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Review

Explaining differences in stakeholder take up of disease management programmes: A comparative analysis of policy implementation in Austria and Germany

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ABSTRACT

Purpose: Understanding why policies to improve care for people with chronic conditions fail to be implemented is a pressing issue in health system reform. We explore reasons for the relatively high uptake of disease management programmes (DMPs) in Germany, in contrast to low uptake in Austria. We focus on the motivation, information and power of key stakeholder groups (payers, physician associations, individual physicians and patients).
Methods: We conducted a comparative stakeholder analysis using qualitative data from interviews ($n = 15$ in Austria and $n = 26$ in Germany), legal documents and media reports.
Results: Stakeholders in Germany appeared to have systematically stronger motivation, exposure to more positive information about DMPs and better ability to implement DMPs than their counterparts in Austria. Policy in Austria focused on financial incentives to physicians only. In Germany, limited evidence about the quality improvement and cost savings potential of DMPs was mitigated by strong financial incentives to sickness funds but proved a fundamental obstacle in Austria.
Conclusions: Efforts to promote DMPs should seek to ensure the cooperation of payers and patients, not just physicians, using a mix of financial and non-financial instruments suited to the context. A singular focus on financially incentivising providers is unlikely to stimulate uptake of DMPs.

1. Introduction

The rising prevalence of chronic conditions [1] has put efforts to strengthen chronic disease management high on the policy agenda in many European nations [2,3]. However, effective implementation has been slow and variable across countries [2–4]. Understanding the barriers to uptake of policies to improve care for people with chronic conditions and the reasons for cross-national differences

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in implementation is therefore a pressing issue in health system reform [5,6].

Prior research on barriers to the implementation of chronic disease management has tended to follow two major strands. One strand of research has highlighted the importance of regulatory and contextual factors in hindering the transition to well-coordinated systems of chronic disease management in many European countries. These system-level barriers comprise fragmented delivery structures especially between ambulatory and hospital sectors [15,16]; limited financial incentives for purchasers and providers to proactively manage chronic diseases [16], deficits in workforce skill-mix, patient self-management, information technology and in the systematic evaluation of costs and benefits [17]. Another strand of research has focused on barriers at the level of individual health professionals, specifically with regard to the implementation of clinical guidelines which typically form the backbone of efforts to strengthen chronic disease management. Identified barriers include a lack of awareness, acceptance and capacity to change patterns of clinical practice [10–14].

Less attention, however, has been given to a systematic analysis of the influence of multiple stakeholders in the implementation process. Although individual health professionals play a vital role in fostering changes in service delivery, policy implementation in healthcare is further complicated by the presence of multiple stakeholders who influence the degree to which policy change can be achieved [18–20].

Focusing on two European social health insurance (SHI) systems, this study seeks to explain cross-national differences in the implementation of disease management programs (DMPs) in Austria and Germany. DMPs were first initiated by pharmaceutical companies and private health insurers in the United States in the 1990s, mainly to contain costs by managing the use of medications among people with common chronic conditions such as diabetes, hypertension or asthma [7]. Germany and Austria introduced policies to develop DMPs in the early to mid-2000s to optimize care pathways for people with specific chronic conditions [8]. However, uptake of DMPs among sickness funds, among physicians and among patients has differed substantially between the two countries (Table 1). By 2010, Germany had achieved nationwide implementation of DMPs for six indications, with high uptake, while Austria had managed to implement only one DMP, in some regions only and with low uptake [9]. This study examines why Germany has experienced greater uptake of DMPs than Austria, particularly with regard to the DMP for diabetes type 2.

The study contributes a comparative analysis of the nature of stakeholder circumstances at the 'decision points' that make up the DMP implementation process in both countries. The concept of 'decision points' was introduced by Pressman and Wildavsky [21] in their seminal book on policy implementation. A decision point is reached when "an act of agreement has to be registered for the programme to continue" (Pressman and Wildavsky [21]: xvi). Since decision points refer to those critical points which need to be overcome to implement a policy and which are typically owned by different stakeholders, understanding the circumstances that facilitate or obstruct progress is essential.

In this study, we focus on patient enrolment in a DMP for diabetes type 2 as the conceptual endpoint of the implementation process. While patient enrolment does not necessarily imply that patients actually receive the recommended care, from a political perspective it is nevertheless an important indicator that signals stakeholder commitment to DMPs. In Germany and Austria, four sequential decision points (DPs) had to be cleared before a patient was enrolled in a DMP and thus had access to structured disease management

Table 1
Take up of DMPs in Austria and Germany at key 'decision points'.

Take up at Decision point (DP)	Austria	Germany
DPs 1 and 2: Payers develop DMPs and sign collective contracts with physician associations	One DMP (diabetes type 2) offered in six out of nine Federal States since 2007. Plans in place for other DMPs, but implementation is slow.[a]	Six DMPs offered in all Federal States as from 2002/03 (diabetes type 2, breast cancer), 2003/04 (coronary heart disease), 2004/05 (diabetes type 1), and 2005/06 (asthma, chronic obstructive pulmonary disease/COPD). [d]
DP 3: Physicians decide to partake in DMP contracts	Participation ranges from 8.8 to 25% of eligible physicians (general practitioners and specialists for internal medicine) (as of September 2012). [b]	Participation ranges from just under 75% to over 95% of eligible physicians (general practitioners and specialists for internal medicine) (as of September 2010). [e]
DP 4: People with chronic conditions choose to enrol in a DMP	About 32,000 people in the diabetes type 2 DMP as of June 2012 (about 8% of estimated type-2-diabetics in Austria). [c]	About 7 million enrolments across all six DMPs as of June 2012 (including about 1 million enrolments across multiple DMPs); about 3.7 million enrolments in the DMP diabetes type 2 (about 50% of estimated type-2-diabetics in Germany). [f]

Sources:
[a] [9]
[b] Authors' estimate based on [57,58].
[c] [9].
[d] [59,60].
[e] Authors' estimate based on [56,61–64].
[f] [59,60,65].