp, too, he believed, harbored his own "delusional dream of centralization and collectivism" and was therefore "openly conducting the business" of the Social Democratic insurance funds, known for their ambition of forming compulsory collective bargaining "as a first step toward the unitary fund system" ("Herr Dr. med. Haedenkamp" 1932, 141–43).

Hostilities between capital and the medico-labor alliance flared again, as they had in the winter of 1930, when the the capitalists' Heinemann accused Haedenkamp of "distortion of the facts," "immeasurable exaggeration," and "cheap propaganda of the vilest nature" for his criticisms of the company funds' protests. In response to one of the doctor's diatribes, Heinemann blasted Haedenkamp for thinking that he can "dress down prominent health fund officials like stupid schoolboys [*wie dumme Jungen*

abkanzeln]" ("Aenderung in der Krankenversicherung" 1930, 198; "An den Herrn Schriftleiter der 'Aerztlichen Mitteilungen'" 1931, 1). One of these officials was Heinemann's son, future *Bundespräsident* Gustav Heinemann. Things had come a long way since the turn of the century, when socialists like Friedrich Landmann and the labor-dominated local funds were doctors' worst enemy.

Aftermath: Nazi Doctors

The doctor-labor agreement of October 1931 became the foundation of a decree imposed the following December against the will of Germany's major capitalist interests. The system it set up became the foundation of Germany's postwar health care system. Reich president Paul von Hindenburg signed it at the urging of Center Party chancellor and former Christian trade unionist Heinrich Brüning. Brüning, it seems, was caught between labor—especially his own increasingly radicalized branch of it—and capitalists. By choosing to forge a medico-labor alliance, he helped shred the tolerance of many right-wing industrial elites for the failing democratic order.

In the end, Brüning's legislation did nothing to appease many of Germany's doctors. For one thing, it had no time to achieve a calming effect. Large numbers of physicians had already begun migrating politically in a rightward direction away from their traditional political home, the DNVP (*Deutschnationale Volkspartei*), whose core constituencies were increasingly doctors' enemies: heavy industry and agriculture. (Haedenkamp himself had served as a DNVP member of the Reichstag from 1924 to 1928.) Indeed, after Hitler seized power, many doctors became Hitler's willing allies, administrators, and executioners in caring for the new patient, *das Volk*, and its body, *der Volkskörper*. One of them was Haedenkamp and the entire staff of the Hartmannbund, which moved from Leipzig to Berlin to run the new *Kassenärztliche Vereinigung Deutschlands* (KVD). Shortly after Hitler seized power in 1933, Haedenkamp wrote, "Never in the past has the medical profession been so closely tied to the will and the objectives of the state as today" (Haedenkamp 1933, 8).

The proportion of doctors who fell in line is astonishing: by 1936, over 30 percent of non-Jewish physicians had become Nazi Party members; in the course of the Nazi dictatorship, the figure hovered around 45 percent (almost 50 percent of male physicians). Corresponding membership levels

for the SA were 21 and 26 percent. The SS claimed roughly 4 percent of doctors in 1936 and 7 percent in following years. No other professional group in Germany was so well represented (Rüther 1997, 166–67; Kater 1987, 311; Kater 1989, 54–88).

Were one forced to sort through the contributory causes and choose the single most important contributory factor that turned German doctors into enemies of democracy and, less directly, psychologically predisposed them to become tools of a criminal regime, one would have to point to Germany's compulsory national health care system. Recent historical research suggests as much (Kater 1986; Thomsen 1996). Doctors even blamed the insurance system for the German public's declining faith in regular medicine's therapeutic superiority. Behind the rising economic success of quackery (*Kurpfuscherei*), Liek and others thought, was workers' dissatisfaction with the impersonal and mechanical mass delivery of services by doctors bustling to earn fees (Timmerman 2001).

But more directly infuriating for doctors was the direct role that national health insurance accorded to capital and labor in the mission to ensure that Germans received quality medical care while economizing on its costs. Because institutionalized incorporation of these organized class interests routinely rode roughshod over physicians (they felt), Weimar democracy itself became tainted. After all, it had been secured early on by the cross-class Stinnes-Legien agreement of 1918 and the resulting, if not terribly successful, corporatist *Zentralarbeitsgemeinschaft* (Central Commission of Industrial Employers and Workers). According to this corporatist system of cross-class collaboration, business and labor leaders would collaborate on the major social insurance problems of the day (Feldman and Steinisch 1985, 34, 46, 53, 80–81, 201, 210–11).

Even Haedenkamp came under fire from the growing extremist wing of the medical profession for his attempts to work with the social insurance system. Speaking through the party's newspaper, *Völkischer Beobachter*, Nazi doctors blasted away at Haedenkamp and the Hartmannbund for its 1931 collaboration with labor (Haedenkamp 1931, 692). But once Hitler came to power, Haedenkamp went straight to work for the new regime. There were no protests to be heard from him about Nazi eugenics: on behalf of the Hartmannbund, he had called for systematic forced sterilizations in 1932 in the name of "racial hygiene"—before Hitler took power. He retained the top leadership role in the Nazi health system. He helped craft the first *Reichsärzteordnung*, the new and separate legal code for the medical profession, turning it into anything but a free, individualistic

—and ethnically inclusive—enterprise dedicated to doing no harm. (He survived de-Nazification and remained a top medical leader until his death in 1955 [Schwoch 2001; Hubenstorf 2002/2003, 213].)

As regards the unsolved doctor surplus, the Nazi regime now gave Haedenkamp the freedom to proceed with impunity in doctor reduction. He helped fashion the guidelines for firing married female doctors and blocking women's entry into medical study and insurance practice. As for the Jews, his was a direct role in expelling them from the health care system. Jews had constituted no less than half of Berlin's doctors in early 1933, and 60 percent of its doctors practicing insurance medicine. By 1934, none of them could engage in insurance practice. By 1938, they were excluded from medical practice altogether, except as nonlicensed caregivers for other Jews. That was the final solution to the surplus doctor question.

Now that Hitler's Germany was shutting all Jews out of medical practice, American organized medicine began, around 1938, refusing to license émigrés trained abroad, many of them from Germany and Austria. Jewish doctors in large numbers were seeking refuge on the other side of the Atlantic. But American physicians had an oversupply problem too. And they used another argument as well: *the quality of medical education abroad was often inferior* (Kohler 1997).

Conclusion: Distributional Politics Are Not Entirely about Distribution

The fiscal strain on the German welfare state from the Great Depression and the unchecked flood of doctors onto the medical market converged in Germany to create a perfect storm of clashing economic interests. The clash of interests gave rise to a most hideous politicization of medicine. But it also gave rise, as postwar German health care indicates, to a highly unique health care system that was not unworkable and—despite inevitable flaws in practice—even somewhat fair and rational in design.

This German story shows that alignments as well as conflicts of labor's and capital's distributional interests, inflamed and brokered by politicians, can drive the politics of welfare state development. Comparative historical analysis of welfare state development suggests that this might be a general pattern (Swenson 2002). But the German story shows that the *quality* of welfare policy, not just its distributional implications, can also play a powerful role. Certainly in the case of health insurance, the question

of quality takes on deep importance. Here, doctors can hold their own against labor and capital. Because the public credits them with superior knowledge about illness and health, physicians can exercise influence over medical politics to an extent far out of proportion to their numbers or resources relative to capital and labor.

The politics of medicine and health insurance in Germany and the United States in the 1930s also show that in the realm of social policy-making, the distributional rhetoric of fairness and justice does not necessarily trump in the democratic game. Reactionaries hold their own with other powerful rhetorics. They often appeal, of course, to the inviolability of property acquired from work and savings—and to the unfairness of taxation to serve the idle and prodigal. But this argument has only a limited democratic reach. Another rhetoric of reaction, elegantly dissected by Albert Hirschman—against the futility, perversity, and jeopardy of reform—enjoys a much broader democratic appeal (Hirschman 1991). Reactionaries throughout history, like Erwin Liek in Germany and his devotees Harvey Cushing and Edward Ochsner in America, routinely assert the futility and even counterproductivity of our efforts to aid the poor. Those efforts put other social values in jeopardy. Money goes to waste. Entitlement to assistance breeds dependence and perpetuates poverty. The moral hazards of insurance bring professional degradation and cultural decay.

In the case of medical care in the 1920s and 1930s, there were *pieces of truth in parts of these arguments*, which gave them credibility to politicians and voters. Thus, the arguments endowed relatively few people with immense power far out of proportion to their numbers. In Germany, the arguments aided the Nazis in their war on the democratic welfare state. In America, the arguments, backed by evidence from Germany, helped block the passage of national health insurance for years to come.

NOTES

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1. Thus, corporatist representation of interests deviates from the individualistic one-person-one-vote system of electoral representation, which segments representation by geography (electoral districts), not economic function.

2. In 1931 there were 3,519 company funds with 2,843,000 members, for an average of about 800 members per fund. There were 2,101 local funds with about 13,000,000 members, or about 6,000 members per fund on average.

3. Throughout the Weimar years of his remarkable and circuitous political career, Gustav Heinemann, unlike Haedenkamp, remained a committed democrat. Initially an activist in the liberal German Democratic Party (DDP), which dissolved, he made a brief attempt to create a viable cross-confessional reform party. In the end he voted for the Social Democrats in 1933, protesting Hitler. A co-founder of the Christian Democratic Union (CDU) in 1945, he broke with the party in 1952, mostly over foreign policy, and eventually found his way into the SPD. As a Social Democrat, he was elected to the presidency of the Federal Republic.

4. A practicing physician in Berlin, Moses chaired the *Verein Berliner Kassenärzte* (Berlin Association of Contract Physicians) and published its journal *Der Kassenarzt* (*The Contract Physician*). From 1922 on, he was member of the Social Democratic Party executive council.

5. The *Hauptauschuß für Krankenversicherung* was to seat representatives of the peak organizations of employers, workers, funds, and doctors and be chaired by the Labor Minister. Its tasks, among other things: "To establish principles and guidelines for the administration of sickness insurance in general, especially for economy and simplicity, for prevention and elimination of abuses and defects."

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