Preventive interventions can be applied at any stage along the natural history of a disease (see Table 1) and can be targeted at a population or individual level.

The World Health Organization estimates that around 80% of deaths from more common diseases, such as cancer or heart disease, are attributable to lifestyle factors (i.e. smoking, alcohol, diet). These are often linked to health and social inequalities. Globally there are increasing numbers of patients with two or more chronic conditions, or multimorbidity. The increasing prevalence of chronic disease shifts the focus of care away from cure to management of conditions and prevention of complications.

**Policy context**

The National Primary Health Care Strategy (2010) prioritises prevention and management of chronic conditions. Ideally general practitioners (GPs) are supported to keep their patients healthy over time and manage chronic conditions, rather than just treating presenting symptoms. At the state and territory level are National Partnership Agreements on Preventive Health, a Council of Australian Governments’ initiative involving $872.1 million over six years from 2009. This funding predominantly tackled the lifestyle risk factors associated with chronic disease. The Australian National Preventive Health Agency was established in 2010 to support Health Ministers with evidence-based policy, social marketing activities targeting obesity and tobacco consumption, and leadership in research and surveillance. Functions of this agency were transferred to the Department of Health in June 2014.

**Infrastructure for preventive care in PHC**

In 2010, the then Primary Health Care Organisations’ (PHCOs) role was to provide infrastructure, deliver health promotion and support general practices to provide preventive health care. PHCOs were required to facilitate preventive care through practice changes, partnerships with state health services, local government and non-government organisations; coordinate and broker new preventive services and programmes; and integrate clinical and population health approaches. Healthy Communities reports, developed for each region by the National Health Performance Authority, served to inform the PHCOs about the communities’ health, wellbeing and care needs and identify preventive health risk factors.

**Co-production of preventive care**

Self-efficacy and empowerment are central to preventive care. Preventive services often fail to combine elements of educating patients about their own health risks, maintenance of their health and ease of receiving appropriate care. Development of automatically generated patient prevention summaries and reminder sheets (PPSRS) to educate, inform, and advise patients prior to a consultation about their status for preventive activities, have been trialled. Generally well received, 72% of patients surveyed reported discussing the contents of their PPSRS with their GP, and receiving or performing some or all of the preventive activities that were listed. Touch screen versions of this approach have also been trialled.

**Time**

The continuum of prevention suggests there are optimal times for action. Predictive risk models can be used to identify cohorts of patients for whom screening is indicated. Routine screening and delivery of point of care feedback is one technique which can prompt health practitioners and patients to engage in preventive care. There are difficulties around the best time to intervene, relating to the varied onset of conditions, and a lack of longitudinal evidence highlighting the key period (e.g. optimal age for breast cancer screening). Timing differs according to whether the action is one of primary, secondary or tertiary prevention.

### Table 1 Continuum of prevention

<table>
<thead>
<tr>
<th></th>
<th>Primordial</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What it is</strong></td>
<td>Actions to minimise future hazards to health</td>
<td>Seeks to prevent the onset of specific diseases</td>
<td>Procedures that detect and treat pre-clinical pathological changes to control disease progression</td>
<td>Seeks to soften the impact caused by disease on individual’s function, longevity, and quality of life</td>
</tr>
<tr>
<td><strong>Mechanism</strong></td>
<td>Focuses on the social ecology of disease and the determinants of health to prevent exposure to risk for populations</td>
<td>Reduces incidence of disease by addressing risk factors or by enhancing resistance</td>
<td>Screening before symptoms of a disease appear</td>
<td>Actions once a disease has developed and been treated in its acute clinical phase</td>
</tr>
<tr>
<td><strong>Example</strong></td>
<td>Improving the quality of roads to decrease accidents</td>
<td>Immunisation; nutrition and exercise counselling</td>
<td>Bone mineral density testing to screen for osteoporosis; assessment of risk of diabetes for over 40 year olds</td>
<td>Referral to specialist diabetes clinic</td>
</tr>
</tbody>
</table>
Lack of practitioner time is one of the most frequently reported barriers to preventive care in PHC settings. The current environment, which sees the Medicare Benefits Schedule (MBS) pay more dollars per minute for shorter consultations, inherently discourages GPs from providing in-depth support. Research on the efficacy of preventive care requires time for long-term follow-up. For example, ASPREE, a randomised controlled trial of low-dose aspirin in older people, has been underway since 2008, and to date has recruited 19 000 patients from Australian general practice. Observations total around 100 000 patient years (5 years of observation per patient).

Resources
Efficient and sustainable funding is required to support preventive care. In some areas of Australia (e.g. SA and QLD) funding for health prevention activities has been withdrawn by state governments which have elected to focus instead on public hospitals. Alternate funding models have also been introduced, including financial incentives to individual providers or practices to encourage preventive activities. These include the Practice Nurse Incentives, Practice Incentives Program and incentives for chronic care plans and health assessments for vulnerable populations.

Decision support systems can assist practitioners on screening, counselling and identification of health risk behaviours. Clinical data systems are vital to support the patient, their GP, practice nurses and other health professionals to monitor and perform preventive activities. Currently the software packages in PHC provide some reminders, but are often not informative, prominent, are presented only to the GP and easily ignored. At the end of a consultation, the GP and patient remain unaware that key elements of prevention have not been offered. For example, a patient with chronic obstructive airways disease may never have received pneumococcal immunisation. No consultation in PHC should be concluded without both the patient and health professional being made aware of outstanding relevant preventive activities for that patient.

The RACGP Guidelines for preventive activities in general practice 8th edition, is an open-access online synthesis of guidelines from Australian and international sources for everyday use in general practice. Based on current, evidence-based guidelines for preventive activities, it covers prevention across the lifespan, including tools relevant to issues such as diabetes, cancer, oral hygiene and psychosocial illnesses.

Ongoing PHC workforce education, training and advanced roles are central to prevention. For example, diabetes educators, trained in supporting diabetes management, may combat issues around the cost and availability of GP services. This also relates to training lay health educators in the broader community. Similarly, the Practice Nurse Incentives cover a broad range of prevention activities, including health assessments, health promotion and advice, educating patients on lifestyle issues and managing recall and reminder systems. The RACGP and Australian Primary Health Care Nurses Association have worked together to align funding of these assessments with MBS items.

Summary
Preventive care is both a priority and a challenge. Infrastructure, engagement and resources to improve time management for delivering preventive care in PHC settings should be carefully considered.

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Acknowledgement: Thank you to expert reviewer Dr Oliver Frank for his comments on a draft of this paper.