The German system of rehabilitation of alcohol addiction: A successful way of treatment or late and expensive intervention?

First of all I would like to give you a short overview of my presentation. I would like explain the German system of health care provision for addicted persons, give some information about the current practice of rehabilitation, tell you something about our quality assurance programme and catamnestic results of the sociomedical process and finish with future trends and aims for Germany.

The German system of health care provision for addicted persons

Social Insurance in Germany is carried by different organisations. These are essentially the agencies of health insurance, the Pension insurance, the statutory accident insurance and the nursing care insurance. The individual functions are assigned to the different bodies according to the principle that the agency has to supply funds for health services that bears the (financial) risk of a possible non-treatment. For the German Pension insurance this means that they are responsible for the rehabilitation of diseases which – if untreated – lead to a restriction or termination of the individual's capacity to work and thus to early retirement from work.

Every year the German pension insurance with its different carriers provides about 900,000 medical rehabilitations. The Federal Insurance Institute for Salaried Employees, in short "BfA", is responsible for about 25 millions of insured people and 8 millions of old age pensioners making us the largest Pension insurance carrier in Germany.

For many chronic diseases there are two treatment options – acute treatment on the one hand, which is funded by the health insurers and rehabilitation on the other hand, which is paid for by the Pension insurance. For addiction this means that acute treatment such as detoxification and its possible complications falls under the responsibility of the health insurers whereas psychotherapeutical treatment and social reintegration is funded by the Pension insurance.

This treatment is carried out all over Germany in specialised hospitals and outpatient facilities. There are more than 14,000 inpatient beds, whereas for outpatients there are about 400 centers, which are authorized for the rehabilitation of addicted persons. Apart from these facilities with a rather high threshold there is a wide net of other services such as "brief intervention" in doctors' surgeries and hospitals, outreach centers providing advice and counselling, motivation and organisation of further treatment, offers of immediate help and harm reduction, substitution treatment for drug addicts, different housing facilities and vocational projects. There are about 8,000 self help groups offering their services to nearly 150,000 people suffering from addiction.

Even though the German system of providing help for addicted people is said to be one of the most complex in the world, medical rehabilitation still reaches only a small percentage of patients with a substance abuse problem. The numbers vary around 2% of alcoholics and 4-5% of the users of hard drugs.

Current practice of rehabilitation

In 2002 about 52,000 rehabilitations for addicted persons were carried out by the German Pension insurance, 19% of which were in an outpatient setting. Of these the BfA carried out nearly 13,000, 25% of which were outpatient.
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Inpatient treatment usually lasts 8 – 28 weeks for patients addicted to alcohol or drugs like sedatives, hypnotics or analgesics and 8 – 42 weeks for users of illegal drugs like opioids and cocaine.

A low-frequency outpatient medical rehabilitation lasts about 9 – 12 months. A maximum of 120 therapeutic sessions - individual or in a group setting – are paid for within a timeframe of 18 months.

The rehabilitation takes place in in- and outpatient treatment centres, which have been approved by the BfA. To obtain this approval the centre has to present a detailed and scientifically based treatment concept and fulfil certain criteria with regards to staffing and layout of rooms. Great attention is paid to the professional qualification of the staff, proof of which is mandatory.

The in- and outpatient facilities in Germany work according to an agreed concept. Most widely used are behavioural psychotherapeutic methods closely followed by psychodynamic psychotherapy. Other methods such as psychodrama, gestalt therapy or Roger's person centered therapy are used.

The approach to rehabilitation is interdisciplinary, which means that the rehabilitation team consists of members of different professional groups The team is lead by a doctor. Involvement of the patient is mandatory. This process starts at the very beginning of the rehabilitation when patient and therapist agree on targets that should be achieved during rehabilitation and together formulate an individual rehabilitation plan.

Quality assurance programme

I would now like to show you how our quality targets are implemented and how the necessary quality of treatment is assured. All facilities have to participate in our quality assurance programme.

The pension insurance started their quality assurance programme already in 1994. Today almost 1,000 hospitals or independent departments take part in this programme. The quality assurance programme evaluates the three dimensions of quality: structure, process and outcome. It is subdivided into different parts for which individual instruments have been developed in order to assess the quality of the treatment centres or the treatment, respectively.

To assess structural quality we use the hospital documentations "structural criteria" and "conceptual criteria". Structural criteria record data on the layout of buildings, staff, diagnostic, therapies on offer, and the therapeutic spectrum of the facility. The conceptual criteria on the other hand deal with conceptual aspects of structural quality such as internal quality assurance, internal and external communication structures, documentation, education and training, supervision and the conceptual orientation of the therapies.

To assess quality of process a checklist of relevant process criteria for the peer-review of discharge letters, a manual for this checklist and a catalogue of the therapeutic aims are used.

Additionally, a questionnaire assessing the patients' opinions on treatment and result of the rehabilitation is used.

In the quality development of the facilities the regular visitations by staff members of the funding agency play an important role, too.

In analogy to this external quality assurance programme the treatment centres and their organisations have developed and realised concepts for internal quality assurance.

I would now like to present results from the peer review process of discharge letters from 2002 in the area of addictive disorders. From each clinic 20 discharge letters were included in the review. The focus of the evaluation was on medical history, diagnostics, therapeutic goals, planning of therapy, course of treatment, epicrisis, sociomedical assessment and continuing therapeutic treatment/aftercare.

The 67 individual items were attributed to the categories "no fault", "minor faults", "obvious faults" and "grave faults", followed by a general summary.

In 2002 230 addiction treatment facilities took part in this peer review; more than 3,000 discharge letters were assessed.

In 2002 the entire rehabilitation process was rated with "no fault" in 15 % of the cases, "minor faults" in 53%, "obvious faults" in 25% and "grave faults" in nearly 7% of all cases. As you can see in this table the highest percentage of obvious and grave faults was seen in the areas of "diagnostics" (32%), "sociomedical assessment" (28%) and the general summary (32%). Here we see a definite potential for improvement.

Compared to the previous evaluation there were significant improvements in the areas "therapeutic goals", "planning of therapy" and in the rating of the entire rehabilitation process.

Each hospital received a detailed report showing their results in comparison to the average of all hospitals with comparable patients. This allows the facilities to focus and work on the apparent deficiencies as part of their internal quality management.

Catamnestic results of the sociomedical process

Compared to the usual catamnestic evaluations the German Pension insurance with their precise overview over employment histories and payment of contributions has with the database of rehabilitation statistics another valuable source at their disposal to evaluate the effectiveness of rehabilitation.

In 2000 6.960 inpatient rehabilitations for addicted people funded by the BfA were carried out and completed successfully. In the two years following rehabilitation for alcohol addiction 62% continually made contributions to the pension insurance and 26% contributed at times. 7% received (vocational) invalidity pensions. 2% reached retirement age, which these days is 65 years of age for men and women. 3% of the patients had died within the two years following treatment.

This means that 88% of the patients remain in working life after a successful rehabilitation contributing for an average 21 of 24 months contribution to the pension insurance. These contributions came in 59% by employed people, in 34% by unemployed and in 7% by those certified off sick.

In the outpatient sector there were 2.376 rehabilitations in 2000 carried out and completed successfully. In the two years following rehabilitation 74% continually made contributions to the pension insurance and 19% contributed at times. 3% received invalidity pensions, 2% reached retirement age and 2% had died.

If you compare the figures from rehabilitation of addicted people with patients with other diseases the results for continuous employment are pretty much the same.

Generally, these results support the statement that the in- and outpatient rehabilitation of addicted persons in Germany is successful. According to several catamnestic evaluations roughly 50% of all patients undergoing rehabilitation for substance abuse remain abstinent during the following year. Since the goal as well as the legal mandate of the German Pension insurance is the maintenance or restitution of working capacity these figures clearly demonstrate that we are indeed quite successful. Particularly, it is sensible to start a rehabilitation and try to restitute working capacity. The alternative with the patient remaining untreated may lead to invalidity and early retirement.

Future trends and aims for Germany

To recapitulate, I would like to state that German health services for addicts are shaped according to the specific structures of the social system. What trends have to be considered in the future?

Even though the outpatient sector of addiction rehabilitation has been expanded continuously during the last few years, providing now about 20% of all rehabilitations, which is quite a lot compared with other diseases, this figure is – compared with international figures – still rather small.

The analyses showing occupational integration two years following rehabilitation demonstrate the restitution of working capacity and return to gainful employment.

Despite these positive results the Pension insurance nowadays strives to improve especially work related aspects of medical rehabilitation to counteract the problems of unemployment and lack of social integration.

In the future, with the advancement of the treatment system Germany will have to deal more closely with the converge of the different social systems within the European Union. We are, however, not interested in low-level or lowest common denominator compromises. In a benchmarking sense the best and most efficient aspects of treatment should prevail across Europe.

In the political field of the European Union the so called „open method of coordination" has been used since 2000. For this guidelines for the realisation of certain goals are defined, together with an exact timetable. As a next step indicators and benchmarks are formulated in order to compare approved practices and methods. With precise aims and appropriate steps these guidelines will be implemented in national and regional politics. In the context of a process, where each learns from everybody else, but where the identity of everybody is still taken into account, the steps are monitored, checked and evaluated regularly.
This method is used quite frequently for the purpose of comparison and competition of administration and management across Europe and on a national base.

For Germany these comparisons and challenges mean particularly an expansion of the outpatient rehabilitation close to home, earlier interventions with substance abuse, a distinct orientation towards work-related aspects of medical rehabilitation, the implementation of evidence based clinical practice guidelines and a stronger link between research and the practising of care.

I hope that conferences such as this one will support this development. Thank you for your attention.

Joachim Koehler, Psychiatrist, Psychotherapist, MPH
Federal Institute for Salaried Employees
(Bundesversicherungsanstalt für Angestellte, BfA)
Department of Basic Principles in Medicine
Address: BfA, R 6207, Ruhrstrasse 2, 10704 Berlin, Germany
Email: joachim.koehler@bfa.de
Phone: +49-30-865-25751
Fax: +49-30-865-27391