

[A Reform of Rewarding Systems to Fight against Disease Mongering](#)

Original Article The Fight against Disease Mongering: Generating Knowledge for Action

A Reform of Rewarding Systems to Fight against Disease Mongering

Posted by [plosmedicine](#) on 31 mar 2009 at 00:12 GMT

Author: Alberto Donzelli

Position: MD - Director of Service of Health Education of ASL Città di Milano (Italy)

Institution: ASL Città di Milano - via Ricordi 1 - 20131 Milano (Italy)

E-mail: adonzelli@asl.milano.it

Additional Authors: Luigina Ronchi, Dr - Member of Board of Movimento Consumatori Milano – Italy

Submitted Date: August 09, 2007

Published Date: August 13, 2007

This comment was originally posted as a “Reader Response” on the publication date indicated above. All Reader Responses are now available as comments.

This essay proposes some cures:

a) to generate better knowledge, that is:

- data on the impact of disease mongering (DM),
- indices to measure inappropriate medicalisation,
- publicly funded rigorous studies to promote noncommercially oriented information about disease,
- the conflicts of interests of panel members, professional bodies and sponsors.

b) to take actions:

- at a consumer level, not accepting pharmaceutical company sponsorship;
- amongst journalist circles, reducing the media’s propensity to exaggerate disease prevalence and severity;
- at professional organizations’ level, recommending that industry-funded disease-awareness campaigns should not be advertising of drugs;
- at shareholders level, to refuse the excess of DM.

What about the public health level? How many chances have these measures to effectively counteract DM? We think very little, because they do not capture the root of the problem, which lies on the main current rewarding systems in the health market, and on their logical consequences on the behaviour of nearly all providers.

If the health systems follow models that actually “pay for the disease”, no wonder that the market adapts its behaviour and “sells the disease” as much as possible, diagnosing/anticipating it even if the prognosis does not change, dramatizing it and even “creating” it.

Paying for the disease puts Health Boards and Systems, and Hospitals, and practices, and doctors in structural conflict of interests with health and wellbeing.

It is time for public health systems to undertaking two main actions.

First, they should react more boldly and give clear-cut answers, highlighting the possible health and economic risks, for both the individual and the community, of many technologies, rather than simply claiming that “there is not sufficient evidence” to recommend/pay for them.

More important, the NHSs should reform the health organizations’ financing systems and the professionals’ remuneration schemes, so that their interests become aligned to the patients’ and community health (expressed as an unequivocal outcome, that is longevity) rather than to their diseases.

Different ways to pay for diseases are:

- Fee-for-service, reimbursement systems, price for drugs
- D(iagnosis of disease)RGs
- Disease management
- Private practice (fee-for-service rewarded)
- Payment for inputs, processes, outputs not related to outcomes.

Different ways to pay for health are (1):

1) Capitation weighted for the patient's age, in a yearly continuous progression, i.e. a centenarian weighs ten times an adolescent.

This would be an equitable way to pay for the additional work for caring for patients getting older; but, above all, it would give a strong signal of a health policy targeted to the main objective of a Health System: a healthy longevity for all. It would give a virtuous incentive - not related to the quantity/complexity (both easily induced by providers) of performed services - to help own patients' cohort to age more and better, thus aligning ethics and better income for GPs (1).

2) A complementary way to pay for Health is: further incentives, based on health (or economic) outcomes (or levels of outcome), may be added for special objectives, not rewarded enough by the age-weighted capitation (1) (for example:

- babies breastfed for one year or more over challenging thresholds (based on local epidemiological data)
- women 50-70 years screened with mammography in a good quality program over definite thresholds
- hypertensive subjects treated with first line low-dose thiazide-type diuretics over high and very high thresholds).

But fee-for-service incentives should be avoided, because they increase technological abuse, profitable services irrespective of their effectiveness, and the sale of sickness.

References

1. Donzelli A. (2004) Allineare a etica e salute della comunita dei cittadini le convenienze dei diversi attori in Sanita. *Mecosan – Management and Economia Sanitaria*, 50: 131-147

No competing interests declared.