

The concept and context of Disease Management Programmes in Europe

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DMP: the German perspective

1. The political background
2. The law and the logic of German DMP
3. The DMP agents
4. Developing the DMP
5. Opposition
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7. Conclusions



1. The political background

Scandalisation of diabetes in the public and in parliament:

Too many secondary complications:

- avoidable amputations > 25,000 (educated guess)
- Underestimation of antihypertensive medication
- Underuse of retinopathy screening

Scandalisation of breast cancer

- No systematic screening (in Germany a topic beyond DMP)
- Too many breast removals
- Unacceptable variation in radio- and chemotherapy
- Insufficient information and support for patients

2. The law and the logic of German DMP

The pre-dmp context

- The DMPs are integrated into the risk structure compensation scheme (RSCS)
 - The RSCS was so far based on groupers according to age, sex, occupational disability and sickness pay (a consequence of offering free choice among sickness funds)
 - Now: DMP participation as a supplementary criterion
- ***Number of insured enrolled in DMPs determines transfer payments in risk structure compensation scheme***

DMP: sharing the responsibilities

- Ministry of health puts down the general rules for DMP in January 2002 by reforming the rules for risk compensation
- The so called Federal Joint Committee is entitled to recommend suitable chronic conditions for DMP...
- ...and to define the requirements of programmes as regards content
- The Ministry has the last word as regards conditions and content

Requirements by law

- Evidence based guidelines
 - Quality assurance
 - Conditions for enrolment (prevention excluded!)
 - Education programmes
 - Documentation
 - Evaluation (costs and efficiency)
- Accreditation and re-accreditation by the Federal Social Insurance Authority

Active participation of patients

- Treatment data disclosed to patients
 - Individual therapeutic goals
 - Education programmes (financed within the DMP)
 - Reminders for doctor's appointments
 - Variety of information (leaflets, brochures, www)
 - Support from health fund: counselling in branch offices or call centres; recommendation of support (self help) groups.
- the first systematic approach to implement shared decision making in the German insurance system!

Central role of physicians

- Identification of patients eligible for DMP
- DMP-specific counselling
- Documentation of treatment data
- Transmission of relevant data to data processing institution (uniform set of relevant data for evaluation and reaccreditation)
- Treatment according to ebm recommendations (no strict control!)
- Referral of patients according to risk status and decision aids
- Referral of patients to psychotherapy and rehabilitation as needed (no explicit criteria)

Central role of health funds

- Establishing contractual framework to implement programmes on the regional level
- Motivation of physicians and patients
- Comprehensive information of the insured
- Comprehensive information of physicians
- Responsibility for quality assurance and evaluation



3. The DMP agents

Ministry of Health → Federal Joint Committee → DMP subcommittee → The members of the Joint Committee are supported by expert task groups

The FJC itself consists of

- 50 %: Care providers (association of hospitals/ association of SHI-physicians)
- 50 %: Central associations of health funds (local funds = AOK-BV, substitute funds = VDAK/AEV, company based funds = BKK etc.)
- Representatives of patients (since 2004, without voting mandate)



4. Developing the German DMP

Starting position:

A. Classical conditions:

- Type 1 and 2 diabetes mellitus
- Coronary heart disease
- Asthma and COPD

B. „Political“ decision:

Breast cancer

DMP as a learning organization

Debate about multimorbidity from the very start:

First result in 2006:

Focussing cardiac insufficiency...

...and obesity

The new dimension within the DMP context: developing modules for DMPs already in existence – preparing the chronic care model (Wagner)

Tools in line with international strategies

1. Treatment guided by evidence-based practice guidelines (more often: problem-based reviews of relevant studies: treatment of hypertension or normalisation of glucose levels in elderly patients?)
2. Emphasis on prevention of exacerbations and complications
3. Patient empowerment (evidence-based teaching programmes)
4. Coordination of care within and across sectors

Elements of quality assurance

- Feedback reports for physicians
- Process and outcome data (treatment goals attained? Diagnostic exams, referrals, education programmes)
- Individual vs. average regional performance
- Reminders for missing record sheets
- Important appointments
- Communication between health funds and their insured DMP patients (leaflets, letters, missing appointments)

Inscription rates

August 2006

- Insured persons enrolled in DMPs: 2,85 Mio (educated guess: of 5 Mio eligible)
- Type 2 Diabetes: 2,04 Mio (start March 2003)
- Coronary heart disease: 0,72 Mio (start July 2004)
- Breast cancer: 64.000 (start March 2003)



5. Opposition

Between health funds

1. Winners and losers within the risk structure compensation scheme
2. Competition vs. high quality of programmes (including the topic of evaluation)

Big pharma

DMP and EbM: a dangerous coalition?

- Or a very costly endeavour? Underuse of efficient therapies?
- In the German context: pressure on false innovations and prices in pharmacotherapy – more money for patient education, non-medical interventions and DMP overhead costs

Patients representatives...

- claim deeper involvement within the DMP process,
- And better stratification of education programmes

Physicians

High work load of recording data

- without making enough sense of data
- instead: loosing control over data

Professionalism and autonomy

- Strong part of health funds and Ministry
- Loosing control over standards of care

Second class medicine

- DMP as cost reduction medicine of lower quality

- The DMP process started a few months *before the election* of a new federal government: physicians announced a total blockade of DMP
- *After the reelection of the Red-Green government* the physicians representatives quickly stated that many of their accusations and the threat to block the DMP introduction had in fact been an misunderstanding and that they would obviously cooperate in the future...

(adapted from Busse 2004)



6. The evaluation

Federal social insurance agency (BVA)

Central agency for evaluating DMP routine data in the process of accreditation and re-accreditation

Allows (at most) comparison between health funds DMPs

...with enormous difficulties to take risk adjustment into account

→The true impact of this approach is unclear

The gold standard

- Academic perspective: no roll-out without superiority trial (i.e.: step by step implementation): cluster randomized trial DMP vs. usual care
- A remarkably strong group of scientists and health fund representatives tried very hard: without success (no sufficient solidarity among health funds)
- The study design shows: an RCT of this kind is no mystery (www.allgemeinmedizin.uni-frankfurt.de/demp_evaluation.htm.)

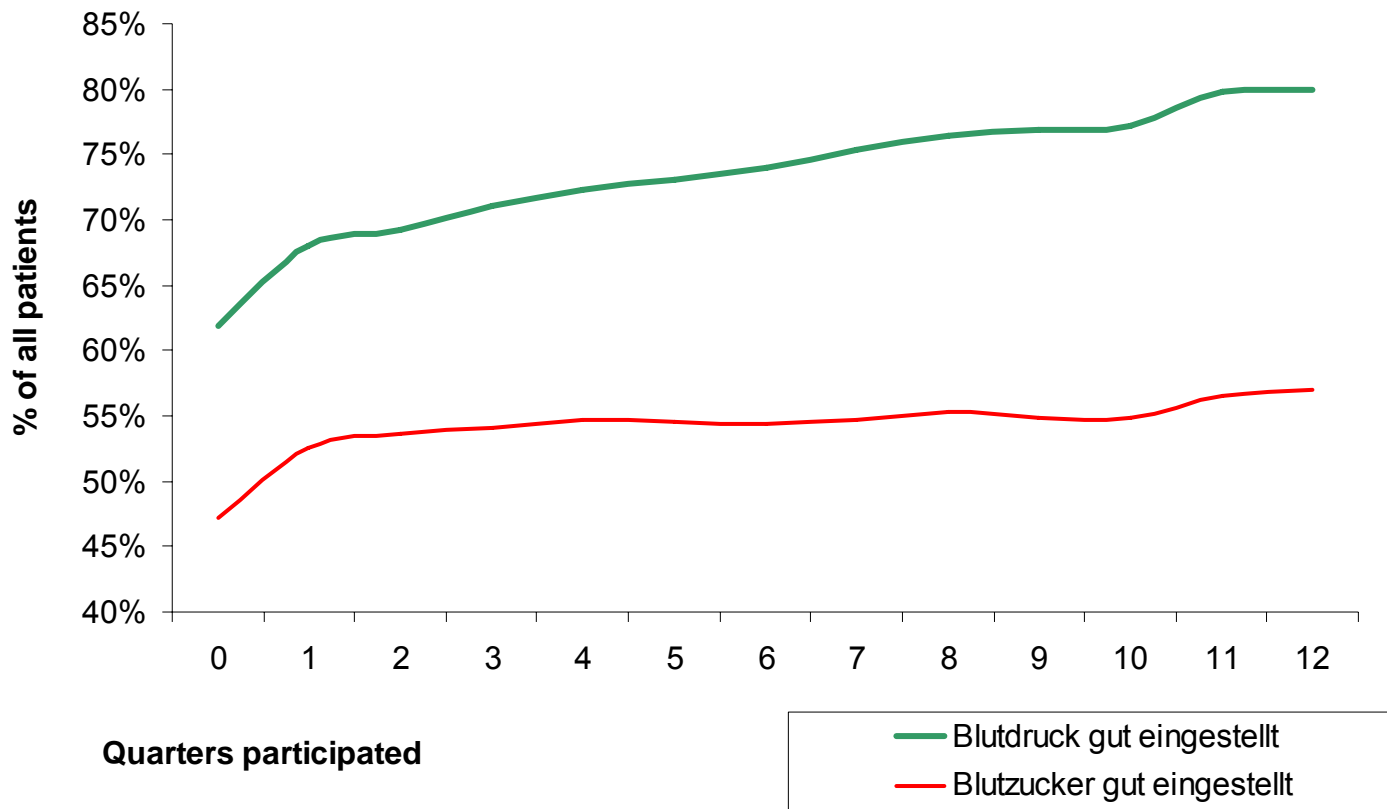
AOK finances the second best solution

- Joos S et al. ELSID-Diabetes study-evaluation of a large scale implementation of DMP for patients with type 2 diabetes. <http://www.biomedcentral.com/1471-2458/5/99>
- ***Three arm design: routine implementation of DMP vs. optimized version (quality circles and peer visits) vs. routine care without DMP***
- The study group hopes also to answer the question: what sort of support do physicians need to implement DMP successfully?

Interim results...

- ...based on routine DMP data, interviews with patients and feedback reports:
1. The longer patients participate the bigger the share of those meeting their blood pressure and HbA1c treatment targets agreed with their doctor
 2. ...and the bigger patients' satisfaction with the DMP participation

Blood pressure and HbA1c Control



Eye exams

- 2003: 32 % of diabetics had regular exams for retinopathy (see Hauner et al. 2003)
- Already during the first year of DMP, between 72 and 89 % of AOK insured patients were seen by an ophthalmologist

Patients perspective

- Telephone survey in May 2005
- 1000 patients enrolled in diabetes DMP of AOK Baden-Württemberg (45-75 years old, participation more than one year)
- 1000 patients enrolled in CHD DMP AOK Berlin and Rheinland (45-75, more than one year)

Patients perspective

„Higher intensity of care“

Type 2 Diabetes: 25 % (multiple options....)

CHD: 23 %

„Agreement on specific treatment goals between patient and physician“

Type 2 Diabetes: 69 %

„DMP helps me better manage the disease“

Type 2 Diabetes: 90 % very true/ rather true

CHD: 84 % very true/ rather true



7. Conclusions

Summary of Reinhard Busse

(Health Affairs May/ June 2004, 23 : 57)

The introduction in 1996 of free choice among sickness funds in Germany was accompanied by a „risk structure compensation“ (RSC) mechanism...Because chronically ill people were not adequately taken into account, competition for newly insured consumers concentrated on the healthy. The introduction in 2002 of disease management programs addresses this problem: Insured people in such programs are treated as a separate RSC category, making them a more „attractive“ group that no longer generates a deficit. **The degree of sickness fund activities and the fierce dispute with physicians are valid indicators that the incentives work“**

Personal reflections

DMP came

- ...almost out of the blue (window of opportunity)
- ...was driven by political expectations (an extremely rare situation where quality, efficiency and political reasoning might possibly have met)

DMP...

- inducted tremendous opposition within the medical profession because
- Health funds got enormous influence
 - The classical physician-patient relationship came under pressure by ebm and transparency of data
 - Physicians were forced to leave the traditional ways of counselling and referring

In so far...

...DMP is an ambivalent innovation...

...unless the medical community can be convinced that DMP and Shared Decision Making is part of a new culture of mutual benefit

...and a fantastic opportunity for primary care physicians to gain a new professional identity due to their status as the most important DMP-gatekeepers

...and the initial opposition disappears gradually, not only because physicians can earn a lot of money by enrolment of patients...

From a health services research point of view DMP might possibly be...

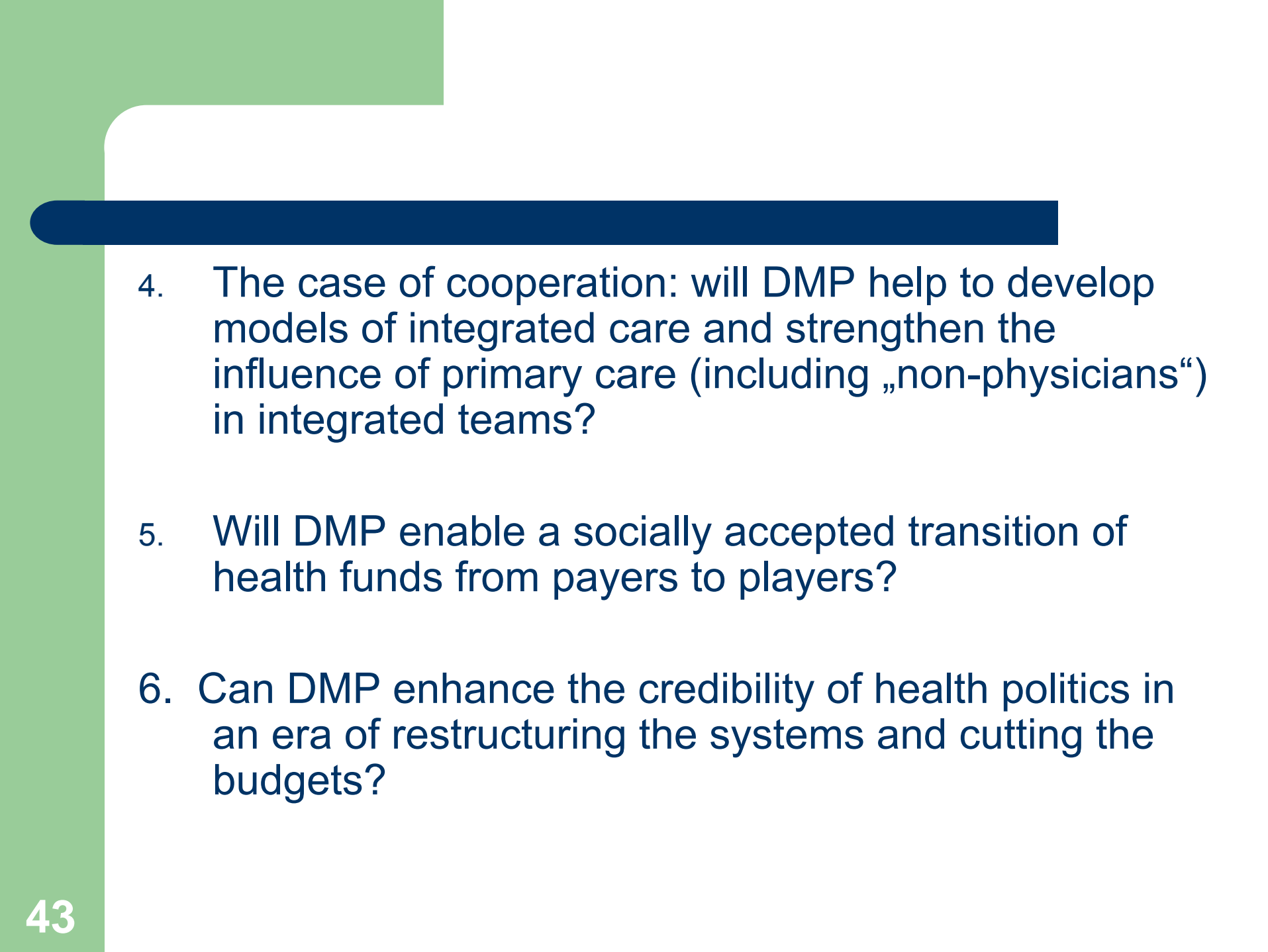
...one of the very few important innovations within our healthcare system because...

- it opened the door for evidence based medicine
- and for shared decision making
- and for reorganizing the cooperation between the professions and the sectors (outpatient – hospital – rehabilitation)

Final remarks:

I suppose that evaluating the German DMP in a broader sense has at least six aspects:

1. the chronic disease as such: do patients with diabetes and CHD and so on take profit measured against the offers of usual care?
2. the culture in medicine: will DMP pave the way for shared decision making and evidence based medicine?
3. the case of multimorbidity and ageing populations: will DMP help to put chronic care on the agenda?

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- 4. The case of cooperation: will DMP help to develop models of integrated care and strengthen the influence of primary care (including „non-physicians“) in integrated teams?
 - 5. Will DMP enable a socially accepted transition of health funds from payers to players?
 - 6. Can DMP enhance the credibility of health politics in an era of restructuring the systems and cutting the budgets?