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A structural health reform: pay health, not disease

Aligning the interests of different actors to ethics and to the health of the community of citizens

(Chapter 14)

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Abstract

The Health Systems are becoming too expensive even in the best-resourced countries.
The structural problem is that they "pay for the disease": the market and the doctors adapt their behavior and "sell the disease", overdiagnosing, overtreating, medicalizing paraphysiological conditions with inappropriate use of technology and providing profitable services, regardless of their effectiveness.
Paying for the disease puts the physicians and the whole medical care system in structural conflict of interests with health.
Governments should reform the health organizations' financing systems and the professionals' remuneration schemes, to align them to the patients' and community health, expressed as unequivocal outcomes, as longevity and relative reduction of disability. Coherently, fee-for-service payments should be avoided, as well as their "evolutions", as DRGs, (payments for) disease management and similar. (Indeed, they increase overdiagnosis, anticipate labelling, technological abuse and profitable services irrespective of their effectiveness, even despite sound recommendations).
The social system finances the NHS with taxation because it seeks health, healthy longevity, pain relief, reassurance from fear, at affordable costs. Individuals do not act against their own interests and health professionals are not so different from other human beings. So, how can doctors work for health, consistently and sustainably pursuing healthy longevity for their patients and the whole community?
The answer is to pay the doctors and their health Organizations in proportion to the health of the community/capita assigned to them, with a progressive increasing weight for age.

Key words: NHS – disease mongering – conflict of interests – rewarding systems – financing systems

Background

Comparative analyses have demonstrated that NHSs, on average, protect and foster health a little better than mutualistic/insurance systems, and they are less expensive. Nevertheless, also in Italy, universalistic NHSs are under attack[1]: the disintegration of the integrated system conceived by the Italian Health Reform of 1978 is ongoing, in conjunction with a drive for privatization and for the return of mutualistic systems, thus resulting in a proliferation of sanitary funds, which offer performances also in replacement of the NHS. While declaring the intention to reduce public expenditure, the Funds are actually powerful factors in determining an expansion of total, private, and even public health spending[2].

The widespread phenomenon of *disease mongering*[3] and the continuous offer of increasingly sophisticated and expensive technologies and services, combined with the international economic crisis, are undermining the NHS sustainability, even in high-income countries.

The health spending inflation is usually attributed to population's aging, technological progress, increased citizens' expectations. However, it is ignored the most powerful determinant (also implicated in two of the previous ones): the pressure from the health technology producers (of drugs, devices, and diagnostics) and from providers. Today their financial interests are not in line with health, but, even in partial conflict with it.[4] It is not surprising that the greatest healthcare power holders, the large producers and providers, are not favorable to effective cost management strategies, just because of the current remuneration system: for them a *less expensive Health* would result in *less revenue and earnings*.

The call to promote and use only proven and effective technologies and services that are cost-effective, that meet relevant clinical and social needs, as well as the one to review the poor or no value practices plethora are an apparently rational response to the inflation of expensive and low value technologies. This appeal is ethically commendable but it is doomed to fail because it is not *convenient* for the health actors, and it collides with the resistance of those who are interested in maintaining the technologies and services that should be reduced. Therefore, it is necessary to reconsider the remuneration model (basic element of the "rewarding system") for the various healthcare actors/stakeholders, and *to align their interests with the mission of the Health System: the individuals and community health defense and promotion*.

Indeed, as for all human beings, even the behaviour of health workers is usually determined by their "rewarding system", their interests or conveniences, and not by the aims set by regulations. For professionals and for the organization employing them (Maslow's "pyramid of motivation" second step and partially also higher steps), the rewarding system is largely determined by the payment and the remuneration/funding system. Thus, it is crucial that the payment/funding system of professionals and organizations is consistent with the health systems targets, to ensure that professionals and organizations pursue them indeed.

The Public Health System primary objectives could be summarized as follows:

- to optimize the production of *health/healthy longevity* for the community of citizens, *freeing them from suffering* and *reassuring them* when it is needed;
- to ensure *economic balance* and health system sustainability by the overall social system;
- and to guarantee the citizens/patients' satisfaction for the Health System and the services provided.

If the "system architects" do not align the health actors interests/advantages with these objectives, and instead they design a rewarding system where the main actors' convenience and the Public Health Service's fundamental objectives *diverge*[5], the System will not completely succeed in getting the results it claims it wants to reach.
Unfortunately, this is what is globally happening in health systems.

How to make people who have interests aligned with the disease really work for health?

The *service-based remuneration system* and its variants present serious problems for health. For the "market" in healthcare, the insufficient consumer's information are a structural limit, which do not allow him/her to naturally adopt the most rational choices to buy the services most useful for his/her health. This also applies to the more experienced buyers (in the different Italian Regions ASL / AUSL / ATS), that often do not know what is the optimal response for large types? of health problems, and ordinarily cannot know what it is really needed in a specific clinical situation.
Many guidelines reflect more the interests of providers' who provided them (and the ones of the producers who sponsor them) than those regarding the health of the community of citizens. Even where valid guidelines about effective and cost-effective interventions are well defined, there is often the structural impossibility for an external controller, however qualified, of verifying the clinical appropriateness (the effective intervention for the right person) of their application to the individual clinical case
This explains the «*absolute freedom of the suppliers paid for performance to encourage the demand for services* [...] *the doctors can absorb the tariff reductions impact increasing the services provided and modifying the composition, to maintain the desired income*»[6].
The service-based remuneration/financing system can be defined as a system that pays (and makes convenient) the disease, in different forms: D-isease RG, Disease management, territorial DRGs...
When the workers (not only in private practice) understand what increases the funding of their company/department/unit and eventually the convenience for each of them, the divergence between the health objectives, at least nominally declared, and the rewarding system actually operating gets worse.
This profound divergence between proclaimed health objectives and real interests in

the disease is at the root of the *disease mongering* phenomenon, which sparked a wide but inconclusive international debate so far.
To curb the distorting effects of the remuneration system depending on the behavior of health care workers, more and more expensive health and administrative control systems, consuming increasing amounts of resources, have been developed without producing health, but only to contain breakdowns, considered inevitable, of an intrinsically conflicting model.
In the USA, where this model predominates, administrative spending and control consume a large part of total health spending, already the highest in the world[7]. However their results are disappointing, both from the point of view of overall effectiveness (life expectancy is lower than almost all high-income countries), efficiency (the ratio between effectiveness and costs is very unfavorable) and the satisfaction of citizens and doctors.
Other countermeasures were not more successful, e.g. *contractual agreements* that set expenditure ceilings and volumes/types of services for the supply structure. It is true that these reduce part of the unwanted effects, but increase the administrative and transaction costs and give an extra power and arbitrariness to the programmers. Anyway, they do not maintain the economic equilibrium in the medium and long period, because a questionable service may be more convenient than a necessary one and because services without expense limit, private practice and health funds are outlets for an excess of services not included in the contract/agreement, which citizens are still required to pay.
Moreover, *paying the disease* induces an excess of harmful unnecessary health services[a]: this is another good reason to consider new paths and new paradigms.
Due to space limits, it is not possible to explain here in more detail how to finance and remunerate the main health actors/stakeholders (above all with progressive age–weighted quotas per capita), but the specific documentation is in the references below[8], and therefore only three examples are summarized in the Boxes.
The hope is that some Region, recognizing the potential of a model that pays health, accepts its challenge by experimenting it for some years, to prove its validity. The expected results are: the reduction of health and administrative costs, the increase in the effectiveness of the system in a few years, with greater longevity and relative lower disability of the population served.

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a. See also hundreds of examples in http://fondazioneallinearesanitaesalute.org.

Box 1 – The model applied to the General Practitioner

Currently, the General Practitioner (GP)/general practice doctor is not paid for the health produced, but with quotas per capita/patient, basically fixed, for a list of benefits reported in the National Collective Agreement, without disincentives for unnecessary specialist visits. He/she is also paid with variable quotas for resources present in his study or for services not included in the previous list (e.g. scheduled home care...), without a proven relation between what he/she does and health results and that must be accounted with a lot of paperwork.
The GPs can increase their earnings providing additional services with extra fees to specific categories of patients, as decided in national, regional or local agreements, or as private practice (ultrasound, spirometry, electrocardiograms, certain visits ...).
The prevention is not convenient and, if a GP had too few sick patients, he/she could be temptation to "help them to emerge": e.g. lowering diagnostic thresholds, or with checkups, or diagnoses that do not change the prognosis, or overdiagnosis followed by overtreatment/iatrogenesis...
With the current rewarding system, more health and efficacy do not increase the doctor's income, that can be increased by efficientism (efficiency without efficacy) and paid services.

To align his/her interest to the community health, the GP must not be paid for services and diseases, but mainly by with a capitation system, growing in link to the increasing age of patients, i.e. by a payment for the desired result: the healthy longevity (in a population, longevity means health and little disability). This aligns the GPs' interests with the healthy longevity of the cohort of their patients and encourages them to do everything necessary in order for their patients to age as well as possible, eliminating any interest in prescribing/providing services not relevant to health.
The basic model has to be integrated with variable quotas according to the trend of the District budget, to involve the GPs in the success of the organization where they work.
Thus, the GPs are paid to produce health in the cohort of their clients (and in the District) and are encouraged to maintain it consistently. When patients are made aware of this, the doctors' credibility will be very high, even when they have to refuse prescriptions for drugs or exams.

Box 2 – The model applied to territorial pharmacies

The local pharmacies are, with the family doctors, the most widespread structure of the Italian NHS. Today, they do not receive incentives for health, but only to maximize sales, favoring the most expensive products. Indeed, with theoretical gains of 27% on self-medication products and 22.6% - although in a regressive trend - on prescription ones, they have diverging interests from those of the NHS.
The proposal of "Service Pharmacy" focuses on the remuneration of new services, believed to be of public utility, and does not resolve the basic conflict of interests with the NHS.
A first structural measure would be the substitution of the percentage compensation with a fixed one per pack sold, to remunerate only the service, and not also the capital invested by the pharmacist to acquire stocks of products. The consumption of these should be refunded to producers at factory price (plus a fixed rate for the wholesaler service) directly by the NHS (for prescription drugs) or indirectly by the citizens, through the pharmacies (for over–the-counter drugs).
A real alliance with NHS and community health would require the paradigm shift already proposed for other NHS actors[5,8], such as family doctors, who prescribe much of what the pharmacy dispenses.
An innovative principle, to develop in further applications and to evaluate in management experiments, may be that the clients chooses his own trusted pharmacy (like they choose their GP registered in their Health Card), building for each pharmacy a *virtual* catchment area. However, differently than with the chosen GP, the patient can go wherever he/she wants, but it would be just a way to calculate a starting budget.

The pharmacy would not be remunerated with a percentage or fixed mark-up on sales, but with a capitation system based on patients' age, with a continuous annual progression (e.g. the centenary quota could weigh 10 times more than the youngster's, the same principle to apply to the GP).
For equity, this would take into account the greater work of the pharmacy for serving older patients. It would also give a strong signal of health policy in relation to the priority objective of the System (healthy longevity for all), and a virtuous incentive - independent from the quantity of drugs sold, in any case "dynamic" - to make their cohort people grow older more and better, aligning ethics and higher revenues[9].
With this remuneration system, the Pharmacist would have the interest to promote healthy lifestyles also as an alternative to drugs and medical products (while today he/she has opposite interests), going beyond the fee-for-service. This would remain in place only for the offsets at the margins, for those who go to a pharmacy different from the one originally chosen (without having to formalize any change of choice). In this case, if it the drug reimbursed by NHS, the drug would be free, if not, the patient would pay the factory price to the pharmacy, plus the price for the wholesaler's service. The pharmacy that dispenses the product would have the service fee (fixed) paid by the pharmacy initially chosen (under its budget), with the possibility that the compensations are managed by NHS structures.
A reform of this magnitude would require a multiyear government agreement with Federfarma and Assofarm, guarantying the safeguard of the Pharmacists' revenues, independently from the likely reduction in sales of products, not considered necessary for health (indeed with the new remuneration system the pharmacist would no longer have any interest in selling them).

Box 3 – The model applied to hospitals[8]

Currently, hospital funding is formally linked to DRG and documented hospitalization or outpatient services. Regions and local health agencies assume a role similar to pay insurances, in artificial conflict with the hospitals of their territory on the care pathway of every citizen.
Those working in hospitals paid by Drg/tariffs experience the uncoupling between health objectives, at least nominally declared, and current payment models. They can understand that the reasons for the increasing revenues of the Hospital, and ultimately of anyone who works there, do not correspond to the produced health, but to the declared services.
Instead, the model that pays for health is based on progressive per capita quotas linked to the residents' age, which make up the dynamic budget allocated by the Regions to the Local Health Units, which in turn negotiate a proportional share with the Hospitals of reference.
In this way, the convenience of those working in the Hospital is aligned to those of the Local Healthcare Company (ASL), and the Hospital and the ASL have a common

interest in collaborating for the result that increases revenue for both: the healthy longevity of individuals and of the whole community. Thus, the hospital and those who work there will lose interest for services that do not contribute to healthy longevity, now offered (also) because they are advantageously priced, and will focus on what they believe protects the health in the best way, also rediscovering the value of Health education, prevention and more cost-effective treatments. Drg and tariffs will no longer be the core of hospital revenue; they will be used only to pay transactions at the margin, for residents virtually assigned to the hospital catchment area and who have freely chosen to turn to another, or vice versasee the illustration of the Model in 8.

There are three guarantees that Hospitals funded in this way do not artificially create revenue surpluses, subtracting necessary care from the residents and increasing the supply to outsiders, to attract customers from other areas:

1) the free choice of patients, who can turn to the structure that best meets their (perceived) needs, will push the healthcare companies to adapt the health offer and to adopt the best information strategies to advertise and to enhance their own valid offers and the results achieved, and to discourage futile interventions, which weigh on the hospital budget without any return;

2) information and analysis of the results of care in the various companies/health facilities, publicized by Regions and the Ministry of Health made available to all;

3) but, above all, the same core of the model that pays for health, which links the far greater revenue to the healthy longevity of the population of each hospital area: offers of poor/no value services would consume the budget without any return, offers to residents of other areas to make cash would compromise the credibility and loyalty of the people of their own area, whose weighted quotas guarantee most of the hospital revenue.

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