THE MARKETECH GROUP MINUTE

INTERVIEW

Converging Trends in Disease Management

Interview with Dr. David Nash

Dr. David Nash is a Professor of Health Policy at Jefferson Medical College and a well known author in Disease Management

Interviewer: Christian Renaudin, TMTG

CR: Is customized care for the individual the next natural step to disease management? Will genomics have an impact on the evolution of disease management?

DN: To clarify, you define customized care as genomics combined with Disease Management, and personalized care as IT combined with monitoring. I agree with this definition as long as it covers the mass customization of clinical information, from an Internet angle.

I hope customized individual care is the next step in Disease Management. However, this will take longer than the experts predict: Russel Coile and Lee Kaiser predict that customized pharmaceuticals will be available in 3-5 years, this is way too soon. I think it is more realistic to estimate that use of genomics and customized pharmaceuticals will take place in 8-10 years. Customized Disease Management in terms of individual care (planning, pathways, etc.), however, should arrive in 1-2 years.

So, the short answer is yes, customized care will have an immediate impact on Disease Management and is only 1-2 years away from an information perspective; but no, genomics/customized clinical treatment/customized drugs will only have an impact 8-10 years from now (simply due to the existing technology/knowledge at present). Wall Street predictions and pressure are unrealistic; they are just looking for custom drugs.

Disease Management companies will first stratify then customize clinical information.

CR: When will genomics and Disease Management converge?

DN: Probably in ten years.

CR: What is the low hanging fruit, the first applications?

DN: This depends on the general consensus on what customized drugs will be. Truly genomically derived drugs such as cholesterol lowering and asthma drugs will be the first to market in 8-9 years.

CR: What are the Disease Management steps?

DN: It starts with an individual being at high risk for a given disease through the identification of abnormalities (such as cancer, heart disease, asthma). The chronological order of the evolution of disease management will be: stratification then intervention then preventive medicine. Ten years from now we will have the ability to add a customized drug that targets an individual's specific condition and physical profile.

So, the promise is "laser beam" targeted therapy: for already diagnosed diseases and prevention (from a genomics point of view as well). Research is underway to develop specific therapy in breast cancer and cardiovascular diseases. The problem is that the public and Wall Street are impatient, expecting much earlier results than possible, which explains the current floundering in the biotech industry.

CR: Will we be able to differentiate between prevention and therapy? Will disease be defined in the same way in the future?

DN: The lines will certainly be blurred between prevention and therapy.

From a Disease Management perspective, the definition of disease will change. A "functional status" will be defined at a detailed level and age: at 55, 65, 75 or whatever age and individual should have a given biophysical profile, and should be able to do certain things (run, play tennis, etc.). Then, there will be specific recommendations for prevention/treatment based on the predictive capability of genomics (and lifestyle). Disease management will transform to wellness management and disease prevention.

CR: What will be the unit of care?

DN: The unit of care will remain population based simply due to economics. We will need, however, to reconcile customized care within disease management. There will be customized care within given populations. The next step is to truly work at an epidemiological breakdown of risk groups for which targeted prevention will become more effective.

At the moment we have a 60,000-foot view of population management, but we are moving towards a higher level of granularity to focus on a smaller group of patients with similar disease characteristics.

CR: How will we provide better, targeted care (individual specific) and control cost?

DN: This is a trade-off between a certain level of granularity and the cost incurred. This is a different issue. In regular disease management, we already see patients dropping out of disease management programs. Self-compliance is a big problem and lack of compliance defeats the purpose.

CR: Personalized care: to what extent will IT and remote systems impact the evolution of Disease Management?

DN: Personalized care is exploding already: there are 17-20 at home, FDA approved systems used at the moment. The problem is that these systems are not linked electronically to the site of care. Eventually, in 5-8 years, these types of systems will be used for routine prevention and disease monitoring (urine/stool test at home where the results are automatically sent to the physician). With miniaturization, greater simplification and lower cost, patients will use these systems like they brush their teeth.

On an economic level this will only make sense if there is an at risk contract on a population basis. I know of a cardiology group that developed a great lipid management program and the physicians complain that they are not paid for this valuable preventive care. They do not share any risk with the health plan. They should not be surprised; there is no incentive for the payer! Managed care does not pay extra for extra care.

The metrics for such a program exist but the economics do not work.

Employers should be involved in personalized care because they have the most to gain both financially and socially (loyalty). They cannot afford to pay hefty premiums without results. But they are still shy for many reasons: social (discrimination, lawsuits, etc.). Privacy is just a smokescreen and a poor reason for not acting. They already know about the employees health status.

Now, this situation exists because employers are not smart enough to demand a healthcare situation where prevention is part of the package (they also do not want to be too involved in the private lives of their employees). The employer is the "sleeping giant" who will certainly have the most influence in the future.

CR: Will there be a change in the payment structure?

DN: This topic does not seem to be on the domestic radar, and there probably will not be a change in the payment structure under President Bush.

Managed care is in retreat at the moment and is not experimenting with new programs. Some states have developed innovative healthcare plans, but more out of budget constraints than by leadership. Since September 11, there has been a major set back in disease management innovation: national security concerns are bleeding off budgets.

CR: What will be the first applications for personalized care?

DN: The linkage of wireless handheld Internet devices in the provider's hand, with the patients' integrated web-access telephone there will be constant collaboration between patient and physician to maintain wellness: a longitudinal relationship with the patient.

We are moving towards a collaborative model with constant monitoring that could change the payment structure to one where the physician is paid to care for someone over a given period of time.

CR: Will there be direct contracting opportunities?

DN: Yes, patient-doctor, but through the employer. This is the "disintermediation" of the system.

CR: Is this the so-called "defined contribution?"

DN: This is part of it. Defined contribution is just a symptom. It is a tool that may speed up the process, but it is not an end-solution. The challenge is to get the employer's full buy-in for personalized care. If the pending bill passes and allows patients to sue HMOs, employers will back out and my just give money away to their employees, shifting full responsibility to the patient.

CR: So what is the future?

DN: My bet is it will be consumer centric. Risk pooling will still exist to cover acute care.

CR: Will personalized care and customized care converge?

DN: It is a natural progression that they converge under one umbrella. For example, through a constant Internet tracking system, a physician will be able to monitor a patient's blood glucose level, call that patient and recommend that the patient come in for a visit. We are ten years away from the convergence of screening, prevention and customized personal care, but the concept is gaining general acceptance.

Self-care goes hand-in-hand with defined contribution. The patient will be more accountable for his/her own care. The more engaged they are, the less they will have to spend. Individual spending will depend on genetic predisposition as well as behavior. The situation will be radically different from the EU, where the notion of common good is more established. In the U.S., your personal health information will be restricted but not totally secret; your risk status will be linked to your health budget.

CR: Will this change the way we look at hospitals?

DN: Hospitals are already specialized: cardiology, neurology and oncology centers. The next step will be elective service centers, and ultimately more homecare.