Editorial

Prioritizing Prevention

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What do we know about clinical preventive services—counseling, immunizations, and screening tests—in primary care settings? We know that they can be effective in reducing morbidity and mortality when delivered on a routine basis. We know that they are considered important by primary care providers of all types. We also know that, in general, their delivery is not optimal. Why?

Five barriers to preventive care delivery are commonly cited. First, there is disagreement about which preventive services to offer and how frequently they should be delivered. Clinicians are confused by the large number of conflicting and frequently changing guidelines issued by numerous "expert" groups.

Second, financing for preventive services has lagged behind financing for curative services, resulting in a lack of time in the clinical encounter for preventive care and unwillingness by some patients to undergo expensive, uncovered preventive services (eg, mammography).

Third, providers may lack necessary preventive care knowledge or skills. Until recently, for instance, smoking cessation counseling was not included in medical school and residency curricula.

Fourth, patients' expectations and attitudes are often not attuned to preventive care. They may not believe that screening tests are important and may not realize the impact of their health-related behaviors.

Fifth, systems necessary for the optimal implementation of preventive care in the office or clinic—chart flow sheets, reminders, "tickler" files for patient recall, and patient education materials—are not consistently used.

The article by Stange and associates[1] in this issue of *The Journal* is relevant to virtually all these barriers. When physicians prioritize preventive services, they decide which services are the most important and deserve provider resources (time) for their delivery. The choices they make may reflect the provider's sense of self-efficacy and a presumption of patient interest, or lack thereof, in preventive care.

There is little literature evaluating how physicians prioritize preventive care, so the study by Stange and colleagues is welcome. It does have important limitations, however, including a 56% response rate and reliance on replies to a case scenario as a proxy for measuring physician performance. Nonetheless, important results emerge. In both the 5- and the 30-minute visit scenarios, counseling interventions ranked high. For the 5-minute scenario, the six highest-rated services included three screening tests (blood pressure, height and weight measurement, and mammogram referral), two counseling interventions (smoking cessation and exercise advice), and the scheduling of a presumably more comprehensive return visit. Of the 18 preventive services recommended by at least one half of the respondents in the longer physical examination scenario, 11 were screening tests or examinations, 6 involved either counseling or a discussion of risk factors, and 1 was an immunization.

These are encouraging results. Given that health-related behaviors account for many of the "actual" causes of death in the United States,[2] behavior modification through clinician counseling is an important strategy for changing deleterious behaviors related to tobacco, diet, exercise, and alcohol.

On the other hand, it is disconcerting to find that one third of respondents would obtain a screening electrocardiogram and that one quarter would order a screening chest radiograph for the 53-year-old woman in the scenario. Neither has proved to be effective in screening asymptomatic patients,[3] and neither is recommended by any medical organization. Physicians continue to overuse tests in response to incorrect expectations of their benefit, perceived medicolegal necessity, and patient demands.[4]

An interesting finding is that the responses of

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younger, residency-trained physicians in group or health maintenance organization (HMO) practice were more likely to be congruent with the recommendations of the US Preventive Services Task Force (USPSTF) than those of older solo practice physicians. This difference may reflect the widespread use of the USPSTF guidelines in residency training,[5] as well as the increased likelihood that group practices and HMOs follow established guidelines for preventive care. It becomes particularly relevant to a discussion of reform of the health care system in this country, as President Clinton's proposed Health Security Act includes a set of covered (no deductible, no copayment) preventive services based on USPSTF recommendations.

All major health care reform proposals that have been introduced in Congress include at least a limited set of preventive services as a covered benefit. Thus, if a new system is put into place, it would seem that at least two barriers to preventive care delivery (payment and specific guidelines) will soon be addressed. However, ensuring payment for a prescribed set of preventive services does not ensure that they will be delivered.[6] The other barriers related to provider, patient, and system remain.

This spring, the US Public Health Service will be introducing a national preventive services educational campaign to address these nonfinancial barriers. Entitled "Put Prevention Into Practice," the campaign will target three groups: primary care providers, patients, and office and clinic staff and systems. Educational materials have been developed and tested to improve provider knowledge of and skills in preventive care; to increase patients' participation in their own preventive care; and to improve the ability of office systems and staff to deliver and track needed preventive services. Major primary care provider groups, including the American Academy of Family Physicians, and private sector health care organizations are partners in the "Put Prevention Into Practice" campaign. They will produce their own versions of the campaign materials and provide educational activities for their members.

A final issue, however, remains to be addressed. Systems for delivery of preventive services are only as effective as the system of medical care on which they rely. Simply providing patients with a "Health Security Card" and telling them they are entitled to preventive and curative care does not ensure access. There must also be support for increased production of primary care providers, incentives to practice in underserved areas, and a strong public health infrastructure to help provide access to needed care for those who "fall between the cracks." These are included in President Clinton's plan and are fundamental to an agenda that places high priority on prevention.

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