Disease management: has it a future?

It has a compelling logic, but needs to be tested in practice

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Disease management, often known as integrated care or care pathways, has wide appeal for health care reformers keen to contain costs and improve outcomes.[1 2] Integrated care is a key plank in the government's NHS modernisation programme.[3] It is also particularly relevant to chronic illness.

Disease management commands wide international support as the optimal approach to planning and delivering health care.[4] It is welcomed as a structured systems response to a set of problems that are evident to some degree in all health services. These include uncoordinated arrangements for delivering care, a bias towards acute treatment, a neglect of preventive care, and inappropriate treatment. The theory behind disease management is that resources can be used more effectively if the patient becomes the pivot around which health care is organised.[5] In place of functional divisions, such as those between primary care and hospitals or between different clinical specialties, the divisions are between diseases. A single organisation conducts prevention, health screening, diagnosis, treatment, and follow up for a particular disease.

Disease management is particularly well suited to chronic conditions because it views patients as entities experiencing the clinical course of a disease rather than viewing their care as a series of discrete episodes. A combination of patient education, practice guidelines, appropriate consultation, and supplies of drugs and services is the essence of disease management.

But for all its obvious, and largely commonsense, appeal, the effectiveness of various disease management initiatives has largely gone untested, as Bodenheimer shows (p 563).[6] Moreover, anecdotal evidence from the United States suggests that aggressive disease management programmes have lost the support of both clinicians and patients.[7] Clinicians fear a loss of autonomy in their decision making as they are expected to adhere to guidelines and protocols. Patients complain that they can no longer choose their specialist or have a say in their treatment. These concerns may be less relevant in Europe, where clinical care at a microlevel has not until recently been managed so closely.

Disease management holds many attractions for commercial interests, who see opportunities for developing integrated care packages for particular diseases and then "selling" these to healthcare organisations. Such so called vertical integration would encounter major opposition in countries like the United Kingdom with strong primary care.[8] Under the last Conservative government there was the prospect of public-private partnerships in the delivery of disease management programmes.[9] The change of government put a stop to most of these ventures, although a few continue, such as the partnership in HIV disease management between Chelsea and Westminster Hospital NHS Trust and Roche. Indeed, the government, in keeping with its "third way" pragmatism, might support further public-private partnerships. Two of the papers in this issue warn against uncritically going down such a road.[6 10]

Bodenheimer describes how US disease management programmes run on a for-profit basis are likely to have unintended and dysfunctional consequences for healthcare systems.[6] He advocates an approach to disease management that seeks to build on the strengths of the in house primary care physician rather than outsource activities to specialised commercial interests. In contrast to the US and some other European countries, the British NHS is well placed to adopt disease management principles of this nature.

In the UK, as in many other European countries, there is experimentation with public-private ventures, although little is known about their impact or effectiveness. As the paper by Greenhalgh et al suggests (p 566),[9] there is likely to be increasing pressure on the NHS to enter into quasicommercial relations with pharmaceutical companies and others. They do not deny the benefits of such partnerships but favour explicit arrangements in place of clandestine liaisons. Whether these will be sufficient to bridge the "cultural divide" separating the public and private sectors remains to be seen.[11]

Unrealistic claims have been made for disease management, and it is easy to be seduced by the latest fashion in healthcare reform. Nevertheless, there is a compelling logic to disease management. The NHS has largely failed to exploit its innate strengths and perform as a whole system. The national bed inquiry report lends support to this view.[12] There is no single model of disease management to be applied everywhere. But the principles of disease management are important in the redesign of services as greater attention is given to prevention and primary care. At the same time, evaluations are needed to show the cost savings and improved outcomes that are claimed to result from disease management.

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DJH has been paid by several pharmaceutical companies to advise them on NHS developments and to speak on health policy. He has received a grant from MSD for a research study on primary care groups and health improvement programmes.

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