Cooperation Between Different Professions and Lay Personnel

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One of the pet ideas of the 1970s was more cost-effective care by means of greater co-operation. We admire the multidisciplinary group practices in the United States and the health centres in the Netherlands and the United Kingdom, and it is difficult to understand why the Federal Republic of Germany should not be able to keep up with these countries. In fact we have only small two-doctor partnerships and widespread sharing of expensive technical equipment; there is little patient-oriented teamwork.

In this paper I shall first give some reasons for this relative lack of co-operation in German public health care, and then call into question some of the team initiatives in the 1970s. Thirdly, I shall describe the more promising starting point of recent developments towards co-operation between physicians, welfare and lay personnel. Finally, I shall analyse the chances of these new initiatives having a good cost-benefit ratio.

Why can we not keep up either with U.S. group practices or with the Dutch health centre movement? Is the German physician a sort of monomaniac entrepreneur, lacking the well-known Anglo-saxon spirit of teamwork?

Man acts and reacts because of severe necessity or very strong incentives (as Oscar Wilde said: "I can resist everything except temptation"), or because desired benefits are easily obtained. The starting point of the U.S. group practices was mere necessity. American surgeons offer out-patient care four times more often than do surgeons in Germany, and anaesthetists do so 35 times more often. Both the surgeon and the anaesthetist absolutely need easily available support from those engaged in other disciplines.

Another reason for the lack of teamwork in Germany is that we have a two times higher ratio of general practitioners. Their best offer is confidentiality, personal understanding, which does not necessarily dovetail with teamwork. A third reason is that German physicians who are fond of co-operation simply work in a hospital. The ratio of such physicians to others is one and a half times higher than in the United States.

The preconditions for teamwork in Germany are therefore directly inverse to those in the United States. Concerning the Dutch health centres, we had neither the strong incentives nor the facilities of well organized first-line social services such as the Cross organizations in the Netherlands.

During the 1970s many young physicians in Germany were fascinated by the concept of the health centre because it was largely in line with the new para-
digm of medical care, i.e. priority of prevention, and treatment of chronic and psychosomatic diseases. Some physicians imported the health centre concept, but quickly got into trouble, in part because of incompatibility with the established health system.

Sectors of the public health administration and trade unions also issued plans, programmes and models of teamwork. The catchwords were integration, centralization and intersectorial co-operation. Paperwork proliferated; expert assessments were ordered, but ideas were seldom implemented. Judging by a bird's eyeview today, I think that a strong necessity for co-operation has not really been demonstrated. There was much lip service to the idea and even more strategies. Operational research was often a committed rather than a sceptical supporter of greater co-operation, piling up a host of data with no evidence at all, and seldom proving greater cost-effectiveness of co-operation on the full scale of intervening variables. Most of this research ended with the refrain that further research was needed.

Today, however, we are observing new initiatives that have a more promising starting point because they answer an obvious need in respect of a co-ordinated set of different services for the care of severely handicapped patients, e.g. retarded children, cancer patients, the elderly, the mentally ill, alcoholics, drug addicts and other fringe groups. All of these groups need close co-operation between three different services: medical treatment, rehabilitation services, and support of daily activities. Specialized medical care alone will never permit full reintegration of the handicapped into daily life. Rather it must be supported by rehabilitation services, and neither can be successfully applied if there is no help in respect of daily needs and activities.

Up to now, such patients have mostly been cared for in hospitals and other institutions, which thwarts re-integration into social life owing to the side-effects of hospitalization. In fact, ambulatory care that keeps the patient within his social environment is the most direct way to optimal reintegration. The problem here is to organize the necessarily permanent and comprehensive set of services between service providers who, by tradition, operate in quite different institutions.

Some doctors have coped with this difficulty. They work in a team providing the medical treatment and the necessary co-ordination of the rehabilitation services. The latter services are offered by welfare personnel team members – together with the family, the neighbours or self-help groups, i.e. lay care that renders daily life outside of hospitals and other institutional care units possible.

This makes a big difference to the health centres mentioned above: they are not reacting to an idea, but to the need of well-defined target groups. They do not offer a wide range of medico-psycho-social services; rather they specialize in only one target group. This is more appropriate to our health system. The Central Research Institute in Cologne is doing operational research on these models. The criteria of effective care for these handicapped patient groups are quite clear-cut. They are:

- The frequency of prevented hospitalization
- The frequency of longer periods of well-being and shorter episodes of relapse