Prevention: Not a Panacea for National Health Budgets

I agree with much of what Gellert[1] had to say in his thoughtful and interesting article in the May issue of the ARCHIVES. However, the assumption that, "Success achieved in primary prevention . . . will produce sustained cost savings of a magnitude to ensure future excellence in treatment and rehabilitation,"[1] is both unproven and dubious. The examples he cites (prenatal care and measles vaccine) as supporting evidence for the economy of prevention over treatment are undoubtedly accurate, but they do not truly address the enormous problem of chronic late-stage disease that consumes disparate amounts of health care resources. He slides around this difficult and complicated problem by noting that behavioral and lifestyle factors contribute to the origin of major chronic diseases and by stating that beginning prevention to modify behavior has no advance costs.

In actuality, work on behavioral modification is one of the most difficult, time-consuming, and treatment-resistant approaches in the clinician's armamentarium. It may not involve much in high-tech costs, but its low-tech costs are high. More frustrating, the long-term efficacy of behavior modification in such a "simple" matter as weight control has yet to be proven for our society at large. What, then, are we to think of the management of the multiple risk factors involved in heart disease, etc, by means of behavior modification?

This is not to say that we should throw our hands up and abandon the effort to modify disease-prone behavior. Gellert is absolutely right when he states, in regard to behavioral and lifestyle factors, that, ". . . much greater national emphasis on the medical, social, and behavioral sciences is needed."[1] However, it is important to face this issue realistically. Changes in national patterns of behavior will come haltingly, if at all, and any impact on changing the epidemiologic characteristics of chronic disease will come even more slowly.

As I have noted elsewhere, "Prevention is immensely worthwhile for the individual, the family, and the community. It is not likely to be a panacea for national health budgets."[2]

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1. Gellert GA. US health care reform and the economy of prevention. *Arch Fam Med.* 1993;2:563-567.
2. Dodge RE. Preventive medicine: not a panacea. *Fla Fam Physician.* Summer 1993:43.

In reply

I appreciate Dr Dodge's kind remarks and essentially share his perspective. While I agree that more sophisticated and quantitative evaluation data are needed to articulate precisely where primary prevention strategies are most cost-effective, I do not share the view that this approach is "dubious." A central issue requiring continual reemphasis is that what the nation faces is not an intellectual choice of one approach over another in reconstituting the health care system. Actually, there is little choice—if late-stage morbidity expenditures are not reduced, it will hardly be possible to provide adequate primary care and sustain the technological and research infrastructure for state-of-the-art tertiary care. The point of intervention and chief focus of the health care system must be shifted to earlier in the causal emergence of disease to reduce the burden of late-stage morbidity, or at least to hold it steady as the population ages. Although technological advances such as gene therapy may help in achieving this objective, primary prevention offers the greatest opportunities in this direction at the present time.

There is little to contest in Dodge's statement that a major component of primary prevention, namely, behavioral change to reduce risk for chronic diseases and injuries, is an arduous and time-consuming activity. It was precisely for this reason that I recommended that "reimbursement mechanisms should be established for prevention and health promotion activities that occur in the community [and] physicians' offices" and that "reform of the health care system that fails to achieve this objective will be incomplete and palliative."[1] Dodge is entirely correct in that these low-tech costs are high, and if greater remunerative equity among low- and high-tech specialties and clinical activities is not forthcoming through reform, primary prevention will never be an integral component of the US health care system.[1]

Dodge also states accurately that achieving such behavioral changes is not simple; however, I do not share his frustration and pessimism that national changes in behavioral patterns are elusive. It is important to recall public health successes in areas in which society has evolved toward more healthy cultural norms. In 1964, for example, over half of the adult US population smoked tobacco. By 1981, only 33% of adult Americans smoked, and this figure had fallen to 26% by 1989. In view of the fact that smoking is the single largest and leading cause of preventable morbidity and mortality in the nation, this reduction—achieved largely through individual be-