Disease management opportunities in France

Jean-Michel Peny and Maryse Dugué examine the obstacles to the introduction of disease management programmes in France and the options open to pharmaceutical companies that decide to enter the field.

Disease management "is like teenagers and sex – everyone is talking about it, everyone thinks everyone else is doing it, but only a few are doing it, and those who are doing it are not doing it well".

This description, from Rob Buccino of the New York public relations company Gross Townsend Franck Hoffman, may no longer apply to Western teenagers but it is relevant to the current situation in disease management which in France has not yet reached the operational stage. Despite the current lack of activity, however, disease management offers exciting opportunities to pharmaceutical companies that can overcome the obstacles – opportunities that are enhanced by the difficulties facing the healthcare system in France.

Analysis shows that the deficit in the health insurance funds (Sickness Funds) is responsible for an increasing proportion of the overall Social Security deficit – 63% in 1996 against 18% in 1991. According to the latest estimates, the cumulative Sickness Funds deficit reached US$21 billion for the period 1994-1996. The main cost driver was hospital spending, which accounts for 57% of total healthcare expenditure and grew by an average of 7% a year during the 1985-1995 period. However, the French authorities cannot afford to introduce drastic cost reduction measures. With 70% of hospital spending generated by employment costs, the social impact and the political risk would be unmanageable.

According to health economists, around 10-15% of total French healthcare costs are due to inefficiency in the system. Moreover, the complexity of the system, coupled with a lack of coordination between the various players, results in a systemic overcost that could be substantially reduced by process re-engineering, similar to the procedures implemented in disease management programmes.

Key elements

Disease management involves six key elements:

- Education of patients and high-risk individuals.
- Information and training for healthcare providers.
- Coordinated delivery of healthcare by providers.
- Computerised data management.
- Systematic outcomes measurement.
- Optimised clinical guidelines.

The six elements and the relationships between them in a typical disease management programme are shown in Figure 1. The extent to which disease management could be introduced in France depends on how readily these elements can be implemented.

Public health information campaigns designed to educate patients and high-risk individuals in areas such as diabetes, hepatitis and cholesterol are not rare in France. However, French people and their doctors are more cure- than prevention-oriented and systematic consultations for early screening, lifestyle education and advice, are not common. Besides, it is unlawful for a French doctor or any other

A holistic approach to patient care

Disease management is an integrated, multidisciplinary approach which aims to optimise clinical and economic outcomes. Its ultimate objective, for a given pathology, is to reduce overall healthcare costs and increase quality of care to patients.

To meet this challenge, key care processes need to be re-engineered and healthcare expenditures must be managed globally to develop a 'holistic' approach to patient care for a particular disease. A disease management programme could therefore lead to an increase in one cost component provided the overall cost is decreased. For example, an increase in drug costs (from improved patient compliance, earlier treatment, more intensive therapy and/or the use of more expensive but more effective innovative products) could lead to a reduction in hospital costs (from improved clinical outcomes, lower hospitalisation rates, shorter stays and better home care) plus saving on consultations, giving an overall cost reduction.

But while disease management offers benefits in specific pathological conditions, the approach is not a universal panacea. In practice it tends to place insufficient emphasis on primary prevention and fails to provide satisfactory solutions for patients with acute pathological conditions or multiple chronic diseases.

Ideally, disease management should soon evolve towards the concept of 'individual health management'. This approach, which focuses on individual patients, not the disease, is intended to manage 'health assets' to provide the best combination of clinical efficacy and cost control. 'Individual health management' should represent a major improvement from a public health perspective and deliver significantly greater cost benefits.

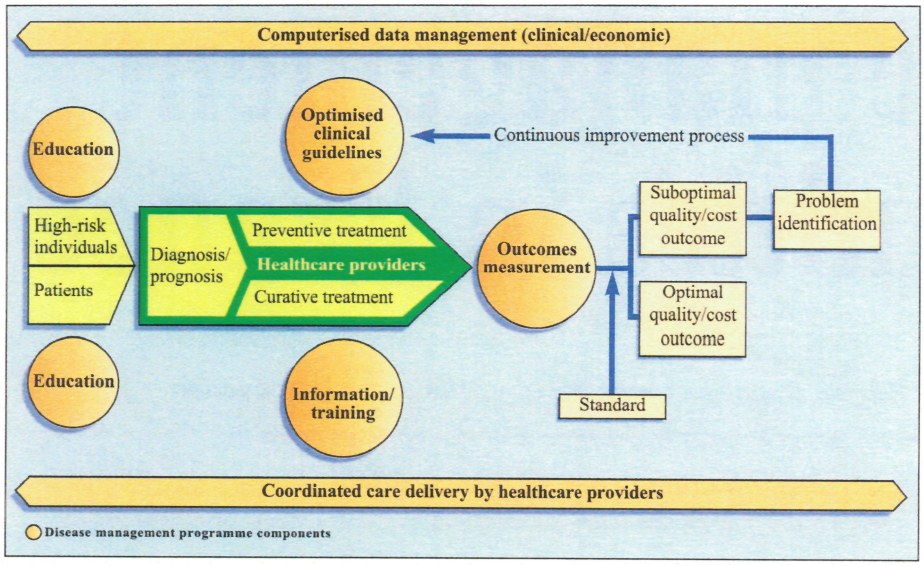

Figure 1: The various components of disease management programmes.
Source: Adapted from R.A.Brown, 1994.

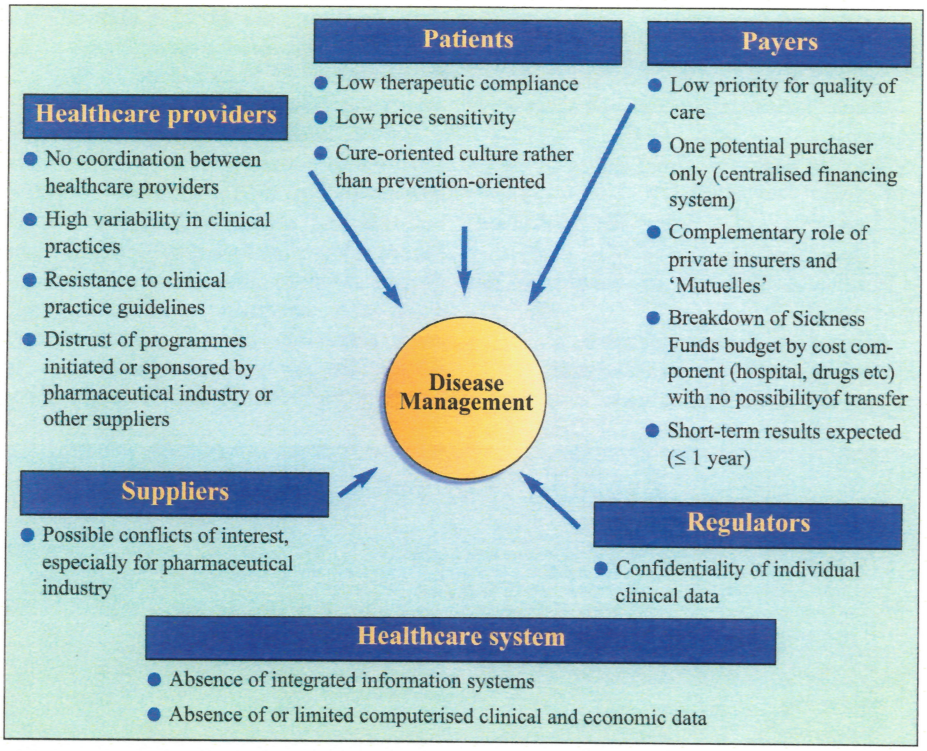

Figure 2: The major obstacles to the introduction of disease management programmes in France.

healthcare provider to call a patient to make an appointment for a check-up.

The provision of information and training to healthcare providers should improve, both qualitatively and quantitatively, through continuous medical education (CME), which has been compulsory for general practitioners in France since January 1997. In addition, the future computerisation of doctors' activities will facilitate the exchange of information and allow computer-assisted training and practice.

The delivery of coordinated healthcare could be difficult to implement. Coordination between healthcare providers is currently poor and their clinical practices often show wide variability. One possible way forward is the recent French government proposal for a five-year pilot study of healthcare provider networks, in which doctors, hospitals, consultants, etc would work together to provide care for patients with diseases such as cancer and AIDS. If successful, these experiments will improve the quality of care and reduce wastage through better coordination of healthcare delivery. However, unless the authorities regulate the number of projects and impose stringent controls on quality there is a risk of an explosion of experiments of patchy quality.

The implementation of computerised data management is also likely to pose problems in the short term. Until the beginning of the next decade, when doctors will be equipped with computers and patients will receive an individual smart card holding their medical records, systematic and reliable sharing of available clinical and economic data will be difficult, if not impossible. The high investment required to develop and implement an integrated information system is another serious issue that will have to be tackled.

One of the most important elements of disease management is outcomes measurement. To date, the most widely used assessment tools are cost/benefit and cost/effectiveness ratios – the former compares programme cost with the financial outcome (eg savings made as a result of treatment protocol) and the latter compares programme cost with clinical benefits obtained (eg cost per life-year saved). However, psycho-social outcomes, which are usually measured by quality of life tools such as visual analogue scales, are becoming increasingly important. Systematic clinical and economic outcomes measurements are essential to ensure continuous improvement of clinical guidelines but many of the methodologies are still at the experimental stage and need to be further improved and validated. A further complication is that, for reasons of confidentiality, French regulatory bodies are not in favour of allowing free access to individual clinical data. Without this facility, reliable outcomes measurements cannot be obtained. The potential efficacy of disease management will also be seriously affected if the recently introduced annual growth ceiling for consultation fees and prescription expenditure for reimbursed drugs is not amended. This measure is incompatible with the 'holistic' approach that is required to provide the necessary flexibility to optimise clinical and economic outcomes.

With regard to the sixth key element of comprehensive disease management programmes, optimised clinical guidelines, the government showed the way in 1994 and 1995 when it introduced 147 mandatory good medical practice guidelines (RMO). The main difficulties in optimising clinical guidelines come from contradictory evidence and the need for a consensus on clinical practice. The problems are exacerbated by the reluctance of doctors to comply with clinical guidelines and the failure of many patients to take their medicines as prescribed.

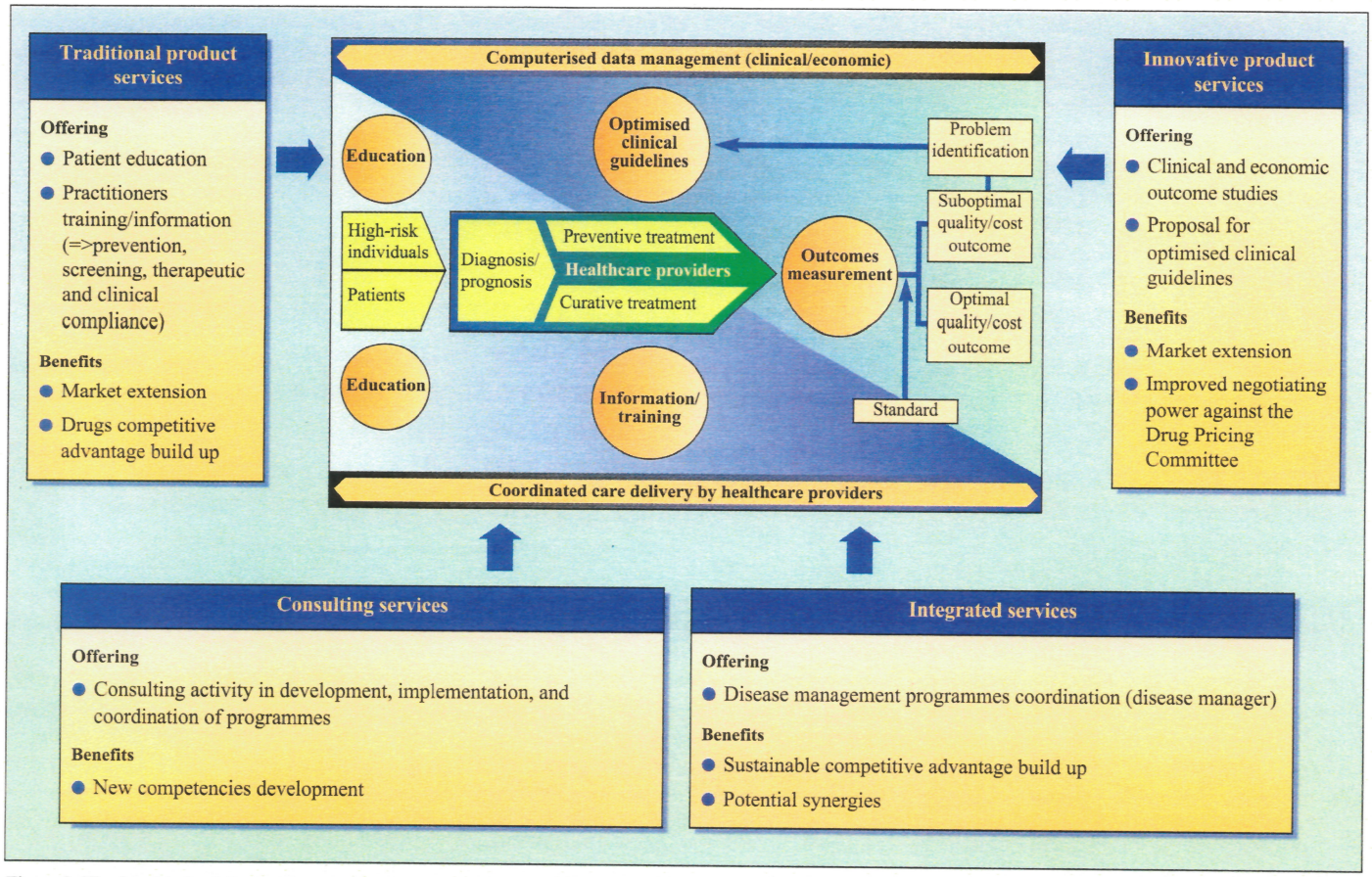

Figure 3: The four kinds of disease management service that pharmaceutical companies could provide in France and the benefits that each service option offers.

Non-compliance by patients has enormous implications for healthcare costs. It is estimated that non-compliance in the US (defined as over- or under-consumption of pharmaceuticals, or failure to fill a prescription) affects around 50% of prescriptions and costs the healthcare system US$100 billion a year, or 10% of total healthcare costs. Hospital costs account for around 30% of this sum, ambulatory costs for about 20%, and reduced productivity for the remaining 50%[1]. If compliance could be improved by 20%, the savings would amount to US$20 billion a year, equivalent to 2% of total healthcare costs. Although strictly regulated in France, compliance initiatives have existed for some time. Calendar packs are often used for chronic therapy, and dietary cards or booklets with lifestyle advice have been developed by pharmaceutical companies and distributed to patients via their doctors.

Obstacles to the implementation of the six elements outlined above are cultural, technical, economic or regulatory, as well as systemic, and affect all the potential players, as shown in Figure 2 on page 57.

Although these problems will have to be resolved, many pharmaceutical companies are already well qualified to play a leading role in disease management.

Opportunities for industry

The unprecedented pressure imposed by the authorities on drug prices and unit growth, plus the intensification of competition, are driving major pharmaceutical companies to develop broader ranges of services aimed at more diverse groups of clients. Lilly's mission statement illustrates this trend: 'Our mission is to create and deliver superior pharmaceutical-based healthcare solutions – by combining pharmaceutical innovation, existing pharmaceutical technology – in order to provide customers worldwide with optimal clinical and economic outcomes'. In this quest for new kinds of value to offer their 'clients', major pharmaceutical companies are positioning themselves for a place in disease management. And they have the resources to do so.

Their R&D capabilities and extensive expertise in selected therapeutic areas enable them to develop more cost-effective drugs and technologies, while their capabilities and expertise in clinical and pharmacoeconomics research can be used to conduct clinical and economic outcomes studies. Pharmaceutical companies are also well-known for their ability to influence providers and patients' behaviour, which is a cornerstone in any disease management programme. And not least, their large financial capacity makes them valuable, if not essential, partners, given the enormous resources needed to develop and implement disease management programmes.

The extent to which a pharmaceutical company wants to participate in disease management initiatives should depend not only on local market opportunities but also on corporate strategic intent. Companies can pursue two basic objectives: they can reinforce their competitive position in their core business by offering a product/service package to healthcare providers and payers; or they can add to their core business an independent disease management activity to sell comprehensive services. Before selecting the type of disease management service they want to offer in France, pharmaceutical companies need to make a careful strategic and financial assessment. They must then prioritise the pathologies on which they wish to focus.

Target diseases

Healthcare payers and pharmaceutical companies will generally have different priorities in selecting targets for disease management programmes. Payers are likely to be most interested in introducing programmes for high-cost chronic patholo-

gies that offer the best potential for clinical and economic outcomes. Pharmaceutical companies, on the other hand, should select a disease state where drugs play an important role in providing patient care. It would make sense for companies to concentrate on therapeutic areas where they have specific expertise and drugs either on the market or in development. This is what has tended to happen in the US where disease management programmes focus mainly on asthma, cancer, cardiovascular diseases, diabetes and central nervous system disorders.

So far in France, Glaxo Wellcome has targetted asthma, AIDS and cancer for disease management initiatives, and Lilly France is also focusing its activity in areas where it has a strong presence, such as depression and diabetes. SmithKline Beecham, however, has made the unusual decision to operate not only in areas where it markets drugs (eg depression) but also in pathologies such as diabetes, osteoporosis, coronary diseases and asthma where it does not have a significant local presence.

Service options

Once target diseases have been identified, companies need to decide what kind of service they wish to offer. The options can be summarised under four headings: 'traditional product' services, 'innovative product' services, 'consulting' services and 'integrated' services. These options and the potential benefits they offer the company are summarised in Figure 3.

'Traditional product' services are given free and are attached to a specific marketed drug with the ultimate objective of increasing its sales. In practice, this type of service encompasses patient education and training/information for doctors. Most pharmaceutical companies have been offering this type of service for years to healthcare providers and patients. However, there is room for improvement, as was shown in a study carried out in France in 1993[2]. 'Traditional product' initiatives should have two objectives: firstly to extend the market for a drug by increasing the percentage of patients who are diagnosed and treated, and who then comply with the treatment; secondly they should seek to strengthen a drug's competitive advantage by enhancing product differentiation, and increasing doctor and patient satisfaction and prescriber loyalty. To achieve these aims excellent services need to be offered.

To date, companies have had little involvement in the 'innovative product' services area which includes clinical and economic outcomes studies and proposals for optimised clinical guidelines. Glaxo Wellcome, one of the forerunners in disease management in France, is preparing a local experiment on asthma with healthcare networks. Another pioneer, Lilly France, is also preparing to launch pilot outcomes studies on diabetes and depression. As with 'traditional product' services, opportunities to extend the market exist. However, the results of outcomes studies carried out and sponsored by a given pharmaceutical company will benefit the entire therapeutic class, including its close competitors.

'Consulting' services offer pharmaceutical companies an opportunity to develop, implement and/or coordinate disease management initiatives for healthcare payers (Sickness Funds, 'Mutuelles' or private insurers) and even other pharmaceutical companies. Lilly in the US is offering this type of service through its Integrated Disease Management division.

The 'integrated' services option allows pharmaceutical companies to participate in a broad range of services up to and including healthcare delivery. Taken to the limit, the company would become the disease manager, assuming responsibility for coordinating the overall healthcare services delivered for a given pathology. Zeneca's acquisition of Salick, the US-based speciality provider of cancer therapy, illustrates this approach. The 'integrated' service option can help a company build a sustainable competitive advantage in a given disease area without creating major risks of conflict of interest.

Companies will need to cooperate with a large number of players and will, to a certain extent, have to share the ownership of the programmes

Whatever their degree of involvement in disease management, pharmaceutical companies will have to resolve a number of issues relating particularly to control, profitability and organisation.

Developing and implementing comprehensive disease management programmes is so complex that no individual pharmaceutical company will be able to offer a complete package. Companies will need to cooperate with a large number of players including diagnostics suppliers, information technology (IT) specialists, contract research organisations, payers, regulators and medical data providers, and will, to a certain extent, have to share the ownership of the programmes with their co-developers.

The financial risks will vary according to the type of service offered. For 'traditional product' services, the necessary investment can be incorporated in the marketing budget of the drugs that are expected to benefit from the initiative. Risks will also be limited with the 'consulting' services option as the companies involved would generally be paid on a fixed fee basis. In contrast, the level of investment in 'innovative product' and 'integrated' services is likely to be high, ranging from around US$6 million for a local experiment up to tens of millions of dollars for a comprehensive package. Moreover, unless the French Drug Pricing Committee acknowledges 'innovative product' or 'integrated' services by granting better prices and higher annual volume increases to the companies promoting them, the return on investment remains questionable. There is also no certainty that the Sickness Funds or other payers will pay extra money to pharmaceutical companies for disease management initiatives.

As far as organisation is concerned, companies will need to adapt their structure to the type of services they want to offer. For 'traditional product' services, where healthcare providers are the key clients, it seems appropriate to integrate the disease management activity into the drug marketing division. For the more extensive 'innovative product', 'consulting' or 'integrated' services, key clients will include healthcare providers as well as payers and it might therefore be better to separate drug and disease management activities. This will limit the risk of confusion and the problems of positioning. In France, SmithKline Beecham has a 'disease management and healthcare system' department which reports to the strategy department, Lilly France has created a division reporting directly to the country manager, and Glaxo Wellcome France has a separate legal entity called Alliance Medica, which is responsible for developing and implementing disease management programmes for the group.

Clarifying the rules

Before moving into comprehensive disease management initiatives that will require massive investment, pharmaceutical companies would be advised to ask the French authorities to clarify the situation.

Among the questions that need to be answered are:

•To what extent are the authorities ready to re-engineer the current healthcare system and move from a 'budget component' to a 'holistic system' approach?

•How fast should disease management programmes be introduced?

•What level of resources are the authorities ready to invest in disease management programmes?

•What role do they want the pharmaceutical industry to play – initiator, coordinator, supplier, investor?

•Who will pay for which disease management service?

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In addition, companies will need to assess carefully the strategic benefit expected (overall competitive position, relationship with payers, authorities and healthcare providers); the financial risks (investment level, return on investment, payback period, etc); the core competencies required; and the entry barriers. Once the decision has been made to launch a programme, companies will need to select the most attractive target pathologies, define the type of services they want to offer, and sign alliances with partners like IT specialists. Only those pharmaceutical companies that have decided to play a leading role in disease management should start to invest in 'innovative product', 'consulting' and/or 'integrated' services. But, irrespective of their strategic intent, all companies should offer 'traditional product' services of excellent quality with the objective of extending their markets and building up a competitive advantage for individual product lines.

Whatever the type of disease management service proposed, pharmaceutical companies will have to adopt a clear position and communicate accordingly in order to overcome the traditional distrust in initiatives that they originate or sponsor.

It is quite clear that pharmaceutical companies which want to remain successful in the future will be bound to offer their multiple clients – patients, providers and payers – integrated healthcare solutions through packages of high-value drugs and disease management services. However a precipitate entry into disease management, without proper preparation and planning, could lead to an exorbitant investment with no guarantee of the outcome. The winners will be those who are wise enough to take a prudent step-by-step approach. SM

References

1. J.S.Berg et al. 'Medication compliance: a healthcare problem', *The Annals of Pharmacotherapy*, 27 (5), 3-22, 1993.

2. J.M Peny et al. 'Building prescriber loyalty', *Scrip Magazine*, September 1993.

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