

Letter to the Editor

The ultimate goal of disease management: improved quality of life by patient centric care

Guus Schrijvers recently proposed a new definition of disease management: *disease management consists of a group of coherent interventions designed to prevent or manage one or more chronic conditions using a systematic, multidisciplinary approach and potentially employing multiple treatment modalities. The goal of disease management is to identify persons at risk for one or more chronic conditions, to promote self-management by patients and to address the illnesses or conditions with maximum clinical outcome, effectiveness and efficiency regardless of treatment setting(s) or typical reimbursement patterns.*

Although this definition is very broad and comprehensive, I do miss two key aspects: 1) Evidence-based practice guidelines and 2) Coordinated health care interventions, according to the Disease Management Association of America (DMAA) [1].

Guidelines are helpful to standardize the interventions of similar providers, and coordination is necessary to bridge and link these interventions into a chain of care. A disease manager ‘supervises’ the integrated care continuum and patients’ interactions and responses and she monitors the fit between the continuum and the disease course.

A more principle aspect, that I think is much more important, is the *goal* of disease management. In my opinion, the goal of disease management is the trigger for patient participation and compliance, namely, to improve patient quality of life measured in clinical outcomes, self reported health status or functional status, etc., to delay and reduce comorbidity and (acute) complications.

The meso level

The aspect ‘*manage one or more chronic conditions*’ is an issue on the meso-level. Disease management, with its roots in the pharmaceutical industry [2], has traditionally targeted persons with a single (chronic) disease to increase compliance for a drug related to a disease.

Now we know that chronic diseases are not stand alone conditions but are often associated with comorbidities and other (non-related) chronic diseases [3].

The challenge for the future is to pioneer with multi integrated care systems to meet both economies of scale and to serve the patient’s comfort and medical needs.

Enthoven [4] and Porter [5] have discussed this. Enthoven [6], the theorist behind ‘managed competition’, shows that the types of care coordination seen in large multi-specialty groups are necessary for care of the chronically ill. We need “efficient integrated healthcare systems, with teams of professionals, who provide coordinated, efficient, evidence-based care, supported by state-of-the-art information technology” [7, p. 420]. These organizations provide complete care: from the doctor’s office, to the hospital, to home care. Competition at the ‘disease’ level, or at the individual doctor or provider level (as advocated by Porter and Olmsted Teisberg [5]), is likely to be counter-productive and ineffective.

Porter and Olmsted Teisberg [5] believe that there is little benefit in broad provider networks, but instead providers should try to be excellent and unique regionally and nationally. They also suggest that providers should consider one bill and organize around one practice area for each disease state. They think that providers need to be distinctive and have a market niche or brand strategy that’s comparable to other businesses in other industries, which means delivering added value to customers as compared to competitors.

The macro level

An important aspect on the macro level is managed competition. Porter is pretty dismissive of managed competition and Enthoven supports managed competition. However, all markets are bound by regulation and market players are acting out their rational incentives within that regulatory framework. If the government uses regulation and subsidies to change the market, one way or another, this is ‘managing’ competition. And governments do this in every market: either by deliberate action or by inaction. The implementation of disease management will vary with the degree of regulation.

The way of implementing disease management will vary depending on the level of (government) regulation in a country. In Germany, disease management was [8–10] introduced by law (in 2002) with financial

incentives for health insurers; the ‘top down’ way of doing it. Insured people who join disease management programs (DMP) are labeled ‘chronically ill’ for the purpose of the risk structure compensation scheme, and spending is calculated separately for them. Health insurers with a high share of DMP participants receive higher compensation from the scheme.

In the Netherlands, it was the other way around. Here, DM was developed by cooperation among groups of providers, so the bottom up way [11]. Providers search for alliances to build up care for the chronically ill, networking in a region with local partners, initiated by the hospital.

So, a DM-program is dependant on the market structure and system reform.

Conclusion

In my opinion, the last part of Professor Schrijvers’ definition: “... *regardless of treatment setting(s) or typical reimbursement patterns*” is not realistic and feasible. Reimbursement, payment, financial incentives

(like functional finance in the Netherlands [12]) and local settings are indeed an issue and they determine a significant part of the structure of the DM programs on the meso and macro level and even more on the micro level (for example, how many disease managers there are in a region)! So we cannot ignore them! It is fighting organizational boundaries and challenging the functional pricing to provide with all network parties in the Netherlands: patient centric care!

The needs of the patient, the ‘demand side’, are of course the starting point for creating DMPs. But the market structure, the ‘supply side’, is the second point and the limiting factor for creating the ultimate in disease management: improved quality of life by patient centric care.

Evelien van der Vinne, Drs, MSc, MM,
Marketing Intelligence Analyst,
Menzis Health Insurance,
PO Box 75000, 7500 KC Enschede, Netherlands
Phone: +31.0317.455455
E-mail: e.vinne@chello.nl

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