German Unification: East Meets West in the Doctor’s Office

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Germany was the great natural experiment in politics and health care: one country with one health system suddenly split and took divergent political paths in 1945. The scholar couldn’t ask for a better way to hold constant those pests of cross-national research—history, culture, traditions, and institutions, even national character, if there was such a thing. It was the perfect opportunity to test the impact of politics on health systems.

The health systems indeed diverged dramatically. The West German system continued its development along a trajectory of universal public financing through hundreds of insurance carriers, fee-for-service reimbursement of private practitioners in the ambulatory sector, and salaried employment of physicians in hospitals owned by state and local governments and churches. East Germany continued the Bismarckian tradition of universal public financing but consolidated the administration of finance into two national carriers. The Free German Trade Union was the insurer for most workers and their families—about 89 percent of the population. The state was the insurer for self-employed people, members of cooperatives, and their families—about 11 percent of the population. East Germany also socialized the medical profession and the hospitals. Doctors became employees of the state, almost all hospitals were owned by the state, much health care was provided in factory-based clinics, and private medical practices and privately owned pharmacies were gradually eliminated.

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Now, with unification, we are witness to another grand social experiment. This report of it is something of a personal notebook. In November 1990, I spent two weeks in Germany to find out how the East and West German health systems would be integrated come January 1, 1991, the date set by the unification treaty. My visit was almost entirely in the former West Germany, and although I did go to East Berlin, it turned out to be difficult to arrange interviews with knowledgeable East Germans. Some of my contacts had already lost their jobs in East German research institutes and simply were not there. The East German railway workers went on strike the night before I arrived in Berlin, thwarting my plans to visit contacts in other cities. And though travel from West to East Berlin via the S-Bahn was relatively easy, it was still impossible to telephone from one side to the other for appointments, because there were no cross-sector phone lines yet. Thus, this is an impressionistic report by an outsider, capturing a particular moment in a tumultuous, fast-moving process, and heavily skewed toward a West German perspective. Caveat lector.

What happens when two health systems, one primarily capitalist, one primarily socialist, unite? That, at least, is how most Germans see the question. And no one for a minute thinks the two systems are merging on an equal footing. The starting assumption is that socialism has failed. “The East German model of socialism has run aground; the political, economic and moral crisis of the country is obvious,” began the representative of the newly formed East German doctors’ union at a forum on health policy in the summer of 1990. “That goes for health care as well,” she continued, “but we should distinguish between the efforts made by health care workers, and the material conditions under which they were forced to work.” (Forum Gesundheitspolitik 1990: 45).

There is a pervasive theme of coercion in the discussions of East German health leaders and workers, although not the coercion of being told what to do by government that is regularly invoked by the American medical profession whenever it speaks of national health insurance. For East Germans, there is above all the coercion of having to work with inadequate resources.

There is also a sense that unification is an onrushing train and East German leaders can think only about surviving the collision. “The process of unification has its own dynamic,” said the director of Social Insurance for Blue- and White-Collar Workers in (East) Berlin. “Oftentimes one stands at the end of this process, not at its leading edge, and tries to reconstruct the design that should have been put in place by good organizational planning.” After discussing some concrete changes he thought would have to be made in the East German insurance system, he warned, “We must be clear, however, that we’re talking about an emergency solution... Conceptions of the future structure of ambulatory care are often built on wishful notions, but we must strive for
pragmatic solutions, in order to survive the next days, weeks, and months” (Forum Gesundheitspolitik 1990: 35–37).

Most of my West German colleagues described unification with metaphors of occupation, colonization, and annexation. “It would have been more honest,” said one, “if we had simply marched in.” Indeed, as things have developed in the health sector (as in most others), there is scarcely any compromise between the two systems. The health system in the East will be almost completely replaced by that of the West. Hence, John Iglehart (1991) could write so matter-of-factly in his recent report on Germany, “The task of transforming East Germany’s state-run health care system into an enterprise modeled on West Germany’s social-insurance plan will require substantial changes” (p. 504). That definition of the task of integration was not a given, however. The precise nature of the integration of the two health systems was one of the most contentious issues in the debates leading up to unification.

From the perspective of the West German Left, not to mention East German physicians, unions, public health officials, and citizens, the East German health system has many virtues worth preserving and emulating in the West. Except for a very small minority of physicians in private practice, the rest are paid salaries. West German politicians, including those from the Christian Democratic—Free Democratic coalition government in power over the last decade, struggle for each minute statutory change that might mitigate the expansionary incentives of fee-for-service reimbursement. An example: the average West Berlin patient who makes an office visit to his private physician is summoned back for four to seven follow-up visits; his East Berlin counterpart receives care in an outpatient department or an ambulatory care clinic, where the physicians are salaried, and he is summoned back for only one to two follow-up visits (Halter 1990). East Germany doesn’t have to worry about those perverse incentives of fee-for-service in the first place.

East Germany has an integrated system of ambulatory and hospital care—something West Germans can only dream about, because office-based doctors are legally forbidden to treat their patients in the hospital, and hospital staff are likewise forbidden to treat their patients outside the hospital. The two groups are for all practical purposes separate professions, and they guard their privileges like territorial monopolies.

The office-based physicians are organized into a powerful network of Associations of Insurance Doctors, which have a government-granted monopoly franchise on outpatient care for the public insurance system. This franchise is called the Sicherstellungsauftrag, a word that somewhat disguises the monopoly aspect, since translated literally it means “the job of assuring the supply of services.” The legal separation of the hospital and office-based professions causes a great deal of duplication of services, especially of preadmission diagnostic testing. Posthospital follow-up care is almost never provided by
the same doctor who treats a person in the hospital. (“Almost never” because the law makes exceptions for the heads of hospital departments and some specialists.)

The major fight in pre-unification debates about health services was over who would get the *Sicherstellungsauftrag* for the former East German territory. Of course, nobody explicitly talked in terms of a monopoly franchise. Instead, everyone talked politely about assuring an adequate supply of services in East Germany.

East Germany has an extensive system of polyclinics and ambulatoria that provide virtually all outpatient care. Polyclinics are multi-speciality outpatient departments usually attached to or affiliated with hospitals, universities, or factories. Ambulatoria are, as the name suggests, ambulatory care clinics operated by cities, states (*Länder*), or workplaces. Polyclinic doctors have staff privileges at the affiliated hospitals, so there is continuity of care between the two sectors.

The organization of health services in East Germany along both territorial and workplace lines is a planner’s fantasy. A system of increasingly sophisticated treatment facilities is laid out to cover increasingly large population bases. First-aid stations, nurse-staffed clinics, physician-staffed clinics, polyclinics, community hospitals, county hospitals, and tertiary care hospitals systematically blanket the territory of former East Germany. In addition, there is a parallel system of factory or plant-based clinics, which offer more or less staff, equipment, and specialty care, depending on the size of the workplace.

Workplace doctors provide primary care for their patients as well as the specialist care they are staffed to handle. Unlike their West German counterparts, they are not restricted to first aid, fitness exams, and monitoring of occupational health and safety. East German citizens, in fact, receive the majority of their primary care at the workplace. In 1987, 7.2 million workers and their family members were treated in workplace clinics; 3.2 million workers and family members were treated in the territorial clinic system (Weber 1990: 90).

The polyclinics and ambulatoria are notable for their integrated, multispeciality care. All have several specialties on staff, with larger ones having more specialties and more sophisticated equipment. West German private office practices, by contrast, are almost entirely solo, one-speciality offices. (Even group practices are almost all single-specialty, because regulations discourage multispecialty practices.) The West German doctor’s office is heavily equipped with expensive apparatus, and there is near universal consensus among everyone but doctors and medical equipment manufacturers that German patients are overdiagnosed and treated with machines. In the state of North Rhine-Westphalia, fully 83 of the state’s 180 CAT-scanners are located in physicians’ offices (Reiners 1990).

The East German system is distinctive, too, for its emphasis on preventive medicine. The polyclinics and ambulatoria provide an array of preventive ex-
aminations for students, workers, mothers, and children. The West German system, to be sure, provides far more prevention than the U.S. system. Every insured person (which means virtually everybody living in the country, not just citizens) is entitled to prevention benefits established by federal law: for adults, general examinations every two years and cancer screening every year; for children, a series of well-child exams up to age six; for everyone, preventive dentistry. But the East German system is even more aggressive with prevention. Mothers are rewarded with DM 1,000 (about $500) if they complete a prescribed series of prenatal exams. Children receive preventive care up to age sixteen. Occupational safety and health standards are much more stringent; monitoring of workers and reporting of occupational diseases is much more extensive (Elsner 1990).

The West German medical profession, especially the Associations of Insurance Doctors, launched a full-court press with the Kohl regime to assure that a monopoly franchise on ambulatory care in the East would be granted to private physicians, even though there were hardly any. At the time of unification, only 395 of about 21,000 doctors were in private practice. The twin ideas of state employment and reimbursement by salary are as abhorrent to the West German medical profession as they were to the American profession in the 1940s, and as state employment still is today. Their fears found a most sympathetic audience in the ruling coalition. Both parties are friends of market competition, and the Free Democrats are known as the party of small business.

There was lively debate in both countries before the unification treaty, and the nature of the integration or “harmonization” of the two systems was still very much an open question. In journals and at conferences and public forums, leaders of West and East German health organizations discussed which parts of the Eastern system were problematic and which should be maintained; whether the East should adopt the Western system of multiple, sometimes competing insurers; whether ambulatory services should be provided through private practice or publicly owned facilities; and what sort of reimbursement methods should be used.

The unification treaty signed on August 31, 1990, closed much of that debate. It granted the polyclinics and ambulatoria a five-year grace period, during which they are authorized as providers for the public insurance system. In 1995, there is to be a determination of whether they are still “necessary to assure the supply of medical services.” The treaty also mandated establishment of local sickness funds to be the residual insurer for all people who do not qualify for alternative funds (these are funds for special occupational groups and white collar workers who earn enough to exempt them from the local funds). The alternative public sickness funds and commercial companies from the West were given free rein to compete in the East. The new system, complete with sickness funds, was scheduled to take effect a mere four months later.
Then the scramble started. Rumor had it that the alternative sickness funds were paying DM 50 a head for names of workers who earned enough to join them. For a while, there were rumors that West German physicians were applying by the hundreds for permits to establish practices in the East. The Associations of Insurance Doctors denied these rumors in some publications; unfortunately, I couldn’t find evidence one way or the other. Even if there were an initial gold rush, however, it was undoubtedly stopped short by later rules that established substantially lower fee schedules for treating patients in the former East German section than those residing in the former West.

West German Associations of Insurance Doctors began to teach the East Germans how to build associations of their own, and more importantly, how to set up private practices. A system of “sister cities” that had been in place since just after the war suddenly bloomed into action—each local and regional Association of Insurance Doctors knew exactly which Eastern territory to take under its wing. The Western doctors put on seminars for the Eastern doctors. They collected used medical equipment to donate to East Germans who wanted to start private practices. A new breed of business consultants emerged, eager to help set up the East German physicians in private practice by explaining the basics: what kind of office they would need, how to rent one, what kind of equipment they would need, how the fee schedules work, how many procedures one would have to do to amortize the machines, pay the rent, and make a living.

The Associations of Insurance Doctors and business consultants were not the only ones fighting for the souls of East German doctors. The medical profession in West Germany is politicized to a degree unimaginable in the United States, and every one of its organizations and factions made a bid to influence the direction of East German medicine. Most doctors belong to two semipublic corporatist organizations: a state Association of Insurance Doctors, in which membership is required to be eligible for reimbursement from the public system; and a state Chamber of Physicians, a self-regulating disciplinary body in which membership is compulsory for all practicing physicians. There are several voluntary, private interest groups as well.

The Marburger Bund, which represents salaried hospital physicians, and the Hartmann-Bund, whose full title is “Union of German Physicians for the Defense of Their Economic Interests,” established sections in the East. The Federal Association of Insurance Doctors together with the Federal Association of Physician Chambers provided East German physicians with ten thousand free subscriptions to their joint weekly magazine, Deutsches Ärzteblatt.

According to Winfried Beck (1990), former chair of the small, left-wing, (West German) Union of Democratic Physicians, West German organized medicine saw four dangers from the East. First, the lower income of East German physicians might undercut the bargaining position of Western physicians. Second, the unified financial administration of insurance offered none
of the possibilities for doctors to play one carrier off against the other in fee negotiations, or for carriers to compete for members by upping the ante on benefit packages. Third, the pluralistic system of ambulatory care threatened the monopoly of private practitioners and their ability to exclude suppliers from the market. Finally, the lack of officially recognized organs of self-government (like the Associations of Insurance Doctors and the Physician Chambers) might weaken the profession's ability to shape the political attitudes of future generations of doctors.

As unification proceeded, not only did West German organized medicine have to fight West German politicians attracted to the cost containment possibilities of the East German system, they had to fight most of the East German medical profession, who were less interested in the professional status politics of the West than in keeping their jobs.

For a brief moment, the East German doctors established their own professional organization, with a name that indicated their commitment to the traditions of public health—the Rudolf-Virchow-Bund—but it lasted less than a year, from November 1989 to September 1990. As Beck (1990) notes, the Virchow-Bund violated two taboos of West German professional politics. It admitted other academic professions besides doctors for membership, such as psychologists and scientists. And it supported the continuation of ambulatory care facilities with salaried physicians.

Most of the West German physicians' organizations steered clear of the Virchow-Bund or attacked it; none offered support of any kind. The West German Association of Private Practice Physicians signed a cooperation agreement with it, forgoing active solicitation of members in the East. At the other extreme, the Hartmann-Bund campaigned for new members in the East and in the process dropped the nuclear bomb of post-Wall German politics: a suggestion that the Virchow-Bund had ties to the Stasi, the East German secret police (Beck 1990).

The future for the polyclinics and ambulatoria looks bleak. The decisions on whether they are still "necessary to assure services" will be made by a licensing committee stacked against them. This committee, another institution from West German medicine, is empowered by government to grant permits to practice under the public insurance system and be eligible for reimbursement. After 1995, polyclinics and ambulatoria will have to apply for permits to practice in the insurance system, just as private physicians would. The unification treaty specifies the composition of the licensing committee for the East German territories: half the seats will be for private practitioners, half for doctors in polyclinics and ambulatoria. As of October 1990, there were a total of nine hundred private practice physicians, so that barely 5 percent of the physicians got 50 percent of the seats.

For East German physicians, adapting to the West German health system will not be easy. More than one-third of polyclinic physicians are over the
age of fifty; if they were to invest in a private practice, they couldn’t pay back their loans and begin to make money before they retire. Of the polyclinic physicians under forty, 70 percent are women. They would find the working conditions of a solo practice rather hostile to child rearing and family life (as do Western female physicians), especially since the extensive state-supported system of day care in East Germany will probably be dismantled for lack of fiscal and political support from the national government.

All East German physicians will find the fee-for-service reimbursement system bizarre and difficult. They are used to thinking in terms of global budgets, but not in terms of making a living by judiciously choosing their mix and volume of services according to a fee schedule. One polyclinic physician told the major national news weekly, Der Spiegel, “We didn’t realize how brutally important money is” (Halter 1990). Just how brutal was calculated by a West German business consultant, who told one of my colleagues that only 10 percent of what an East German pediatrician does is even billable under the West German fee schedules.

Much of what doctors do in East Germany—listen to patients, talk to them, explain, reassure—will disappear, as it has under fee-for-service medicine elsewhere. East German pediatricians typically attend their patients with house calls. Those, too, will probably become just a happy memory. And, of course, utilization rates of all the reimbursable procedures will rise. East German patients will be more tested, measured, injected, irradiated, illuminated, and magnetized. And drugged. An East German surgeon who now practices in the West showed me her catalogues of available pharmaceuticals for the two countries, the equivalent of our Physicians’ Desk Reference. The East German book was about one and a half inches thick, the West German one about four inches. She felt the pharmaceutical armamentarium of the East was fully adequate. There seems to be general agreement that East Germany had some supply problems with certain classes of drugs, such as antibiotics and chemotherapeutic agents for cancer. But West German health experts have concluded that almost a third of prescription drugs on the West German market have not been proven effective (Reiners 1990: 13), and drugs are overused in a variety of ways (Enquéte-Kommission 1990: 499–535).

In the process of unification, former East Germany will acquire more than just a new system and style of medical care. The unified health insurance structure will be replaced with what the West Germans call a “jointed” (gegliedert) system of insurance. Jointed means that there is a complicated coverage and membership structure, with around 1,200 sickness funds divided into legally defined membership categories such as local, craft, factory, agricultural, alternative (white-collar), and commercial. On top of that division is an overlay of coverage categories: health insurance for workers, for pensioners, and for the unemployed, and accident insurance for everybody. All
of these branches of insurance have their own regulations and their own personnel, specially trained and credentialed for the specific kind of carrier. The system is far too complex to explain here. Suffice it to say, strong insurance and physician lobbies carried the banner for “jointed health insurance” in the East, right alongside the banners for “freedom of choice” (for patients to choose their sickness fund), “freedom of contract” (for doctors to bargain with sickness funds), and “self-government” (of sickness funds and doctors’ organizations). How could anyone be against them?

The jointed health insurance system evolved over a hundred years, shaped early on by government concessions to existing insurance organizations, and then by the tenacity of vested interests. By now, policymakers and politicians realize that the jointedness celebrated by employees of the system is the source of many of the system’s troubles. The more jointed the system, the more the population is segmented into homogeneous risk groups and the less risk spreading there is across the population as a whole. Competition between funds for members drives up prices and expenditures. And coverage of a population by such a diverse collection of carriers, each with its own rules and bureaucratic forms, entails huge administrative costs. These are problems all too familiar in the United States, and many West Germans point to us as a warning about where not to go.

Nevertheless, a jointed system is what the East Germans will get. No sooner had the unification treaty called for establishment of local sickness funds and division of health insurance into the branches of workers, pensioners, unemployed, and accident insurance, than the West German local sickness funds detailed mid-level managers to their sister cities to begin laying the groundwork. For them, one of my colleagues pointed out, duty in the East was the career opportunity of a lifetime. If they succeeded, they would become directors of a sickness fund. The new sickness funds would have to be built from scratch. That meant buildings to be rented and computers to be bought, accounting and information systems to be established, channels for collecting premiums to be forged, personnel to be recruited, trained, and hired, forms to be printed. By one estimate, 35,000 new professional personnel would be needed, and that’s not counting skilled jobs in the printing and paper industries. . . . No doubt health insurance will be a major source of new jobs for some of the people losing jobs in other sectors.

Unification cut short passionate conflict in West Germany over structural reform of their own system. A major reform that took effect at the beginning of 1989 had significantly increased patient cost sharing in an effort to keep the lid on total costs, but deeper structural reforms were politically blocked. By U.S. standards, even the new cost-sharing amounts seem trivial—DM 3 or about $1.50 per prescription, DM 5 (about $2.50) for each of the first fourteen days of hospitalization, DM 20 (about $10.00) for transportation to the
hospital or doctor. Still, the felt need for structural reform was acute. Several of my colleagues insisted that the Kohl regime might well have fallen over intense popular opposition to the new cost sharing, but for Gorbachev.

I might not have believed the intensity of that opposition had I not jumped into a taxi one day in Bremen. My part of the conversation consisted of “Good day,” and “Would you please take me to the university.” The driver opened with a speech about how the sickness funds don’t pay for taxi rides to the doctor anymore since the Health Reform Law went into effect, unless the ride costs more than DM 20. Naturally, the taxi concerns fought against this but they couldn’t stop it, and as a result, business was down about 25 percent. (I had been thinking about health insurance somewhere in the recesses of my mind, but I swear not out loud. Of course, I engaged her in the topic all the rest of the way to the university.) She advises her passengers to save all their receipts, because all those little two Marks over the twenty-Mark deductible add up, and you should get what you’re entitled to from the sickness funds. She acknowledged that the taxi benefit was often abused by patients “with band-aids on their fingers,” but she also had her horror stories about callous doctors who would not certify that a taxi ride to the office was medically necessary. By the time I got to the university, I was reeling; my taxi driver was lobbying me without a clue that I actually care about health insurance, and I could only marvel at the length of the health insurance gravy train in Germany.

Signs of the gravy train are everywhere. I stepped into a health and fitness spa in Bonn to inquire whether I could have a swim and a massage later on. I was handed the business card of Mr. Bruno Schneider, government-licensed masseur, therapeutic swim master, and sports physiotherapist, all sickness funds accepted. I picked up a copy of *DM*, a yuppy money-management magazine much like *Money* in the U.S., because it was a special issue on assessing your insurance needs. Inside was an article advising readers how to take advantage of their sickness fund prevention benefits, especially how to use them to pay for health and fitness club memberships.

When I still questioned one of my colleagues about his assertion that the Kohl regime was in trouble over its cost-sharing increases, he tried to impress on me the strong sense of entitlement that grows from one hundred years of ever-expanding insurance. Aunt Hildegarde paid into the system all her life, why should she have to pay five Marks a day for hospital care? Her grandmother and great grandmother paid their premiums and got their care. Why shouldn’t she?

I asked many people why West German Social Democrats, Greens, and public health reformers and East German health care workers and citizens didn’t put up more of a fight to preserve the good parts of the East German system. In part, I was told, the big decisions were made swiftly behind the scenes in Bonn, so opponents of a total West German solution didn’t have
much chance to fight. One colleague invoked the age-old strategic handicap of the Left: while the Left sits around discussing the alternatives ever so democratically, the leadership of the Right is able to impose its favored solutions from the top and inevitably beats the Left to the finish line.

As for the East German physicians and health care workers, they were by all accounts in a state of shock. Though they attended seminars put on by the West German physician organizations, they were overwhelmed, numbed into silence. A press release from the Association of Insurance Doctors in Schleswig-Holstein reported that even though 540 East German doctors had attended its recent conference, many of them probably had no intention of setting up private practice but were attending “just to find out which direction the train was running” (Ärzte-Zeitung 1990). A colleague told me of a seminar put on by Left occupational physicians for factory physicians in the East. When the seminar leaders asked the audience to talk about how they perceived their self-interest in the future health system, the East Germans were unable to talk. “They weren’t used to having a self-interest under the Communist system, let alone talking about one.”

With massive unemployment looming in East Germany, health care workers were worried about economic survival more than anything else. They were more interested in whether the polyclinic would be there at all than in discussing the fine points of fee schedules, even though the schedules would determine their economic fates and practice styles should they set up private practice.

Near the end of my stay, I tried out the occupation metaphor on a fellow passenger in the S-Bahn who had told me he was East German. He spent the rest of the ride trying to disabuse me of that view of things. He saw unification as an opportunity for the East, a chance to modernize and have better economic conditions. He was, it turned out, twenty years old and studying engineering at the Technische Universität in Berlin, West Germany’s premier engineering school. I suspect that age makes all the difference in how East Germans see unification. If you are young, haven’t yet invested years in acquiring skills and learning the ropes of a social system, and haven’t yet held a job you might lose, unification might indeed be a brave new frontier.

When I returned home, I tried out the occupation metaphor on James Morone, editor of this journal. He told me I had been away too long. He reminded me that from the U.S. perspective, the collision between capitalism and socialism that Germans see in their health sector looks more like a fender-bender. After all, both systems have socialized the costs of medical care almost fully; and both have such extensive state involvement in the legislation and regulation of health care that they are heavily centralized by comparison with the U.S. The U.S. has never had the luxury of suffering from whatever problems West Germany might be spreading in the East.
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