Many South Asian people probably need pre-diabetes care

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Prevention and cure of type 2 diabetes

**General practitioners are treating more cases of diabetes**

**Editor**—Most studies measuring the prevalence of diabetes have been carried out in one locality and have generally measured point prevalences. Hence, although the prevalence of diabetes in England and Wales is increasing, time trend data on prevalence and future projections based on sound data are both lacking. We recently estimated the prevalence of diabetes in England and Wales between 1994 and 1998 using data from 210 general practices with a combined list size of 1.2 million.  

We found that the overall prevalence of diabetes during this period increased from 1.90% to 2.43% in males and from 1.69% to 2.04% in females. This striking increase in the prevalence of diabetes in primary care is likely to be due to a combination of factors, including better case ascertainment, rising rates of obesity, an ageing population, and an increase in both the size and average age of the ethnic minority population. Overall, 29%, 48%, and 24% of males with diabetes and 26%, 48%, and 26% of females with diabetes were treated by diet, oral hypoglycaemic drugs alone, and insulin respectively.

We estimated around 1.15 million people had a diagnosis of diabetes mellitus in England and Wales in 1998. If the age specific prevalence of diabetes increases by a modest 30% over the next 25 years (less than predicted by many authorities), then the number of people with diabetes will increase by 70%, to 1.96 million by 2023. If age specific prevalence increases by more than 30%, then the increase in the number of cases will be even larger.

Our findings illustrate the potential size of the diabetes epidemic facing England and Wales. The epidemic will have major implications for the NHS, which will have to provide diabetic services for these patients, as well as deal with the clinical and psychosocial complications resulting from diabetes. We therefore reinforce the need to tackle the underlying causes of this epidemic, particularly by increasing levels of physical activity and reducing rates of obesity in our society.  

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**Let’s move upstream to obesogenic environments, please**

**Editor**—Another BMJ brings yet another editorial on obesity and associated diabetes. Once again there is no reference to the real cause of this problem—obesogenic environments. Why is it that commentators constantly shy away from digging deeper? Why do they repeatedly refuse to venture upstream? It must be blindingly obvious to everyone by now that there is, and never will be, any conventional medical treatment for obesity or diabetes. Doctors should come clean and tell patients and populations that the cure lies not with medicine but in how our societies are created.

Children are denied vital play space because politicians favour selling play space to developers. Sixty per cent of the green space used for housing in London in the past 10 years came from the sale of playing fields (Open spaces conference, Bankside Trust, London, March 2002). We exclude children’s play from our streets by permitting a 30 mph urban speed limit. If we are to encourage an extra 3 miles of walking daily to enable 4 kg weight loss, reducing the risk of developing diabetes by 58%, then we must create an environment where people are able to walk. It is facile and cruel just to tell people that they must walk more. Healthy people need healthy environments.

Politicians have the central role in creating healthy populations. They should stop pandering to powerful lobbies such as the pharmaceutical, motorizing, food, and tobacco industries. If we as doctors do not tell them that they have the prime responsibility for health then they will continue to abuse us by heaping us with impossible responsibilities for changing the health of our nation. When we inevitably fail then they will give us the blame.

General practice in the United Kingdom is currently tittering on the brink of such stupidity in the shape of a new medical contract that will enslave us into performing the impossible tasks of reducing blood pressure, weight, glycaemic concentrations, and cholesterol concentrations, etc. We will soon be shackled to tick box medical consultations stuffing irrelevant data into computers in a pointless and ever increasing spiral of ineffectual intervention while the good that we can do, but which has never been recognised or rewarded, will simply wither and die.

Perhaps the next obesity and diabetes editorial should be commissioned from a sociologist?

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**Many South Asian people probably need pre-diabetes care**

**Editor**—In their editorial Venkat Narayan et al make a case for the American Diabetes Association’s recommendation on a screen for pre-diabetes in people over 45. Pre-diabetes is defined as either impaired glucose tolerance (two hour glucose concentration 7.8-11 mmol/l after a glucose load) or an impaired fasting glucose concentration of 6.1-6.9 mmol/l. Those screening positive are counselled on weight loss and increasing physical activity. This recommendation has profound implications for the health care of South Asian populations originating in the Indian
subcontinent living in urban settings where pre-diabetes is common.3


Women with gestational diabetes should be targeted to reduce cardiovascular risk

Editor—Sattar and Greer discuss the probability that complications in pregnancy may predispose women to vascular and metabolic disease in later life.1 The link between pregnancy complications and coronary heart disease remains unexplained. We believe that during pregnancy the hormonal and other stresses provoke cardiovascular and metabolic abnormalities in susceptible individuals, which may recur and become permanent as the patient ages. Many of these are coronary risk factors; disturbances in glucose metabolism, which underlie the development of gestational diabetes, are a good example.

An uncomplicated pregnancy is characterised by obvious changes in lipidaemia early in pregnancy.2 These include the formation of small, dense subfractions of low density lipoprotein, an important risk factor for atherosclerosis.3 These are retained in the arterial intima, are more easily oxidised, and once oxidised are rapidly taken up into macrophages, creating foam cells and atherosclerotic plaques. The additional effect of pregnancy on lipid metabolism in people with diabetes and those at increased risk of developing diabetes may markedly increase cardiovascular risk in these women.

We recently studied three groups of pregnant women: healthy controls (n=17, mean age 29.2 (SD 1.1) years), women with type 2 diabetes (n=12, mean age 32.5 (1.6) years), and women with gestational diabetes mellitus (n=12, mean age 32.8 (1.5) years). Venous blood was taken during each trimester (first, 1-13 weeks; second, 14-27 weeks; and third, 28 weeks to term). Samples were analysed for subfractions of low density lipoprotein (polyacrylamide gel electrophoresis) and triglycerides. A score for low density lipoprotein was calculated from the area under the curve for each subfraction; the higher the score the smaller, denser and more atherogenic the low density lipoprotein particles.4

Triglyceride concentrations increased throughout pregnancy in all groups. This was most obvious during the second trimester in women with gestational diabetes (figure). Low density lipoprotein score progressively increased throughout pregnancy, implying the formation of potentially atherogenic lipoproteins. These changes were exaggerated in women with type 2 diabetes but more particularly in those with gestational diabetes (figure). We found that pregnancy and diabetes have an additive effect on the development of an atherogenic lipid profile. Importantly, this is exaggerated earlier in pregnancy in gestational diabetes. This finding may identify women who are particularly susceptible to the premature development of atherosclerosis. We agree with Sattar and Greer that women with gestational diabetes should be targeted during and after pregnancy with advice on diet and lifestyle to try to modify this excess cardiovascular risk.

We thank Dr Nigel Unwin for helpful advice in preparing this letter.


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We thank Dr Nigel Unwin for helpful advice in preparing this letter.
The global response to mental illness

First line care facilities and support for providers have to be improved

Editor—Thornicroft and Maingay highlight the inadequacy of international responses to mental illness.1 In low income countries the burden of mental illness is amplified by financial insecurity, poverty, and partition of families, if not by violence and war. Prevention in mental health is intimately linked with overall human development. Individual care is also necessary. In some societies religious or traditional healers still provide culturally relevant and socially acceptable responses to problems labelled as mental illness. Nevertheless, mental suffering is manifest among users of modern medical services, where it goes largely unrecognised.

Besides poor availability of drugs, human resources are of utmost importance in understanding the apparent neglect of mental health problems. Doctors and nurses in low income countries are often described as rude to their patients,2 partly because they have low salaries and poor professional perspectives, which affects their morale, self confidence, and dedication.3 Some have problems similar to those of their patients—for example, domestic violence or living with HIV. Some are not prepared to face the emotional burden of listening to patients’ suffering. Adequate professional support is unusual, and dealing with emotions is seldom valued by the organisational culture.4

If health care in low income countries is to be oriented towards more biopsychosocial approaches, efforts have to include improving first line care facilities and support for providers. Well functioning first line facilities are crucial to integrate mental health programmes accessible to the population. This does not rule out specialisation, but these tend to remain concentrated in cities and are often of limited accessibility financially. In the case of mental health services, stigmatisation furthermore limits their acceptability to potential users.

The integration of mental health programmes in first line care facilities should of course not be detrimental to the comprehensive character of the service delivered. The purpose is not to divert available resources to serve a specific programme but to take advantage of the existing relations between a service and a community to widen the scope of responses provided locally. Health care in low income countries is increasingly thought of as a series of vertical programmes, so the need for access to regular health care is crucial, and specific programmes must strengthen general services rather than weaken them. Indeed, mental health programmes may improve first line care. Concerns for mental health are likely to promote listening skills, to foster patient centred care, and to broaden the professional identities of care providers, currently focused on biomedical issues. This could be an important step on the way to quality general practice adapted to social and cultural contexts.5

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Focus on mental health means new opportunities for developing countries

Conclusions

In conclusion, the global situation is a challenge to professionals to think innovatively.

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Discontinuation of thioridazine

Risks must be balanced

Editor—Until the Committee on the Safety of Medicines restricted the use of thioridazine in 2000, it was the most widely used antipsychotic drug in the United Kingdom, with 50 million years of use by patients worldwide. In Scotland in 1999, were 250 808 were prescriptions dispensed in primary care (hospital data not available, but the safety committee reports that it was the most widely used antipsychotic drug in hospitals too). This dropped to 39 177 in 2001, according to information from the Primary Care Information Unit in Edinburgh.

Is thioridazine safer, cheaper, and more effective than alternative antipsychotic drug treatments for anxiety, agitation, mania, or hypomania? We do not have enough evidence to answer this because thioridazine has been widely used for 30 years—before the days of rigorous randomised controlled trials. Lack of evidence is not evidence of no benefit. Conversely, there is only evidence of a handful of adverse cardiac events, some of which may not have been directly caused by thioridazine or may have been due to combination with other drugs. Although the reported cardiac deaths are lamentable, it
seems that thioridazine is much safer than other effective drugs such as aspirin, which continues to be sold over the counter. Even if adverse events are under-reported, there is far more practical evidence of long term safety for thioridazine compared with much more expensive and much less tried and tested drugs. A recent study noted that many new drugs have a high rate of serious side effects which go undetected until late in postmarketing surveillance. The Committee for the Safety of Medicines needs to balance these relative risks.

The manufacturers of thioridazine have raised few objections to the restricted use of thioridazine because it is an extremely cheap drug, costing only a few pence compared with newer antipsychotics that may be up to a hundred times more expensive, as well as having different and sometimes distressing side effects. The prescription costs of antipsychotic drugs has risen sharply in Scotland in the past two years.

Anecdotally, considerable numbers of patients with hypomania, anxiety, and agitation are having considerable problems in adjusting to a change of drugs, and, as Davies et al point out, informed consent may be a problem. It would be very helpful if the National Institute for Clinical Excellence or Health Technology Board for Scotland reviewed the evidence, risks, and benefits of thioridazine, and considered more humane guidelines for its future use. It seems quite wrong to deprive so many patients of a well-challenging behaviour (12 patients). Based on the above information, a decision was made to gradually reduce (12 patients) or suddenly stop thioridazine (16 patients).

As an alternative, a tranquilliser was prescribed for all 28 patients. Risperidone was the most commonly used atypical antipsychotic drug because of some evidence of its effectiveness in challenging behaviour. A review of patients’ mental state three months after the substitution of tranquillisers indicated that twenty one patients either remained stable or improved, and seven patients deteriorated. These seven patients subsequently improved, either by a change to a different psychotropic drug or by adjusting the dose of existing drugs. No patient needed to restart taking thioridazine.

Review of previous psychiatric treatment helped us to identify instances of rebound increase in behavioural problems when thioridazine was stopped. It also prompted us to avoid using neuroleptics that were either ineffective or caused unacceptable side effects. Evidence of rebound aggression on stopping neuroleptics was also observed by Mos et al. This lead us to withdraw thioridazine gradually in most cases.

In our opinion risk associated with the withdrawal of thioridazine was managed carefully and minimised by taking into account the diagnosis, the dose and duration, and consequences of previous reduction in medication followed by a careful strategy of either gradual reduction or sudden stoppage with replacement of alternative tranquillisers in appropriate doses.

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Competing interests: None declared.


What happened to thioridazine?
Editor—The article by Davies raised some important issues on discontinuation of thioridazine in populations with learning disability. We had successful withdrawal of thioridazine in our services in Salford district.

We looked at the following issues before withdrawal of thioridazine:

(1) Initial diagnosis before thioridazine was prescribed
(2) Duration and dose of treatment
(3) Review of previous psychiatric treatment including attempts to reduce or stop thioridazine.

Results indicated that 28 out of 175 patients under the care of a psychiatrist specializing in learning disability received thioridazine. Twenty three patients received small doses (50-100 mg) for many years. The main indication for use was marked

Muthuswamy temple

religious and superstitious. In Indian villages myths, misconceptions, blind beliefs, and superstitions abound. Quacks and local healers thrive on the illiteracy and ignorance of naive and gullible people and try to hoodwink them into believing that they have magic cures for their ills. Muthuswamy temple might be an exception, for it does not charge people who stay there, and, more importantly, offers no specific healing rituals. But local newspapers and quacks may distort the conclusions of the study by pointing out that even a Western journal recognises—and endorses—the hidden healing powers of Indian temples.

The news might make thousands of people seek a cure for their chronic diseases in temples and shrines. Even people with potentially curable diseases may choose not to see doctors in the hospitals but seek shelter in holy places. The consequences of such an attitude could be terrible.

History tells us that when tuberculosis was a formidable foe in the 19th century people thought that their best chance of conquering the disease was residing in a sanatorium. Patients and their doctors all over the world believed that a salubrious environment, clear mountain air, and nutritious food was the best way to ensure cure. Thousands of patients with tuberculosis chose Switzerland as their health destination. Myths were woven around sanatoriums, and people who could afford it resided in what they considered “magic mountains” for as long as 10 years.

The sanatorium made most patients feel better for a while, but their infection progressed unabated and killed all of them. Doctors and lay people took 75 years to realise that sanatorium was a highly expensive—and terribly ineffective—and terrible ineffective—and terribly ineffective—intervention for getting rid of tuberculosis.

I think healing temples for alleviating psychiatric disorders and magic mountains for curing tuberculosis share one thing: a strong placebo effect fostered by local superstitions and traditions. Patients with chronic and psychiatric diseases often do not go to their doctors, but we should avoid creating an impression among the public at large that healing temples are capable of restoring their health.

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Letters

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Spiritual care is important

Editor—As a senior house officer in an acute psychiatric ward in central London, I can understand why there was improvement in the condition of the psychiatric patients who resided in the Muthusamy temple in India, as reported by Raguram et al. Patients were brought into a place of “refuge” with people similar to them, who understood their condition. This would result in less expressed emotion and distress and better care of the individual, not only by relatives but also by temple staff in a supportive, non-threatening environment. Here people can make sense of their mental illness. This is good “psychosocial” psychiatric care.

How does this contrast with an acute psychiatric ward? Patients are placed in a busy and emotionally charged environment with others who may be more disturbed, usually with little support from relatives. Relatives’ visiting rights are limited, and patients may not have anyone to confide in. Here there is good “biological” psychiatric care, with emphasis on psychotropic drug treatment.

What is the way forward? We need a more holistic approach to inpatient psychiatric care to try to “heal” our patients, rather than just treat their psychopathology. Family members need to be fully involved. For serious mental illness, the individual’s spiritual needs, which are important to most people, must be looked after. The power of cultural beliefs and spirituality is important, as seen by belief in the healing power of the temple, and this is largely neglected in modern psychiatry. The result is increased stigmatisation of psychiatric wards, which are viewed more as places of containment than refuge.

What would have happened if Raguram et al distributed psychotropic drugs to the patients at the temple? I am sure their condition would improve more quickly as there would be “holistic biopsychosocial healing.” I hope for the day when psychiatric temples, or places of worship, without stigma and with a cultural belief of healing, will replace psychiatric wards. Then holistic biopsychosocial care of mental illness can truly be achieved.

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Primary prevention strategies for cardiovascular disease

Editor—The assumptions made by Marshall and Rouse in their study are too broad and may lead to erroneous conclusions. Using the Framingham equation with average values is going to stratify the population only by age, sex, and diabetes status. Such stratification is simplistic and will prove only that older people and people with diabetes are more at risk. By assuming the subjects are non-smokers Marshall and Rouse exclude the most important single weighting in the Framingham calculation. Most practices have a register of smoking status for most of their patients, so this should be included.

Marshall and Rouse admit that their method may not be able to screen all of the population, so some will lose out. By concentrating on the oldest patients and patients with diabetes first, it will not detect some who have most to lose, such as 50 year old smokers with hypercholesterolemia and hypertension. Adding a few extra years to the life of a 70 year old non-smoking non-motivisive diabetes patient may be laudable, but just because it is easier and cheaper does not mean that these patients should be prioritised to be assessed first, as this method seems to suggest.

Many of Marshall and Rouse’s other assumptions do not fit well with the day to day realities of general practice. Few general practitioners would be able to stabilise anti-hypertensive treatment with only four prescriptions and two follow up consultations in a year. Government policy is to issue 30 days’ supply, so Marshall and Rouse underestimate dispensing costs. Not all of this work can or should be done by practice nurses. Other diagnoses will be found requiring medical intervention, and many patients need more careful clinical assessment than a simple protocol provides.

Marshall and Rouse’s assumption that two 20 minute consultations by a practice nurse are all that is needed to treat is wrong, so their economic argument is flawed. Their conclusion about statins and angiotensin converting enzyme inhibitors costing more, so strategies avoiding these may allow more disease to be prevented is odd. It would be actionable to omit a cholesterol measurement on a high risk patient or if a high level was found, negligent not to treat. Avoiding them is not an option in the real world.

This paper adds little to the subject other than confusing people into thinking there is a quick and cheap method of cutting short the hard and expensive, but necessary, work of finding all those at risk of heart disease and lengthening their lives.

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practice with the bare minimum of electronically recorded data.

With our preselection strategies, a woman’s cardiovascular risk is equivalent to that of a man 12 years her junior. A good approximation of our preselection rankings is obtained by assigning a ranking number to every patient. For men it is their age, for women their age minus 12. Patients are prioritised for cardiovascular risk assessment by their ranking number (highest number first).

Risk/benefit ratio is important in treating atopic dermatitis

Ennor—Williams acknowledges the efficacy of tacrolimus and pimecrolimus in atopic dermatitis but subsequently his editorial is negative and lacks any patient perspective. The issue lies not in clinicians’ disembodied comparisons of efficacy but in what treatment provides patients, or their affected children, with the most acceptable benefit:risk ratio.

Only 40% of patients with eczema are reportedly satisfied with their treatment, and work from Williams’s own department has shown that in many cases using a topical corticosteroid produces risks, especially of skin thinning, which are unacceptable high to the patients, resulting in non-compliance and inadequate treatment.

Patients’ fears about steroids can hardly be dismissed as irrational, even though they may be exaggerated. Far from being rare, the risks of adverse events from the use of steroids are directly related to the duration, quantity, and potency of the steroid used. Thus today’s patients are just as much at risk as before unless they choose to endure the misery of their condition and leave it untreated. The main fear which patients had was of skin thinning. Topical tacrolimus and pimecrolimus are free of this and other risks associated with steroid use and offer a realistic alternative of proved efficacy whatever their potencies relative to each other or to corticosteroids.

Although the editorial declares the use of probiotics harmless, the long term risks of using such strategies are currently unknown and the subject of debate. Their safety has not been tested on anything like the 13 000 included in the trials of tacrolimus and pimecrolimus.

As with any new treatment, close monitoring will be mandatory, but longer term studies with pimecrolimus and tacrolimus show no clinically significant increase in infections or skin cancers. Since the drugs are non-mutagenic, are absorbed only slightly and do not permanently impair primary immune responses, an increased risk of cancer either topical or visceral is most unlikely. It is of note that with over 40 years of use of potent topical steroids—which not only deplete cutaneous Langerhans cells but are highly immuno-suppressant as well as being systemically absorbed—there is no evidence that they predispose to cancer either cutaneous or systemic. These new drugs for atopic dermatitis are welcomed by patients, parents, and doctor as a wholly new treatment option for this demoralising disease. They are the first major advance in its management in half a century.

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The authors have received funding from Fujisawa and Novartis to advise on and carry out clinical studies on tacrolimus and pimecrolimus.

Using evidence based tools to manage chronic illness

Ennor—Von Korff et al discussed how to organise care for chronic illness. Since 1993 we have used evidence based care tools that combine patients’ needs, values, and perceptions with scientifically valid patient based assessments to measurably improve and maintain health related quality of life.

We routinely use the functional health assessment questionnaire (SF-36) and the Zung depression, Beck anxiety, and Epworth sleepiness scales. We integrate these data with patient self care data
(reports on weekly exercise, self monitoring of blood pressure, breast self examination, seat belt use while driving, etc) and condition specific data (glycated haemoglobin concentration, cardiac risk index, T scores on bone densitometry, ejection fraction on cardiac echocardiography, etc). The process is appealing in both prepaid and self payment health care because the health strategy can be tailored, focusing on the patient’s concerns and needs first and including any remaining concerns from practitioners. Clients enter the integrative health process through an initial integrative health consultation. The SF-36 is used as the baseline measure of quality of life. It contains scores summarising both physical and mental function and eight subscales (physical functioning, role physical limitations, bodily pain, general health perception, vitality, social function, role emotional limitations, and mental health).

A standardised interview identifies patients’ perception of why they are underfunctioning as well as their perception of what is necessary to bring their experience of health to a place of excellence. We keep the clients engaged by addressing both their pain and their hopes simultaneously in one strategic plan.

We are in the process of refining our collaborative methods for displaying trends during telephone conferences with a group of focused, local health practitioners and, when necessary, the patient and a family member. Such a conference would allow evaluation of trends and modification of the strategic plan as needed. Our principal challenge has been technological. These methods will be widely accessible when simple communication, assessment, and reporting technology becomes practical, affordable, and available to busy practitioners.

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Criticism of new German chronic disease management is unfair

Error—Tuffs’s news item on the new chronic disease management programmes in Germany is misleading. 1

The new programmes have arisen from economic analysis showing the importance of ensuring that health insurance funds should not continue to be penalised financially when they have large numbers of patients with chronic diseases. The economic rationale for these programmes is not simply to fund deficits. There will be no extra money put into the system. Instead the existing risk adjustment strategy will take the higher costs for patients with chronic disease (initially type 2 diabetes and breast cancer) directly into account. Ultimately the government hopes to implement a new risk adjustment model that takes account of all pre-existing morbidity.

The federal government’s new programmes have arisen after the latest report of the Sachverständigenrat (the government’s advisory council) using data from the Organisation for Economic Co-operation and Development (OECD). Germany has the highest health expenditure in Europe with questionable quality of care. The programmes aim to eliminate overuse, underuse, and misuse of care.

The German Medical Society, statutory health insurance physicians, the hospitals society, and health insurance companies participated in the working group and the political committee that recommended these programmes to the government. The physicians could appoint their own experts and agree on all aspects of the programmes. All agreed, except for the hospitals society, which opposed requiring an evidence base for specific drugs. Thus it is hard to understand why the German Medical Society should have agreed on programmes that its president, Jörg-Dietrich Hoppe, now considers meet only minimal standards. 2

Condemning the new disease management programmes as inferior to routine care is pure polemic. For the first time in German medicine, such programmes have been built on a solid basis of evidence based medicine, combining the best available evidence with clinical expertise.

We conclude that the doctors’ opposition to these programmes results from the deep cultural shock felt by those who thought that medical experts could never come into conflict with evidence based medicine, which for the first time has become an integral part of official government programmes. Physicians’ representatives are also not amused that the health insurance companies showed their willingness to become players rather than just payers in the development of these new disease management programmes.

These programmes will be updated regularly and must go through a tough process of certification and evaluation before they can become part of the risk adjustment mechanism. We strongly believe that they will enable us to overcome the important obstacles that we presently face in providing integrated care for people with chronic diseases.

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