Lifestyle-related behaviors account for half of the ten leading causes of death in the United States. Everyone pays lip service to preventive health care, but as is often the case, the numbers, which in this case are not encouraging, reveal the true concerns of people. Only 5% of the $1.4 trillion spent on direct health care in the United States goes to preventive health measures and the promotion of general health. Secretary of Health and Human Services Tommy Thompson recently likened this to waiting for your car to break down before you take it in for maintenance. Many do it, but it certainly isn’t the best approach if you want to keep going on the road or in life!

A recent article evaluated whether the source of health care (single physician, HMO, or urgent care center) helped determine whether patients received three types of preventive health services (PHS): flu shots, mammograms, and advice to stop smoking. The study is based on data from a 1996-1997 national telephone survey of 43,000 non-institutionalized US adults. The large number of participants should be a representative sample of the U.S. adult population.

The study does have some limitations; for example, it does not reveal information on institutionalized adults, those without telephones, those who block calls from unrecognized outside callers, or those who refuse to participate in surveys. Factors such as inadequate recall, poor compliance with recommended PHS, or lack of knowledge of the PHS received, make the results of the study (dependent upon self-report) potentially less accurate than patient records. Also, the article evaluates only three of many recommended PHS. Furthermore, the data is nearly ten years old and may not represent today’s PHS picture. That said, the data should still be useful for accomplishing its goal, analyzing differences between sources of care.

As one might expect, differences in PHS were evident. Those seeing a single doctor received the highest level of PHS. HMOs (which usually have patient-tracking systems) deliver a higher level
of PHS than urgent care centers. Over 2,000 years ago, Hippocrates recognized the importance of the physician-patient relationship to providing care in the best interest of patients. The Oath he composed became the basis for the development of Western medicine. Medical facilities and health plans are not subject to such an oath or duties. They are instead based on a business model, which suggests that they choose the most cost-effective practices. Since PHS recommendations are based on practices that bring more benefit than risk, such recommendations should, therefore, be generally more cost effective, at least in the long run.

Our biggest concern, however, should not be the small (though significant) differences between the three analyzed sources of health care delivery, but between the goal and delivery of PHS. As shown by the following chart based on the study, all three groups failed to provide PHS to between half and two-thirds of their patients.

<table>
<thead>
<tr>
<th>Source of Health Care</th>
<th>Flu Shots</th>
<th>Mammograms</th>
<th>Stop Smoking Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center</td>
<td>38</td>
<td>36</td>
<td>40</td>
</tr>
<tr>
<td>H.M.O.</td>
<td>48</td>
<td>49</td>
<td>46</td>
</tr>
<tr>
<td>Single Doctor</td>
<td>54</td>
<td>55</td>
<td>46</td>
</tr>
</tbody>
</table>

If we are to ensure that each patient receives PHS, we must know what factors influence whether patients receive them. There are many recognized barriers to adequate PHS other than the source of medical care. Factors related to the clinician include lack of PHS training, lack of confidence that PHS work, competing time demands, conflicting recommendations, and low or inadequate reimbursement for PHS. Barriers related to health institutions include lack of knowledge, motivation, readiness for change, or support among office staff members; emphasis on clinical rather than preventive care; and inadequate systems for PHS tracking, monitoring, and follow up.⁴

Patient attitudes toward and willingness to comply with recommended PHS are also vital. It is of no value for a physician to recommend PHS if the patient is unwilling to comply or to accept further evaluation or treatment, should such measures be recommended.

Active patient participation may be a useful additional approach to help ensure the receipt of PHS. Patients?rightly so?are more actively participating in their own health care, realizing it is at least as much their responsibility as that of their doctor. One promising example is the Unites States military. Air Force medical personnel have given patients a ?Putting Prevention into Practice? PHS guide, which outlines appropriate PHS for them based on gender and age. The guides are useful for explaining to patients what PHS are recommended for them. They also help patients actively participate in their own care by documenting both the results of various screenings as well as future preventive care needs. The Air Force experience reinforces data that show that many patients appreciate personalized guidance.⁵

Finally, optimal PHS for all requires that it be made available for the uninsured and the underinsured. Currently, PHS is only available to them on only a limited basis. All of these factors must be addressed if we are to provide optimal health care for patients.
Preventing chronic and/or often-incurable diseases such as breast cancer and emphysema certainly is preferable to long-term clinical treatment, with its associated suffering, limitations, and costs. As patients and health care providers, we should see to it that PHS are given more attention and delivered with more effectiveness than has been the case. As the old adage says, ?An ounce of prevention is worth a pound of cure.?


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