

Is diabetes suitable as a model for IT-supported shared care?

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Introduction

In recent years ‘shared care’ has been a popular topic in the Danish health services, especially in relation to chronic diseases. Shared care aims at creating coherent treatment of the patient through close collaboration and shared responsibilities across sectorial boundaries. In practice this vision is not always carried out.

We have undertaken a comparative analysis of the circumstances *for* and the results *of* the implementation processes of 2 database systems for diabetes patients in two Danish counties, which are examples of IT-supported shared care. In this abstract we will describe some of the observed implications hereby.

Method

Our empirical work mainly consists of observations and interviews with doctors from both primary and secondary sector, interviews with representatives from the system developers and representatives from the counties of Roskilde and Funen.

Result

In Roskilde the system was developed using a bottom-up methodology, which implies that the development process has been initiated on a small budget by the end users. The system is slowly being adopted by other hospitals in Roskilde and Copenhagen while the version for the GPs is still in the testing stage.

In opposition to Roskilde, the system on Funen arose from a top-down development with financial support from the pharmaceutical industry. The initiative came from the county who is also responsible for implementing the system in the hospitals and with the GPs.

The two opposite development strategies have resulted in two functionally and structurally different systems. In spite of this the consequence of the implementation of the

system is the same: the secondary sector has adopted the system but the primary sector is more sceptical.

Discussion

Because the idea of the system in Roskilde arose in the mind of an end user, one could be tempted to expect that the end users would adopt the system in opposition to the system on Funen, which has arisen from top level. However none of the systems are well anchored in the primary sector.

In both counties we found that the purpose of the system is ambiguous and that it doesn’t seem to benefit the existing workflow in the primary sector. Both systems are real-time systems and are therefore meant to be used during consultation of the patient. But most GPs do not work with the computer and the patient at the same time. They prefer to use the computer after the patient has left, as they see a contradiction between “quality time with the patient” and “using the computer during the consultation”.

Furthermore the sectors don’t actually seem to share many diabetes patients. Either the patient is treated at the hospital *or* by the GP. If a patient *is* shared, it means that the patient is treated at the hospital e.g. for a year or two before s/he is treated by the GP again. Also the hospitals need data that already exist in the GP’s own patient administration system.

These points taken into consideration together with the fact that diabetes accounts for only approx. 5 % of the GPs’ consultations, make the concept of shared care in relation to diabetes seem pointless for the GPs.

The issues listed above combined with the fact that most of the GPs we interviewed did not explicate any needs for further information exchange about diabetes patients, makes us doubt whether diabetes is suitable as a model for IT-supported shared care.