

## Editorial

# Fatal attraction? The rise of disease management programmes in Europe

On my travels to conferences around Europe, but particularly in the UK, it is clear that disease management commands wide support as the 'optimal' approach to planning and delivering health care. It has been welcomed as a 'system response' to problems evident in all health services including: the growing burden of long-term chronic diseases; the lack of integrated care; the bias towards acute treatment; and the relative neglect of primary and community alternatives. The rise of disease management in Europe has also been rapid. In Germany, for example, disease management programmes (DMPs) were introduced by law in 2002 for diabetes, breast cancer, coronary heart disease, and COPD [1]. Parts of the Netherlands, Spain and Sweden have similarly begun DMP experimentations [2, 3]. In England, policy has focused on adopting US managed care models of the type implemented by Kaiser Permanente and United HealthCare's Evercare model of case management [4].

For policy-makers, the theory behind disease management is immediately attractive as a basis for system reform since it makes the dual claim that health care resources can be used more cost-effectively (through vertical integration) whilst simultaneously improving and/or maintaining good health for the individual patient. However, engaging with the debate in Europe reveals that the foundations for the 'movement' appear to be based on exaggerated and unrealistic claims. At least three fundamental problems exist: the lack of a common understanding to the concept of disease management; lack of evidence on its long-term cost-effectiveness; and, significantly, little evidence to support its claims for better health outcomes.

The first problem is immediately apparent at international conferences where the concept of disease management is perceived in very different ways. The term, for example, is used synonymously with a range of related but different concepts including: case management, care management, managed care, shared care, transmural care, integrated care, care pathways, chains of care, self-care and so on. This is perhaps not surprising given that disease management is a very broad concept and is multi-component in nature.

Differences in our understanding, therefore, are born from the heterogeneity of components unique to every DMP that—as one systematic review of the evidence

points out—largely precludes any general conclusions to be made about their collective effectiveness [5]. Clearly, there is a need for a more rigorous interpretation of the concept of disease management to enable more reliable syntheses and conclusions.

The second problem concerns the weakness of the evidence on the cost-effectiveness of DMPs. In England, for example, much of the empirical justification for current system reform cites a few (well publicized) studies from the USA that have reported how DMPs can have a significant impact on reducing unplanned admissions and length of hospitalisation whilst reducing rates of complications from chronic diseases and retaining patient satisfaction levels [6–8]. The argument is persuasive and compelling to the converted, but it is also very clear from the wider data available from DMP studies that the case for disease management in general is inconclusive. We just don't know whether disease management in Europe is a more cost-effective solution than standard care in the long term.

This is a problematic realisation. The 'tipping point' for the growing disease management movement in Europe was primarily based on the premise that it would help alleviate the foreseen long-term economic time-bomb of aging populations and the growing burden of chronic diseases. Aspects of disease management have since been aggressively implemented as a lever to break the traditional authority of physicians as health systems seek multi-professional, multi-disciplinary solutions with a focus on 'upstream' prevention and the promotion of well-being. Should the approach prove unfounded—that long-term cost-effectiveness and improved health outcomes remain elusive—then clinicians and patients are likely to reject disease management policies in much the same manner that has led to the current demise of the HMO movement in the USA.

The third problematic observation is that the debate progresses with relatively little evidence (even concern) for improved patient outcomes. It is true that most DMPs that have been evaluated in appropriately designed studies have been shown to be effective compared to 'standard' or 'usual' care in improving the quality of care to patients with chronic conditions—at

least measured by proxies such as providers' compliance to set standards of care and the ability of patients' to monitor their disease [5]. The less good news is that the evidence appears limited to diabetes, depression and coronary heart disease with benefits being inconclusive in other cases. Moreover, there is little long-term knowledge on benefits to mortality or morbidity and what evidence does exist suggests no statistically significant differences. Most important, perhaps, is that every DMP trial appears different in design and so complex that we cannot be certain about what combination of components are responsible for any particular result.

So what can we conclude from these observations? It is clear that there is never going to be a single model of disease management in Europe that can be universally applied, but it is essential that evaluations and lessons from experience—using a common conceptual framework—are collated to show the long-term cost-effectiveness of DMPs and whether longer-term health outcomes can be improved. Furthermore, countries need to examine critically whether introducing

DMPs—particularly in the form of new organisations—is necessary when other solutions are available. For example, in countries like the Netherlands and England, primary care-based networks that provide multi-component, integrated and co-ordinated support over time may be better than DMPs that potentially preclude more holistic care.

There is certainly a compelling logic to disease management—and that is often all that is needed to justify policy reforms—but one gets a sense in which a fatal attraction has been established in which policy-makers are being seduced into the latest fashion in healthcare reform without fully understanding its consequences.

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