CORRESPONDENCE

Disease Management Programs for Type 2 Diabetes in Germany—A Systematic Literature Review Evaluating Effectiveness

by Sabine Fuchs, M.Sc. Ph., Dr. rer. oec. Cornelia Henschke, Dipl.-Soz. Miriam Blümel, Prof. Dr. med. Reinhard Busse, MPH FFPH in issue 26/2014

Only Health Insurances Are Interested

The authors must have been in a far from enviable position when they searched the literature for their review. With far too low subject numbers in the various studies and issues with controls or no controls at all, these studies were not designed to generate high-quality evidence. Who is actually interested in continuing the DMPs? For us physicians, a DMP patient means more time spent on documentation. This is the reason why DMPs are unpopular or even annoying. It is true that with 10 Euros per patient each quarter a relevant additional fee can be charged, given the poor standard service volumes; however, this does no refinance the total time and effort spent in the case of elderly patients who frequently have mobility impairments. Most insured persons regard DMPs as irrelevant; either way, they will receive the required care. Younger patients see the DMP appointment as a nuisance because of the time involved and usually it takes considerable persuasion to convince them to enroll. The only ones really interested are the health insurances; apparently, they hope to generate higher financial returns from the health structure fund via the DMPs. However, the positive effects on mortality and survival time that the statutory health insurances "love" to postulate—also to be found in the article's "conclusions"—are pure fiction. Here, the worst kind of selection bias is at work. The truth is that patients almost always drop out of the program when they are no longer able to visit the practice as the result of their disease. Therefore, "mortality"—who would be surprised—is almost nil within the DMP-Diabetes. This has nothing to do with survival improvements. The conditions that determine a patient's prognosis with regard to improved survival are neither established in medical practices nor in DMPs but in the food aisles of supermarkets.

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REFERENCES

1. Fuchs S, Henschke C, Blümel M, Busse R: Disease management programs for type 2 diabetes in Germany: A systematic literature review evaluating effectiveness. Dtsch Arztebl Int 2014; 111: 453–63.

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In Reply:

With regard to the interest in the DMPs, the point of increased time spent on documentation in a general practice setting where time resources are already limited is understandable. However, DMPs indeed provided a financial incentive for health insurances until the end of 2008 due to the integration of the DMPs in the risk adjustment scheme. This changed with the introduction of the morbidity-based risk adjustment scheme (Morbi-RSA) and the elimination of the DMP enrolment as a separate RSA category. In addition, the program cost flat-rate fee for each enrolled insured person fell from €180 in 2009 to €145.68 in 2014 (1). As a result, health insurances were increasingly interested in evaluating the program's effectiveness. However, evaluations meeting methodological minimum requirements are needed. The analysis of currently available studies provided in our article shows this very clearly. None of the studies included in our review performed an analysis of those participants who dropped out from DMPS—as required by the intention-to-treat principle. Likewise, the DMP routine documentation fails to systematically record data on this patient population. There are various reasons for dropping out, ranging from the termination of membership to a lack of active participation and hospital admission, to death. Detailed information about this is provided in the Quality Assurance Report 2012 DMP in North Rhine where cases of drop-out from the DMPs were analyzed (2). Fullerton et al. (3) analyzed cases of drop-outs where there was no DMP documentation. We agree that these patients will require special attention in further studies on the effectiveness of DMPs and should explicitly be included in future analyses.

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REFERENCES

1. Bundesversicherungsamt (BVA): Zulassung der Disease Management Programme (DMP) durch das Bundesversicherungsamt (BVA). 3. Verknüpfung mit dem Risikostrukturausgleich. www.bundesversicherungsamt.de/druckversion/weitere-themen/disease-management-programme/zulassung-disease-management-programme-dmp.html#c198 (last accessed on 13 November 2014).
2. Hagen B, Altenhofen L, Groos S, Kretschmann J, Weber A, Nordrheinische Gemeinsame Einrichtung Disease-Management-Programme (ed.): Qualitätssicherungsbericht 2012 Disease-Management-Programme in Nordrhein. Düsseldorf: Nordrheinische Gemeinsame Einrichtung 2013.
3. Fullerton B, Erler A, Pöhlmann B, Gerlach FM: Predictors of dropout in the German disease management program for type 2 diabetes. BMC Health Serv Res 2012; 10: 8.
4. Fuchs S, Henschke C, Blümel M, Busse R: Disease management programs for type 2 diabetes in Germany: A systematic literature review evaluating effectiveness. Dtsch Arztebl Int 2014; 111: 453–63.

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Conflict of interest statement
The authors of all contributions declare that no conflict of interest exists.