Prevention in Family Practice - Preferred Method or Postponed Effort?

Preventing disease or ill health is supposed to be a *forte* of family practice. Family doctors are expected to screen their patients for early signs of disease, immunise them against serious infectious diseases, and counsel them to change their risky lifestyles. This month we review some evidence on how we fare with prevention in South Africa and provide new perspectives on some old sins.

The value of prevention has long been grasped by many generations of family doctors, probably even before the time of Edward Jenner. It has now finally been proven to be effective in a number of conditions. Immunisation is a good example, with the success of poliomyelitis immunisation serving as a case in point. The earlier identification and treatment of hypertension has also led to a more than 50% reduction in the age-adjusted mortality from stroke in the U.S.A. since 1972.[2]

The health care industry is globally moving towards evidence-based health care. Health care funders, including the taxpayer, want cost effective and high quality health care, and only want to pay for those interventions that have been proven to be effective. Much research has been done in this regard, and information on effectiveness has become much more readily available. For instance, important initiatives to document effective preventative health care, such as the U.S. Preventative Services Task Force Guide to Clinical Preventative Services,[3] which provides recommendations for clinical practice on preventative interventions for more than 80 target conditions, is now freely available on the Internet

The greatest challenge to family doctors today with regard to prevention, lies in the changing in the personal health behaviours of patients, long before disease can develop or manifests itself. There is growing support in the literature that a small number of risky behaviours are linked to some of the most important causes of death in South Africa, such as human immunodeficiency virus infection, heart disease, injuries, cancer and cerebrovascular disease.[4]

In spite of this family doctors often fail to practise prevention, because there are many barriers in South Africa to the delivery of preventative services. In the private sector it is probably due to inadequate remuneration for preventative services. That may be changing, as evidence about cost effectiveness becomes more convincing. In the public sector preventative services are often swamped with the demand for curative services, and primary care providers very often have inadequate skills to provide preventative services.

When it comes to practising prevention, the following guiding principles should be borne in mind:[1]

- Focus on **primary prevention** actions, such as modification of risk factors such as smoking, physical inactivity, poor nutrition, alcohol and other drug abuse, as they hold greater promise for improving overall health than many secondary preventive measures such as routine screening for early disease.
- The clinician and patient should **share decision-making** about the institution of preventative services, as many involve substantial risks or costs that must be balanced against their possible benefits.
- **Be selective** in ordering tests and providing preventive services, as many may not be of proven effectiveness.
- **Use every patient contact** as an opportunity to deliver preventive services, especially to persons with limited access to care. Those individuals at highest risk for many preventable causes of premature disease and disability, such as cervical cancer, tuberculosis, human immunodeficiency virus infection, and poor nutrition, are the same individuals least likely to receive adequate preventive services.
- **Community-level interventions** may be more effective than clinical preventive services for some health problems. Family violence, initiation of tobacco use, and unintended pregnancy in adolescents are good examples.

We are not advocating that primary care providers should become counsellors to the detriment of their clinical duties, but unless protected time and dedicated resources are provided for prevention in the developing District Health System, it may become a Diseased District System! The emerging epidemiology of chronic diseases, injuries and infections dictate just as much involvement of family doctors in preventative services as in treating disease. Let us make prevention our preferred method, lest it becomes our postponed effort!

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2. Garraway WM, Whisnant JP. The changing pattern of hypertension and the declining incidence of stroke. JAMA 1987;258:214-217.
3. U.S. Preventative Services Task Force Guide to Clinical Preventative Services. 1995. http://odphp.osophs.dhhs.gov/pubs/guidecps/
4. Kochanek KD, Hudson BL. Advance report of final mortality statistics, 1992. Monthly vital statistics report; vol 43 no 6 (suppl).