Can a Nationwide Policy for Office–Based Diabetes Education be Replicated in the United States?

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The American Diabetes Association has long identified a structured, comprehensive approach to the management of diabetes mellitus as integral to quality care. The objectives of diabetes education programs include improving knowledge and skills, promoting positive behavior changes, and enhancing health outcomes. Using health outcomes to evaluate a physician's office-based diabetes education program, Gruesser et al. (1) provide further documentation that a structured systematic approach provides positive patient outcomes.

An important aspect of this paper is the examination of who treats, manages, and teaches the diabetic patient. In Germany, diabetes specialists are not managing the majority of diabetic patients, so that the environment in which Gruesser's patients were seen is in many respects representative of where diabetic patients in the U.S. receive their care: in the offices of internists, general practitioners, and family practitioners rather than endocrinologists.

Although it is valid for the authors to compare the contents of their program to those in the U.S., the comparison does not consider the fundamental differences in financing health care in the U.S. and Germany. In the U.S., financing and delivery of health services are provided through a loosely structured system, whose reimbursement schema vary widely: there are 50 state-based Medicare programs, more than 1000 private health insurance companies, and the federally based Medicare program. Not only is reimbursement not uniform across the country, but because of varied interpretation of federal regulations, services provided are not uniform.

As of April 1993, the American health-care finance system is nothing less than a patchwork quilt system that precludes uniform, nationwide negotiations with payers for diabetes education services or any other health service for that matter. Although the content of the program described by Gruesser et al. (1) certainly could be adopted in the U.S., the differences in the financing of health care and specifically the lack of uniformity in the American system makes it unlikely that a national implementation of this program in the U.S. could occur.

The American health-care finance system does not make it easy to adopt the team approach described by Gruesser et al. (1) Although the insurance companies state that they do reimburse for diabetes education, the services are frequently only reimbursed when provided by the physician. Indeed, many health insurance companies still believe the physician is the person who teaches diabetes self-management. The reality is that it is the diabetes educator. . .a nurse, dietitian, or other health-care professional who can provide this at lower cost and more effectively. The reality is that the amount reimbursed for the service makes it financially untenable for the physician to personally provide this service.

Simply in terms of dollars and cents, health services in the U.S. are more expensive than abroad; the fee structure reimbursed by the German system would hardly cover the comprehensive programs currently reimbursed in the U.S. For example, in an AADE survey (2) of diabetes educators the median charge for service was $42.57, the mode charge was $50.00, and the range was $15–$83/h. Group charges ranged from $1.00 to $900.00 for varying time frames. Many primary-care providers state that they cannot afford a diabetes educator for their practices. Of the respondents to the survey, 45% had performed an analysis to identify the cost of providing diabetes education. The analysis documented that the cost of producing the service was more than the charge for providing the service. It is no wonder that diabetes education programs rarely break even. Adequate reimbursement would encourage physicians to provide office–based diabetes education for their patients.

Gruesser et al. (1) have focused on the delivery of a high quality and effective diabetes management program. The current focus on health-care reform is welcome in the U.S. It is hoped that while the proposed health-care cost control measures and programs providing health care for all Americans go forward, the quality of care does not suffer.

As of this writing, it remains unclear what direction the new administration's health-care reform will take. The

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level of health-care spending continues to make headlines, even as the discussions continue on health-care reform to curb the rising costs. Spending increases are attributable to structural changes in the U.S. health system: for example, growth of the private and public health insurance and expanded medical technologies in the hospital sector. As emphasis is being placed on catastrophic illness, this redistribution of resources could jeopardize the health-care system's ability to achieve other reforms such as increasing primary services or prevention of long-term complications and disability caused by chronic conditions such as diabetes.

Currently, the U.S. could not replicate a nationwide program such as the German study for several reasons. First, the fundamental differences in the U.S. and German health-care systems do not allow the U.S. to negotiate with the health insurers for a nationwide policy for reimbursement of diabetes services. Second, unless the physician office-based practices receive reimbursement for diabetes education services as well as medical management of disease, adequate time and energy will not be devoted to the educational component of the visit.

Gruesser has shown that the uniform health-care financing system in Germany has facilitated the implementation of a consistent, office-based, team approach to educating the diabetic patient. Clearly, this strategy would improve the quality of diabetes self-management in the U.S. This is particularly true in areas not served by hospital-based diabetes education programs that meet national standards for diabetes education. The options presently open to the U.S. are to legislate improvements in reimbursement for diabetes services or to emphasize the public demand for health-care reform, which recognizes chronic disease and long-term cost savings.

References

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