

Demand Management: The Next Big Thing?

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Have you noticed all the consumer ads for prescription drugs lately? They appear on TV, in magazines and on the radio with increasing regularity and more variety - and they work. Consumers ask their doctors about them, and doctors prescribe them. The ads are almost exclusively for expensive, patented proprietary medications for which generics or identical competitive formulary products may not be readily available. However, other options are almost always available, and they are much cheaper.

New patented, proprietary medications often have little or no clinical or outcome advantage over other types of drugs. Having created a consumer demand, doctors prescribe them more; brand loyalty is achieved and drug company profitability is enhanced. But who pays they cost? Usually, it is the insurers, and by extension, you and me, the premium payers. Previously, the vehicle for fostering more prescriptions was academic detailing of doctors by pharmaceutical reps. With less discretionary time on their hands, it's not as easy to get physician "face time." Hence, direct consumer marketing is commonplace for new drugs needing rapid return for the R&D, FDA approval, and manufacturing costs.

A similar approach holds true for new procedures and surgical instruments. Marketing is being targeted to claims managers and referring physicians. Risk-free trials and other incentives are being used to "sell" niche medical products to those other than the prescribing or performing physician.

One of the more common situations you might see in your patients is the use of opioids for intractable pain. New ways of administration (e.g., patches), and brand-name derivatives of common opioids have been shown to work little or no better than cheap generics, yet are many times more expensive; many also have more side effects. Consumers, without seeing any meaningful difference in their co-payments, may opt for the once-per-day tablet or patch over the twice-a-day dosage, but be completely unaware of an increase of 20 times the price for a small amount of convenience. Where the consumer directly bears the cost, brand loyalty and convenience may sustain a price premium, but brand-name acetaminophen that costs \$200 a bottle would not compete in the marketplace against the \$10 generic.

Regulators and payers have been caught off guard by these new marketing tactics, and are confronted with rapidly escalating drug costs. Calls for federal prescription benefits in Medicare, and direct regulation of drug companies, are placing this issue on the national political stage. Meanwhile, a new approach to dealing with greater consumer demand for the brand name products has given momentum to a little-recognized public health and health administration strategy known as "demand management."

Demand management, sometimes referred to as demand moderation, is a set of behavioral change strategies directed at consumers and providers to affect how they respond to indications of injury, illness and disease. Typically, the strategies include community-wide or targeted group education to help consumers interpret signs and symptoms, learn self-care strategies, obtain ready access to diagnostic information, and in some cases, even deploy alternative "expert" access mechanisms,

such as medical consultation by phone, website, or other means.

The concept of demand management is being harnessed. Ideally, demand management is a strategy aimed at fostering informed, appropriate demands by consumers for medical and pharmaceutical interventions, with greater reliance on self-diagnosis, care, and social support. Advantages and limitations depend on the stability of the condition, the level of commitment of the consumer, and the integrity of the demand management strategies. A successful example is the public/private partnerships in diabetes education.

What is attractive about demand management is that it is the antithesis of managed care. It does not include any classic medical utilization, such as pre-authorization; utilization review; mandatory protocols or guidelines; limited networks or preferred provider strategies. The distinguishing characteristic of demand management is the promotion of patient knowledge in the choices of care and providers.

As chiropractic care is a safe, reliable and cost-effective alternative, demand management can be a vehicle to encourage more appropriate utilization of what we have to offer. And therein lies the rub: Appropriate, self-care empowering, and cost-competitive chiropractic should fit nicely into such community health care strategies. But differentiating this from some of the high-cost, high-frequency, high-utilization practice-building approaches to chiropractic can be a challenge.

Just as managed care looked good on paper, and performed well in some settings, demand management has promise, but runs the risk of becoming just another counter-offensive to spiraling health care costs. In an ideal world, managed care should ensure appropriateness and prevent underutilization and overutilization, with better informed primary care providers having financial incentives to assure coordinated service delivery. But in reality, pressure by the bottom-liners gutted hopes of sustained, meaningful reform of health care delivery and financing.

Provided demand management remains focused on patient empowerment and appropriate care-seeking, its increasing prominence should be a welcome addition to a health care system much in need of improvement. However, as ammunition to counter the ever-present greed within some segments of the industry, it too may become co-opted and geared toward cost containment alone. But because dispersion throughout the health care system is the hallmark of demand management, patients and fair-minded providers of excellent care will have a fighting chance.

A couple of new "buzzword" concepts in the clinical world have the potential to beneficially impact quality of care and patient outcomes. However, the potential for them to be applied myopically could establish them as "good on paper" but with devastating side effects on par with those seen in poorly implemented managed care settings. "Evidence-based medicine" and "best practices" are terms being applied to clinical protocols grounded in solid research and/or agreement of clinical experts. But what does practicing based on evidence really mean? Horror stories abound within the field of medicine in which interventions and tests that were promising in the laboratory failed to deliver, or may even have been harmful, in widespread application. This often relates to inappropriate application (e.g., indiscreet patient selection in practice), or for situations or conditions for which the intervention has not been tested ("off-label" use).

Patients want health care that will predictably contribute to bettering their condition or health status. How do we know that a given procedure or intervention will do just that? The "classic" naïve answer is that high quality research that "proves" a procedure's effectiveness must be available before providing or paying for the service. This is rarely the case. Indisputable evidence of effectiveness is required before advertising or making claims for something's effectiveness. However, the Holy Grail of perfectly designed clinical trials, and treatment comparisons for a

broad range of patients and varying degrees of clinical confounders, comma the exception when it comes to making treatment decisions.

The applicability of research findings' applicability in a specific situation may be limited by the population that was studied (e.g., excluding people over 60 years old); the expertise of the clinicians used in the study (skills may be different in clinicians in general practice); design of comparison groups; or any number of other confounders. When a study has effectively addressed these kinds of issues, it is said to have good "external validity," meaning that the results may be applicable to the real world. As you might imagine, these things are often hard to control for and make complex, more expensive designs.

For example, if the changes expected between two treatment groups with only subtle differences (say manipulation by an osteopathic muscle energy technique compared to chiropractic high-velocity adjusting techniques) are likely to be small, many more subjects will have to be included in order to see a statistically significant difference. Careful accounting of such methodological issues intrinsic to the design of the study is called "internal validity."

Because studies with poor internal validity would not even have applicability to the settings in which they were studied, an emphasis on internal validity is the hallmark of grant-writing, reviewing and funding, and scientific publishing to assure that internal validity is high. Even so, poor studies get to press for any number of reasons, even in some of the most prestigious publications.

Finding both high internal and external validity is even more of a premium. As you might imagine, this has become one of the most fundamental issues in health services research and policy development. Attempting to base real-world decisions on better evidence requires assessment of both internal and external validity.

I can't think of a better argument for why research is important to the "average" practitioner than this: Your peers; health care administrators; adjudicators; peer reviewers; and policymakers are turning more than ever to the published literature to make decisions. It becomes ever more important for the practitioners, leaders, and professional representatives in chiropractic to be able to understand how "evidence" is assessed and how "best-practices" are determined. Better yet, the more DCs that can engage and contribute to the process in a high-quality manner, the better.

Just as some scientists and their methods may have a bias that favors internal validity, practitioners may have just as much bias in favor of external validity. Yet, for research to have usefulness for making real-world decisions, it must have large measures of both.

Evidence-based medicine; best-practices; clinical care pathways; guidelines; technology assessment; outcomes/performance measurement; and clinical accountability are all evolving to better reflect the balance of internal and external validity. In the long term, this will be of value to quality-of-care. Unfortunately, how it is applied during the learning curve phase (especially by those with inadequate understanding of the complexity of the issues involved) could have unforeseen consequences.

Unaccountable medicine contributed to unnecessary surgeries and treatment, skyrocketing health care costs, and poor patient outcomes in many situations. When costs got high enough, the marketplace and regulators reacted with managed care that has severely reduced the autonomy and discretion of providers. And that has contributed to underutilization of appropriate care, short-term savings with long-term negative ramifications, and poor patient outcomes in many situations.

Obviously, either extreme is undesirable. With patients' rights legislation and court cases setting some precedents on how far payers can go to control costs and clinical autonomy, the pendulum is beginning to swing around again. However, where it goes next will likely embrace research and evidence more strongly than ever before. Consumers have already voiced the importance of affordable health care. Policymakers are more explicitly implementing decisions based on evidence. As a result, the demand on scientists to address external validity in clinical studies is increasing. The result is ever more relevance for the chiropractic community to better understand how research is designed and applied in the world around us.

More than ever, we need our professional community leaders and ordinary practitioners to have a working knowledge of research issues if they are to become effective policymakers with constructive involvement in deciding the future of health care. The level of research sophistication of payers, patients, providers and policymakers has tangibly increased in recent years. Becoming a research "consumer" through support of the chiropractic research enterprise and an understanding of research issues; or familiarity with our own professional clinical and scientific literature, is becoming more important every year. Without it, our profession's ability to compete within the shifting health care marketplace is diminished.

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