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# Assessment of Physician Priorities in Delivery of Preventive Care

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## To prioritize services to achieve a healthy longevity, pay for health, not for disease-related services

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The Authors[1] assessed the physicians’ priorities in preventive care. Interestingly, the physicians agreed to prioritize interventions improving quality and length of life. These goals are not obvious: eg in Italy many health authorities give incentives for patients joining cancer screening, and physicians prioritize them, although on average such screenings do not extend life.[2] Moreover, for the hypothetical patients the first priorities were smoking cessation and blood pressure control, also included in the first four priorities based on prior literature.[1]
Physicians have not prioritized weight loss, healthy diet and exercise, despite large potential gains in healthy longevity. Motivational interview or exercise prescription to increase physical activity are preventive interventions with minimal cost per QALY,[3] and a counseling/prescription to eat whole cereals[4] is probably highly cost-effective.

To ensure that physicians make the best choices to extend lives (and to avoid/reduce disability, prerequisite for a population healthy longevity), a powerful tool would be aligning their financial interests with the longevity of their clients. It would be necessary to reform the remuneration system, adopting a “pay-for-health model”[5] for the different healthcare stakeholders, in order to align their interests with the mission declared by Health Systems and expected by the people: the individuals’ and community’s health care and promotion.
Currently, the primary care providers are not paid for the healthy longevity, but fee-for-service, or by fixed-capitation, or for “performances” usually disease-oriented, not patient-oriented. With such rewarding systems, more healthy clients (promoted and maintained) do not increase providers’ revenues, and fee-for-service incentives might even have an opposite advantage.

A rewarding-system simpler to monitor for payers, with less bureaucracy, and unequivocal goals for physicians and patients, could be a capitation, not fixed, but with quotas linked to the patients’ age, eg. with a coefficient 1 for teenagers, increasing every year, up to 5-10 fold for centenarians. This would pay for the desired result: the healthy longevity, at population level meaning health/minimal disability, and usually good health-related quality-of-life. Aligning the physicians’ interests with the healthy longevity of their clients’ cohort is a powerful incentive to do whatever it takes for patients to age well. This would also decrease interest in disease mongering and in prescribing/providing services without proven health outcomes, irrelevant to health. The physicians would be paid to produce and maintain health consistently in their clients’ cohort (and in the community). Patients aware of this would trust their doctors, even when they deny low-value drugs or tests.

References

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**CONFLICT OF INTEREST:** None Reported