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Overdramatization of the Burdens on Health and Social Services: A Continuing Debate in the History of German Medicine

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**OVERDRAMATIZATION OF THE BURDENS ON
HEALTH AND SOCIAL SERVICES: A CONTINUING
DEBATE IN THE HISTORY OF GERMAN MEDICINE**

Norbert Schmacke

Departing from the latest academic research into Nazi medicine in Germany, the author looks at theoretical and ideological concepts in German history that left their mark on the formation of race hygiene. He argues that the overdramatization of the economic burden caused by the special requirements of the chronically ill and handicapped runs through all epochs of modern medical history and that this culturally pessimistic way of looking at a serious social problem in Germany reveals a frightening tradition which reached its cruelest climax in the so-called T4 operation of the Nazis. The author makes a plea for this dark chapter of German medical history to be carefully analyzed and for the results of this research to be used in the current discussion on the further development of the health system, particularly in regard to patients who require special care.

Between 1940 and 1945, the offices at Tiergartenstrasse 4 in Berlin (T4) functioned as the headquarters for a massive government-run operation designed to register and kill approximately 200,000 psychiatric and chronically ill patients. Psychiatric clinics had to fill out questionnaires about their inmates, which were then used to determine which patients were to be considered irrevocably unfit for work or untreatable. With these questionnaires, physicians made life and death decisions. This government-controlled operation was run under the name "euthanasia," and until today, T4 is synonymous with the mass elimination of mentally and physically handicapped people during the Nazi era (1). In view of the brutality and perfectionism of the T4 murder campaign, one hesitates even to ask how far the historical development of the theory and practice of modern medicine can be understood against the background of these Nazi crimes. However, there are several reasons why we need to pursue the nature of these relationships if historical research is not to be misunderstood as the analysis of a closed historical period with no continuing significance.

THE CONTINUING EFFECTS OF SUPPRESSION

The primarily nonacademic research of the past decade has established that the Nazi regime's acts of annihilation cannot be seen as merely an expression of the organized madness of society. An analysis of the T4 operations, especially, reveals the therapeutically motivated impetus for modernization, which saw the murder of the "not therapeutically treatable," particularly those patients unfit for work, as an integral part of an overall therapeutic concept. At the same time, this concept included healing at all costs using aggressive methods of therapy such as introducing electric and insulin shocks to separate the "curable" from the "incurable."

The available results of research today leave no doubt that the medical crimes of the Nazi regime cannot be understood without their ideological predecessors. Long before 1933, biologism, social Darwinism, and economic thinking had merged in large areas of the public health and social welfare system. The racist hygienic ideology of "elimination," which directly prepared the way for the murder operations of the Nazi era, was based on a broad social consensus emanating from various sources. Scientists, doctors, and psychiatrists were the main participants in this gradual abandoning of the right to human life and the subsequent liquidation of the "burdens of existence." They acted out of idealistic convictions and were by no means forced into popularizing and participating in the planning and execution of mass sterilization and murder operations.

Looking for signs of continuity in order to critically observe the present must mean more than showing the frequent alarming parallels that have occurred in the postwar era. Perhaps the most striking example of this is the growing debate about euthanasia, often conducted under the misleading term "mercy killing." To expose the continuity between Nazi and contemporary medicine, we need to understand the dialectic interaction between social reality and opinion-forming theories and the ensuing inquiry into the fundamental attitudes that still allow the professional health and social welfare system to label chronically sick and non-productive individuals as a "burden" on the whole of society.

The question of historical continuity still touches a deep-seated need to suppress historical truth. It must be remembered that, after the war, Nazi culprits were, in a variety of ways, entrusted with important tasks. A case in point is the psychiatrist Villinger who worked as a T4 and genetic-health court expert during the Nazi era.¹ After the war and with the consent of the American occupation authorities, he was able to draw up a new sterilization code, which went beyond the Nazi race law in the area of medical grounds for treatment. Furthermore he

¹ Werner Villinger (1887–1961) was senior consultant at the psychiatric hospital in Bielefeld from 1934 to 1940 and professor at the psychiatric hospital in Breslau from 1940 to 1945. In 1946 he became a professor at the psychiatric hospital in Marburg. A few weeks after the court hearing on his role in the Nazi era, he fell and was killed when mountain climbing. Insiders spoke of a planned suicide.

became a doyen of child and youth psychiatry in the former Federal Republic of Germany and was significantly involved in the development of the organization Help for the Mentally Handicapped founded in 1958.

Villinger played an important role in the creation of a new sterilization law after 1945 (2, 3). He believed in the continuing necessity of a "eugenic" sterilization law, ruled out any negative consequences from forced sterilization—which also served as the basis of argument against demands for compensation—and in this respect apparently saw no reason to mention in his 1961 textbook on psychiatry his own role during the Nazi era.

While open denials of guilt can still be heard today, people like the President of the Federal Medical Association, Vilmar, are representative of a more modern form of "coming to terms with the past." The rejection of a collective guilt, a concept originating in the immediate postwar era, was, with the general support of the medical profession, reintroduced by Vilmar into the present debate on the role of the medical profession in the Nazi state. By using distorted quotations from well-known anti-fascist scientists such as Mitscherlich and Kogon, Vilmar made them the main authorities for a new apologia for the doctors of that time. Vilmar went as far as to question the extent of the German medical profession's involvement with the NSDAP and even presented party membership as a matter of "keeping up appearances." This ultimately led to an entreaty not to forget the past, including the role of doctors in Nazi crimes. Such an entreaty appears to directly contradict the tendency of the medical profession to refuse responsibility in cases such as development of the elimination ideology. In this light the debate about the Nazi era appears as a closed chapter (4). Only after 30 years of scientific work and political opposition did the German Medical Association in 1996 finally assume responsibility for the role of the medical profession during the Nazi era (5).

One still sees a reluctance in Germany to tackle the question of continuity by ignoring the terrible "normality" that masked the barbarities of the concentration camps and the murder institutions. It is important to consider that overdramatizing the burdens on the health and social services prepared the way for the elimination operations, and analyses of similar attitudes and patterns in the present must include a genuine attempt to learn from the past.

THE MYTH OF HEALING

Since the advent of science-dominated medicine, the enlightened and progressive optimism of the medical community, as well as of society in general, has been linked with the idea of curability or incurability of disease. Despite the experiences of the Nazi era, the psychological, social, legal, and economic consequences of this intellectual separation of curable and incurable have been largely neglected. For doctors themselves, and for the general public, the curing of illnesses has remained the most fascinating aspect of the medical profession. This

is reflected daily in the overall system of personnel and material resources, the training of medical students, and the separation of medicine and nursing. It is sometimes argued that in the 1980s the success of the growing self-help movement in the health service lay in its inherent critique of the established professional and science-dominated system. This is not the place to deal with the range of influence engendered by self-help thinking. It is possible to conclude, however, that the surprisingly large number of diverse self-help groups was not successful in altering the fundamental perception of the health system.

Nevertheless, the merciless logic of the T4 operation is best understood when viewed within the context of an unbroken belief in the progress of an all powerful medicine. This logic led to the rigorous separation of curable patients, who could be treated by means of active therapy, from incurable patients, who forfeited their right to treatment because they were perceived as a burden on society. It is along these lines that doctors of the Nazi era interpreted and realized Binding and Hoche's 1920 thesis "The Freedom to Exterminate Unworthy Life" (6).

What is required is a thorough investigation of the psychodynamics that influence medical thought and behavior, especially when medicine's promise of cure cannot be kept. Such an investigation would no doubt reveal the degree to which therapists are confounded by the multitude of illnesses, which, due to theoretical limitations, are simply not curable. Clearly therapeutic "failure" inspires many to look for more radical solutions, a connection not discussed in medical studies. Thus it is not enough merely to condemn the myth of healing without at the same time accounting for the power of that concept, which comes from the desired and partially forced separation of curable and incurable patients.

Doctors and therapists rank spectacular diagnostic and therapeutic operations much higher than alleviation of problems less amenable to treatment and often more difficult to bear, such as caring for the weak and infirm in nursing homes, looking after chronic psychiatric patients, or caring for the dying. The psychiatrist Ehrhardt, in one of the first comprehensive works on "euthanasia" to be published after 1945, dealt with this problem as follows (7, pp. 52-54):

When, in the interest of a humane community, the killing of the weak and the sick must be rejected in favor of the promotion of the necessary communal principle, then the concrete question arises as to who will look after the many patients who are insane, epileptic, mentally deficient, or senile. However, whether these difficult tasks can ever be properly managed without the selfless commitment of religious idealists seems very doubtful.

In Ehrhardt's work, not a word is said about the defects in the supply system of institutionalized psychiatry in the 1960s or about the necessity and possibility of support from family members and professional helpers. And finally, his work also ignores the relationship between the history of the exclusion and extermination of these same groups of patients and the manner in which orthodox German

psychiatrists exercised their therapeutic role. The gap between medicine and care, between therapeutic promises and detention practices, still persists today. Doctors, psychiatrists, and therapists tend to locate the question of the value of human life within the sphere of religion instead of making it a matter for medical self-reflection.

In contrast, doctors feel themselves called upon to play the key role in solving ethical conflicts in research, diagnosis, and therapy. In the last few years this has resulted in a rapid increase in so-called ethics commissions. In "Behind Closed Doors," an analysis of such commissions in U.S. hospitals, Lo (8) maintains that the exclusion of nonmedical professionals from these commissions reaffirms the status of patients and their relatives as mere objects of medicine.

Among other things, ethics commissions are increasingly dealing with the question of so-called "therapy limitation" in cases of grave illness. In 1987 the journal *Lancet* reported on a medical conference on this topic which emphasized that people who declare their conscious choice of "therapy limitation" (e.g., renouncing the use of intensive medical measures) often do so in a state of perfect health (9, p. 63):

Many people take such steps not only for their own protection, but also because they do not want to encumber their relatives and friends with a long period of care and nursing. Moreover, they do not want to take advantage of medical supplies which are of no use to them and which they would be taking away from others.

In Germany, ethics commissions, based mainly in the medical departments of universities or in state medical councils, are concerned almost exclusively with research that is dominated by pharmacological studies. So far, health authorities have mostly overlooked ethical questions dealing with diagnostic and therapeutic conflict situations (10).

This implies that the existing social conditions determining the treatment of the severely ill, those in need of nursing, and the dying shape attitudes of the general public and health professionals toward long-term care, death, and dying. The economic parameters of the health service affect the level of immediate allocation of resources and consequently the degree to which health professionals can gain experience in general and specialized training. This is especially true for the promotion or hindering of creative ideas in coping with serious problems in medicine and nursing.

ILLNESS AND HANDICAP AS A SOCIAL AND EMOTIONAL THREAT

Irrespective of the changed morbidity spectrum, the concept of the chronically ill as a "strain" on the health care system remains significant. The history of

medicine is steeped in prophecies of social and economic collapse through rampant mass illnesses. In the preindustrial era, the plague and syphilis were symbols for the downfall of society. Throughout the period of the German empire, and even more so in the Weimar Republic, the medical profession and the general public saw hereditary diseases, both real and supposed, as a sign of warning. In the postwar period, after overcoming the first great economic and social upheaval, the theory of "civilization illnesses" was adopted from England and the United States, and has been kept alive up to the AIDS era. Whereas changes in the spectrum of illness—brought about by the containment of serious infectious diseases such as tuberculosis—have been uncritically attributed to advances in medical science, chronic and debilitating illnesses have tended to be regarded pessimistically as by-products of cultural decay. This perspective has culminated in the developing debate about shifts in German demography, their possible redirection, and their financial strain on society. As a consequence, the 1980s gave rise to fundamental doubts among both politicians and the medical profession about the financial viability of the health and social services. In 1988 the German Minister for Labor formulated the defense of his policy as follows: "Intelligent people have worked out that, by the year 2098, the entire gross national product will be needed to finance the continuing expansion in health insurance costs" (11).

The "cost explosion in the public health system" has become an almost generally accepted concept in Germany, generating a scenario centered around the overburdening of society by the old, the sick, and the handicapped. Changes in the population's age structure have resulted in wildly differing projections as to the number of elderly people that will eventually be in need of care. According to data from the U.S. Centers for Disease Control, estimates for the number of old people in the United States needing long-term care in the year 2000 vary between 9 and 15 million (12). In all developed industrial societies with high average life expectancy, senile dementia has become a center of attention for the medical profession and the general public. In a series of publications dealing with Alzheimer's disease, researchers have noted with alarm that more than 15 percent over-85 year olds are demented and thus in need of a high degree of care (13). Despite general acknowledgment of this situation, which proves especially difficult for the relatives of senile people, there is not sufficient support for working models of relief and rehabilitation. At the same time, the progress paradigm has reappeared in the medical debate: in Alzheimer's research great expectations are being raised by animal experiments in which investigators are attempting to implant nerve cells in the central nervous system, with the hope that healthy nerve tissue transplants can eventually be used for the treatment of Alzheimer's patients (13, p. 80). Discussion among experts and the public focuses on spectacular medical interventions which on the basis of present-day knowledge must be classed as scientifically vague and ethically problematic.

While it is indisputable that the percentage of elderly people in societies such as Germany will continue to increase, scenarios depicting the early exhaustion of social resources by an army of old people needing complete care are irrational. The revived image of infirmaries strengthens existing fears and produces feelings of helplessness and encumbrance in society. The development of outpatient models for the help and care of the aged has long been regarded almost exclusively from the aspect of cost. Only during the last few years has a discussion about providing graded supply models—from home care, day help, and temporary care to permanent inpatient care—attracted attention. The additional funding for outpatient care, made available through the 1991 reform of the public health law and designed to give partial relief for those bearing the costs of social welfare, can at best be considered a modest first step in the direction of financial security for long-term home care. This issue will determine whether, for the first time, the legal and social separation of the ill and those in need of care—of the “curable” and the “incurable”—can be abolished.

Largely unnoticed by the general public, radical solutions are again being considered and proposed. At a 1985 conference of the Jungius society in Hamburg, the population expert Juergens (14) gave a talk on the “Regulation, Manipulation, and Explosion of Population Density.” Juergens presented calculations on the burden on society represented by the elderly and the now unaffordable retirement and health services. He proposed—as a possible starting point in eliminating the “mountain of old people”—that “death should be at a person’s disposal.” Juergens linked his proposal to the Eskimo custom of abandoning old people and to the Japanese tradition of “suicide out of responsibility.” According to Juergens, however, the introduction of such measures in Germany would have to be preceded by “a manipulation of social ethics” (14).

This contempt for the value of elderly life appears to justify many of the concerns critics have raised in the present debate on euthanasia in Germany. Doerner (15) anticipates that continuing this adopted course would warrant concern about societal expectations that all handicapped, incurable, and old people should consider it an act of decency to accept death from the medical representatives of science.

Here one is reminded once more of the writings of Binding and Hoche from the year 1920: “Are there lives which have so clearly forfeited legal protection that their continuation has forever lost all value for the people themselves as well as for society?” (6, p. 51). And together with the psychiatrist Hoche, Binding answered the question in the affirmative for people who had cancer or tuberculosis, were mortally wounded, or were “incurable imbeciles,” who were also described as “empty human shells” and “burdens of existence” (6, p. 59). In 1923, Hoche wrote in Binswanger and Siemerling’s psychiatric textbook (16, p. 245):

Caring for thousands of mentally dead people puts an enormous burden on a society which is fighting against economic disaster without getting anything

worthwhile in return. A more sophisticated morality of a hopefully not too distant future will approve of the elimination of totally worthless life.

One must also remember the intention of the Nazi regime to replace the obviously criminal T4 operations with a legal regulation of "euthanasia." The bill was entitled "Law on Euthanasia for Those Incurably Ill." In paragraph 1 it states: "Whoever is suffering from an incurable disease, one that is a heavy burden on oneself or on others, or one that will certainly lead to death can, at his express request and with the permission of an especially authorized physician, be administered euthanasia by a physician." And in paragraph 2: "The life of a person, whose incurable mental illness would result in life-long custody, can be ended imperceptibly by medical means."² Those who, after long hospital observation and use of all available modern therapy practices, were deemed completely incapable and "incurable" should be killed. None of the consulted experts expressed any kind of fundamental dissent in the discussions.

The question of continuity in the current debate on euthanasia also requires a reconsideration of the popularity surrounding the film "I Accuse," made in 1940–41 in cooperation with Hitler's chancellery. The film dealt with the question of euthanasia, using the examples of a doctor's wife suffering from an advanced stage of multiple sclerosis and a girl whose survival of meningitis had left her blind, deaf, and severely mentally handicapped (18, 19). An analysis of this propaganda film leads to the crucial recognition that the issues of "mercy killing"—death on demand—and the killing of people whose lives are considered unworthy because of handicaps are still inextricably linked. Both in the current ethical discussion on questions of intensive care at the beginning and end of human life and in the highly emotional argument about the relief of uncontrollable pain and suffering, one gleans that "mercy killing," whose advocates are trying to change the current penal law, actually means homicide and that the question "killing on *whose* demand?" rightly points to an incapability and lack of willingness to endure severe suffering and serious handicaps. This continuing debate on mercy killing gains its dangerous power from the amalgamation of economic considerations and the emphasis on supposedly uncontrollable individual suffering (20). The latter frequently motivates jurists to break the taboo on killing through legal exceptions. Thus, in 1986, the German jurists' conference expressed its fundamental opposition to a change in the current law but at the same time decided: "It is to be recommended that there should be provisions for the court to be able to refrain from punishment in cases of death on demand if the killing is carried out with the intention to end a situation of unbearable suffering"

² The origin of these legalization plans was described by Roth and Aly (17). It can be deduced from the document's appendix how willingly the psychiatric experts took part in this debate. Roth and Aly reconstructed the text of the individual sections (the state of the probable final draft of October 1940). The law was not passed.

(quoted in 21). The fact that, at certain times of historical crisis, the motif of suffering could be so easily linked with economic and social Darwinist ideas has until now not been considered with the necessary clarity by either doctors or jurists.

In the past few years Holland seems to have started one of the largest euthanasia operations of modern times—obviously under the moral label of compassion and in response to a supposedly widely articulated need for death on demand. Even though the societal and theoretical background in Holland is far removed from the ideology of Nazi social Darwinism, the operation displays a troubling dynamic in which sincere motivations and definitive medical grounds for treatment do not seem easily maintained. It is estimated that each year since the beginning of the 1980s, between 2,000 and 10,000 people in Holland have been killed by doctors without any legal authority. This has been possible because of an apparent ethical consent within society at large—the criteria mentioned are total willingness on the part of the patient and confirmation of the medical grounds by a second physician (see 22, 23). Naturally it cannot be ruled out that the extent of such activities is comparable in other societies and countries without being widely discussed by the medical profession and the general public.

AIDS: A TEST OF LEARNING CAPABILITY

Until a few years ago, statements about changes in the age pyramid and the cost of medical progress, especially in the area of intensive care, dominated the discussion about the "overtaxing" of the health and social services, but today the argument about AIDS takes on more and more importance in society. We find the same irrational patterns in frightening proximity to each other that helped to bring about radical "solutions" in the past. Fear of an uncontrollable spread of this illness has left its fallout and has caused reaction in all areas of society. Contrary to all normal procedures of epidemiology, researchers and health authorities are using cumulative statistics for AIDS. A similar computation of the frequency of heart disease or lung cancer would immediately illustrate very clearly the problem in such a line of action.

A rational information program about the main methods of infection and the possibilities of protection is constantly being undermined by panic-producing reports about hypothetical or insignificant ways of becoming infected. AIDS takes on a doomsday scenario in which the terrors of pestilence, cholera, and syphilis are all put in the same basket. One still witnesses, under a fragile mantle of tolerance, a sense of repugnance and feelings of hate directed toward homosexuals, a situation in which this "perverse" sexuality is regarded both with aggression and with self-interest. On the one hand, the frequency of illness among homosexual men is viewed as punishment for "unnatural" behavior, while on the other hand the fear-driven interest of the general public concentrates on the question of how widespread HIV infection will become.

At the same time, statements in both the general press and medical journals swear to the immeasurable increase in costs for the treatment of AIDS patients. No plausible reasons are given why AIDS, compared with other conditions, depletes the resources of industrially developed nations in their ability to finance health services. In this context Kirchberger (24) pointed to, among other things, the parallel problem of financing dialysis treatment for renal insufficiency, a form of therapy which, in the early 1960s, was also discussed from the cost perspective and was initially withheld from older patients and those with multiple diseases. Today the question of "dialysis or transplantation" is still discussed in financial terms, but in societies like Germany dialysis has become an integral part of health care. Such experiences are seldom adequately considered in the current AIDS debate. Thus the rather rousing memorandum of the AIDS clinicians Stille and Helm is an example of a problem taking an apocalyptic turn (25, p. 239):

Because of AIDS certain private insurance will no longer be financeable. Vital banking interests are also affected by AIDS. When 10% of potential property buyers are dead, a further high percentage chronically ill or discouraged, then it seems inevitable that—at least in the long run—the property market will collapse because of AIDS.

Insufficient awareness of other significant problems in the area of prevention and therapy for the HIV afflicted in the poor regions of the world is only an apparent contradiction.

Osborn has described the danger of excluding HIV-infected and AIDS patients on the basis of prejudice and fear as follows: "Political strategies which are governed by overreaction are in danger of building walls around sick people and tormenting them, and even the most stable democracies may not be strong enough to withstand such exclusionary forces" (26). This way of thinking not only gives rise to punishment fantasies, demands for mass examinations, and compulsory registration, but simultaneously paves the way for considerations of euthanasia. Such demands are likely to gain more force as a considerable number of AIDS patients, at certain stages of the disease, require substantial medical and nursing services, and damage to the central nervous system in many patients impairs both their vital functions and their ability to make their own decisions. How these patients are dealt with will demonstrate the extent to which our society is able to learn from the past. This would mean promoting the available positive models in caring for those most in need, and thereby counteracting the idea of seemingly unsolvable problems. Fortunately, caring for AIDS patients has become a more integral part of general health care in countries of the northern hemisphere during the past decade, a development that is an important step toward a more civilized and humanitarian system of health care (27, 28).

Economic considerations are not the only obstacles to overcoming problems in the care and medical treatment of patients such as those with AIDS. Also

important are established behavioral and mental attitudes among professional helpers. In this context, a description of the hospice movement in the United States shows that even though physicians gladly transfer gravely ill patients—including, in recent years, many with AIDS—to hospices, they often relinquish immediate responsibility in the actual care of these patients (29). The authors attribute this mainly to doctors' basic problems in dealing with the dying. During their training, doctors should learn not only how to cure illnesses but also how to care for those patients who cannot be cured (in the orthodox medical sense). The authors conclude that physicians should, above all, learn to understand "why dying patients make them so uncomfortable" (29, p. 378).

SOCIETAL WEALTH AND POLARIZATION

U.S. medical journals have more thoroughly analyzed the conflicts underlying the health and social services, making them transparent for both experts and the general public. In Germany prominence is given to the economic burdens caused by the rapid progress in medical research, diagnostics, and therapy, but the social consequences of this progress are a great deal more serious in the United States. This is due to the lack of comprehensive social insurance and the high costs of private health care, which make general access to medical services difficult. And this does not apply only to a significant part of the unemployed population; in the 1980s the percentage of uninsured also increased among those in regular employment. All in all, around 15 percent of Americans today do not have full health insurance coverage. At the same time, the increase in spending on health care has had no positive influence either on the state of people's health or on the supply of medical care. The United States ranks 15th in the world in male life expectancy, 7th in female life expectancy, and 13th in infant mortality. Low-income workers spend up to 25 percent of their budget on health costs (30–32). Budget cuts during the Reagan era made access to medical services even harder and increased the number of people with chronic illnesses and disabilities who are insufficiently or not cared for. Thus political decisions have a clear role in generating problems which then appear no longer financially tolerable or solvable. In a society with a huge and ever-growing medical-industrial complex, internationally recognized fundamental principles for the care of chronic psychiatric and geriatric patients are coming increasingly under pressure. Home care is inadequately financed by private health insurance, and nursing homes of often poor quality take on the character of a final destination for long-term patients (29, 33).

In this context, psychiatric reforms in the United States are of special importance. From 1955 to 1985, under "dehospitalization," the number of psychiatric beds was reduced from 560,000 to 116,000. Yet there is general agreement among critics that social-psychiatric outpatient services simply cannot make up for the resulting deficits. In 1987 Visotsky wrote: "The problem lies in the mobilization

of the political, administrative, and financial resources necessary to run such a system." He concludes in dismay: "The stigma of mental illness which had recently been on the decrease, has gained new impetus with the public exposure of seriously ill patients without adequate attention, shelter, food, or care, wandering or sleeping on our streets" (34, p. 1662). It is precisely this vicious circle, produced by society, which becomes an insurmountable hurdle in the integration of the most disadvantaged chronic psychiatric patients. Even though the situation in Germany is different and much progress has been made through reforms in psychiatry since the 1970s, there are still massive shortcomings, the elimination of which is always contested by the cost argument. The increasing impoverishment of a large number of long-term drug addicts in the last few years has helped illustrate how the overdramatization of the burdens on society and basic fatalistic positions mutually reinforce one another when it comes to problems of accommodation and insufficient supply of therapy. On the other hand, the extremely high costs in other areas of the health system remain essentially unchallenged (30, pp. 611-613).

In Germany the "cost explosion in the health services" has by now become embedded firmly in the public consciousness, even though it can be shown that total expenditure, measured against the development of gross national product, has remained relatively stable since 1975 (35). With the exception of a few marginal areas, health system research has recently been limited to areas of economic interest. Moreover, the general population and patients see themselves as having a right to health services, and this is a key factor in the perception of problems in the health care system. The problem is aggravated by the fact that until very recently, decisions on medical spending have been left to physicians and hospitals without being critically questioned by either health insurance agencies or the government. This has helped to bring about a massive promotion of the "medicalization" of life, which has been significantly determined by the economic interests of the medical industry. Today, more than ever, health and social policy depend on the regulating forces of the free market, and the considerable problems in the health systems of failed socialist countries seem to confirm the opinions of those who promote advancement of a market economy in this area.

A look at the considerably more polarized situation in the United States shows how wide the gap can be between highly sophisticated medical services and completely inadequate care under market-oriented conditions (32, 36, 37). The problem of discussing the distribution of resources in the health services with a focus on cost explosion and public expectations soon becomes evident. Basically, the issue is not about prioritizing the humane use of modern diagnostic and therapeutic procedures. The use of highly specialized medicine with all its questionable implications is not a matter for discussion in those sectors of the population with high incomes and adequate insurance. Much more to be feared is that, by stirring up feelings against an alleged "luxury medicine" and the misuse of

medical services, the level of basic health care will suffer. However dominant the particular interests of the large health insurance companies may at first remain, social welfare will be increasingly burdened with the social and financial management of poverty, even though it can be argued that people's right to social services is now legally protected and consequently any *random* lowering of standards in the care of the sick and elderly cannot be carried through. Nevertheless, present social policy in Germany is consciously accepting a widening division in the social system, which is based on participation in long-term gainful employment. Those who cannot adequately meet the demands of the working world will be referred to the services of the welfare system, which will become considerably curtailed in the next few years without some basic changes in the distribution of wealth in society. The question of restoring and safeguarding both outpatient and inpatient care will remain an important touchstone, a problem whose dimension has until now been either suppressed or exaggerated.

On the question of costs, only a sophisticated approach can cope with today's challenges. Cassel and Neugarten recently raised concerns about one-dimensional interpretations (38, p. 80):

Many factors are contributing to the rise in health care costs, including general inflation, the rapid escalation of physicians' fees, and the mushrooming costs of hospital care, as well as the increase in the number of old people with their needs for health care.

And, as they point out later in their chapter, it is rarely appreciated that the large expenditure in the last year of life is much more likely to be for persons aged 65 to 80 than for the very old (38, p. 81), as Scitovsky (39) first described in 1984.

THE CHANCE TO UNDERSTAND HISTORY

The question of the continuing effects of the health and sociopolitical traditions of the Nazi era cannot be approached constructively if this epoch is perceived as a hermetically sealed period. Narrowing one's focus on the obvious barbarisms in Nazi Germany—operations in which physicians participated extensively—also presents an obstacle to knowledge. At the same time, the perception and analysis of the full extent of human extermination in the Nazi era are still insufficient.

Even though we must be cautious in making any direct comparisons with the ideology and practice of German National Socialism, we also have a responsibility to investigate the roots of racist eugenic and economic thinking and the continuation of such beliefs. In the present deep and enduring social and economic crisis in Germany, and against a background of global ecological catastrophe and the start of a worldwide mass migration that increasingly affects our cities, we still need to demythologize the continuing overdramatization of the strain on our health and social welfare system and confront new

"radical" solutions as early as possible. Knowing that such efforts can lead to success—some examples are the relatively widespread resistance to the authoritarian AIDS policy visions of exclusion and quarantine, and the social psychiatric movement that started in the 1970s (40)—works as a catalyst in the reaction against historical fatalism. However, we cannot understand the present without knowledge of the 12-year Nazi regime and its origins. Although the process of unification has changed the focus on history from Nazism to Stalinism, any effort to gain a comprehensive understanding requires the consideration of both. Acquiring such knowledge is the most decisive step in addressing the question of historical continuity.

Note — This article is a revised and extended version of a lecture given on March 24, 1988, in the Staatsarchiv Bremen in the context of the exhibition "Aktion T4 1939–45: Die staatlich geplante und durchgeführte Vernichtung 'lebensunwerten Lebens' im Nationalsozialismus" (The government-planned and executed elimination of "lives unworthy of living" in National Socialism). Translated by Sean Mullan and Jutta Rateike-Fear.

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