European Journal of General Practice

ISSN: 1381-4788 (Print) 1751-1402 (Online) Journal homepage: www.tandfonline.com/journals/igen20

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To cite this article: Veerle Piessens, Laura Rodriguez Benito, Serdar Öztora, Carlos Martins & John Brandt Brodersen (2025) Seven ways to optimise prevention in general practice and family medicine - a EUROPREV position paper to spark debate on prevention, European Journal of General Practice, 31:1, 2531880, DOI: 10.1080/13814788.2025.2531880

To link to this article: https://doi.org/10.1080/13814788.2025.2531880

Published online: 23 Jul 2025.

EUROPEAN JOURNAL OF GENERAL PRACTICE
2025, VOL. 31, NO. 1, 2531880
https://doi.org/10.1080/13814788.2025.2531880

COMMENT

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Seven ways to optimise prevention in general practice and family medicine - a EUROPREV position paper to spark debate on prevention

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KEY MESSAGES

- The increasing volume of preventive services competes with curative demands in busy primary care practices.
- Providing accessible, high-quality care has inherent preventive value.
- Focusing on evidence-based prevention for patients who will benefit the most will enhance health, efficiency, and equity in general practice and family medicine.

ABSTRACT

Prevention is a fundamental aspect of the work of general practitioners (GPs) and family doctors (FDs); however, its implementation poses significant challenges due to conflicting guidelines, time constraints, competing demands, and equity concerns. This position paper proposes seven guiding principles to help GPs and FDs navigate preventive care effectively. It encourages GPs/FDs to recognise the intrinsic preventive value of high-quality general practice and adopt a critical approach to the evidence underpinning preventive recommendations. Prioritising a limited number of preventive services with a strong evidence base and targeting those patients most likely to benefit will contribute to sustainable, evidence-based, and equitable patient care.

ARTICLE HISTORY
Received 14 February 2025
Revised 2 July 2025
Accepted 4 July 2025

KEYWORDS
Prevention; general practice; family medicine; high-quality care; accessibility; equity

Introduction

Prevention is a core task of general practice (GP) and family medicine (FM); it is part of the comprehensiveness that characterises a general practitioner's or family doctor's (GP/FD's) work [1]. However, GP/FDs face many challenges in delivering preventive care: prevention is rarely the patient's reason for encounter (RFE), guidelines provide diverging recommendations, public calls for more prevention often lack evidence and ignore potential harms, prevention diverts resources from sick patients to the worried well, increases inequity, and risks consuming all the available time a GP/FD has [2,3]. GP/FDs want to act in the best interests of their patients and appreciate the value of good preventive care; however, they hold different opinions as to what prevention should take place in primary care and what the role of the GP/FD is in the preventive agenda [4].

GP/FDs work in diverse settings, from small solo practices to groups of GP/FDs collaborating with other healthcare providers to large multidisciplinary health and welfare centres serving thousands of patients. Larger practices have more staff to provide prevention, and much of the preventive work may be taken care of by nurses or assistants. However, no primary care practice has infinite resources, and the challenges related to prevention will ultimately be similar. We believe this position paper can be inspiring for all GP/FD practices, regardless of their size and composition.

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Over the past decades, we have seen a progressive increase in preventive work in primary care [3]. There are many contributing factors to it: development of new techniques and interventions (e.g. new vaccines, new drugs, liquid biospy), broader target groups (e.g. statin treatment), lower thresholds (e.g. hypertension), and more intensive follow-up. There is also a significant commercial interest in focusing on medical prevention. The medical–pharmaceutical complex benefits directly from more tests and treatments. Moreover, the focus on individual prevention conveniently serves the interests of non-medical industries (e.g. the processed food sector), as it allows them and policymakers to shift their accountability for widespread health problems onto individuals and their health professionals [5].

Many interest groups advocate for more prevention, always predicting an 'epidemic' of their disease of interest, typically describing it as a silent killer and promising that millions of lives could be saved if only GPs would just pay a bit more attention to this problem.

As a result, the preventive agenda expected to be delivered by primary care has become unmanageable, inevitably leaving the GP/FD feeling overwhelmed and inadequate [2,4]. This is unsustainable for the patient, the GP/FD, the healthcare system and the planet. In most countries, general practice is already under pressure, with access to primary care services compromised [6].

However, throwing out the prevention-baby with its muddy and overloaded bathwater would be a shame. Therefore, EUROPREV suggests seven ways to optimise prevention to help primary care teams focus on what is essential (Box 1). EUROPREV is a part of the WONCA Europe network and it's main objective is to promote evidence-based disease prevention and health promotion in general practice and family medicine. EUROPREV has members from Finland to Portugal and from Ukraine to Ireland. All representatives support this position statement (see acknowledgements).

Box 1. Seven ways to optimise prevention.

1. Accessibility and quality of general practice are the basis
2. Become knowledge experts in evidence-based prevention
3. Avoid prevention not based on high-quality evidence
4. Appreciate the value of structural prevention
5. Symptomatic and high-risk patients have priority
6. Proportionate universalism: extra efforts for socially disadvantaged patients
7. Start low and go slow.

Because we anchor these principles into a basic understanding of prevention, we start with a short recapitulation of the core concepts of prevention and continue with a thorough description of the seven guiding principles.

Prevention

Prevention encompasses far more than the traditional interventions that easily come to mind when discussing prevention in GP/FM. To get a comprehensive picture of the full scope of prevention, we need to start with the fundamental question: 'What is the ultimate goal of prevention, and how can it be achieved?'

The core objective of prevention is to make people live longer and better by reducing mortality and morbidity and improving quality of life. To do so, prevention must reflect the determinants of health and the pathogenetic mechanisms of disease. This becomes evident in the five levels of prevention (see Figure 1). While primary, secondary, and tertiary prevention are better known, primordial and quaternary prevention are equally important and probably most relevant from a citizen's perspective [7,8].

Primordial prevention addresses the societal and environmental determinants of health, such as safety, clean air, reducing child poverty, traffic safety, good quality housing and strong healthcare systems. This level of prevention has the largest impact on people's quality of life and longevity. GP/FDs have no leading role in primordial prevention, but they work within a context shaped by primordial prevention, and they contribute to it, for example, by providing accessible care or antibiotic stewardship.

Primary prevention aims to prevent diseases by reducing exposure to the pathogenetic causes or factors (e.g. smoking cessation, condom use, blood pressure treatment) and improving individuals' resilience against the pathogen (e.g. by improving fitness, vaccination, and nutritional status).

Secondary prevention seeks to detect a health problem or risk factor at an early, asymptomatic stage to improve the prognosis (e.g. neonatal screening, cancer screening) or to reduce further spreading in case of infectious diseases (e.g. tuberculosis screening).

Tertiary prevention refers to all interventions that improve the prognosis, evolution and outcomes once diseases become symptomatic and people seek help (e.g. accessible healthcare, exercise programs after AMI, statins after CVA, adjuvant chemotherapy).

Quaternary prevention is an operationalisation of the ethical principle 'First, do no harm' and refers to interventions taken to protect people from harmful

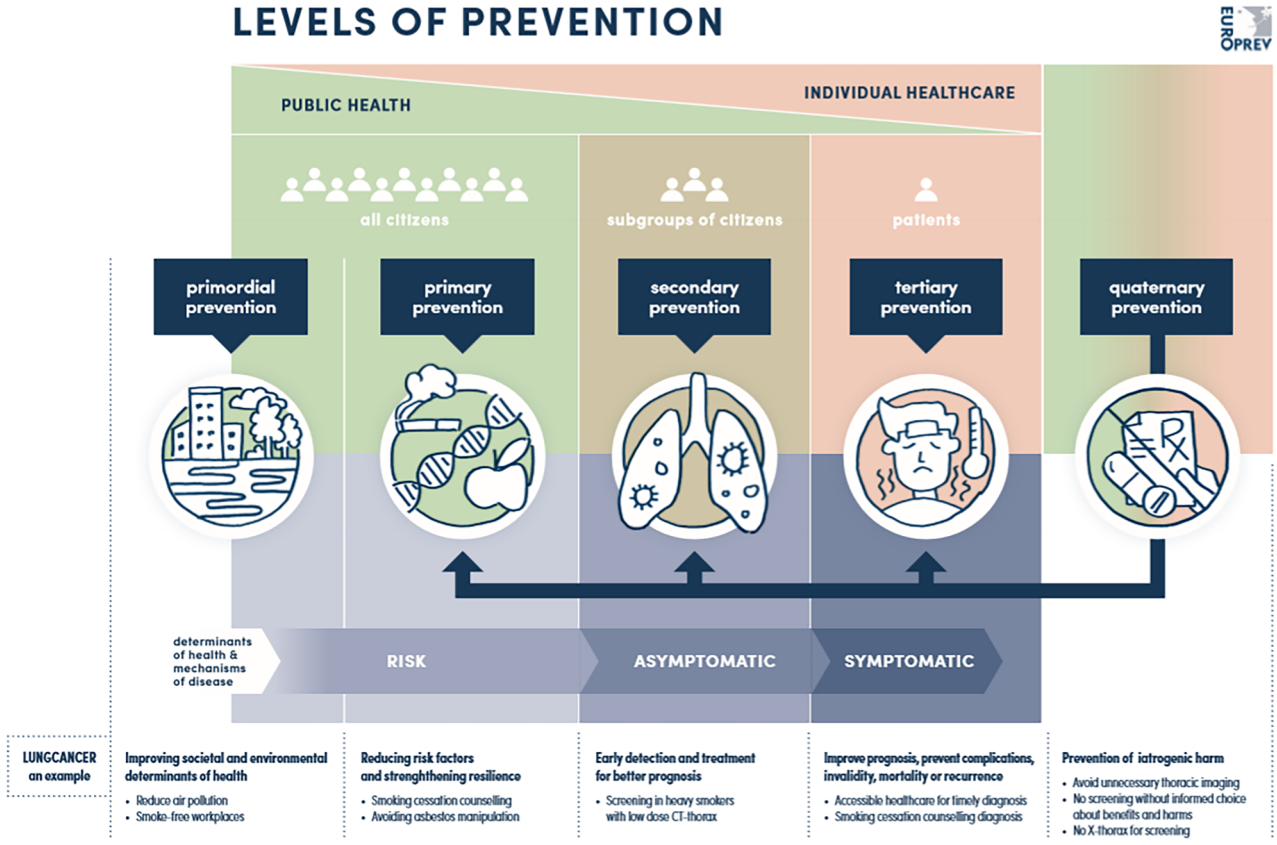

Figure 1. Five levels of prevention (images from flaticon.com).

medical interventions (e.g. avoiding unnecessary diagnoses, deprescribing redundant medications, and promoting informed choice in cancer screening) [8].

To achieve this comprehensiveness in prevention, throughout all levels, a combination of structural and individual interventions is needed, implemented by public health authorities and individual healthcare providers.

Structural preventive interventions are societal or organisational measures that structurally improve environment and conditions and achieve a preventive effect on health [9]. This can mean interventions to living and working conditions (e.g. smoke-free workplaces, safe bicycle paths, legislation to halt global warming), but also interventions within the health system (e.g. hand hygiene, available and affordable medicines). Structural interventions benefit larger populations all at once without the active participation of the targeted individuals. Individual preventive interventions, on the other hand, require action by each individual separately and repeatedly. Individual prevention encompasses a broad range of possible interventions, such as lifestyle actions (e.g. tobacco counselling, bicycle helmets), vaccines, screening, and preventive treatments (e.g. statins, preventive oophorectomy in women with BRCA-mutations). Individual prevention is often organised programmatically to improve reach and efficiency. For example, childhood immunisation or population screening. Despite the structured organisation of these programs, they can only achieve the health benefit by applying the intervention to each individual separately.

Public health (PH) and individual healthcare (IHC) contribute to prevention in complementary and mutually dependent ways. The primary objective of PH is to improve the entire population's health through structural interventions in coordination with policies in other societal domains (e.g. education, housing, mobility) and through the facilitation of individual prevention (e.g. organising immunisation programs). IHC primarily has the health of individual patients at its core and delivers prevention mainly through individual interventions.

Tertiary prevention is self-evident in general practice, but GP/FDs are active throughout all levels of prevention. We will argue that GP/FDs already deliver a substantial amount of prevention by being good GP/FDs. These guiding principles intend to help GP/FDs focus on what is essential in prevention and to free up time to provide high-quality care. However, we have no intention to be prescriptive as to what prevention ultimately should (not) be done. What happens in the

consultation room is at the doctor's discretion and results from shared decision-making between the patient and their doctor. We hope GP/FDs find these seven ways helpful in navigating the vast and challenging terrain of prevention.

Seven ways to optimise prevention

Accessibility and quality of general practice are the basis

An inaccessible GP/FD cannot provide any form of prevention. However, there is more: ensuring the accessibility and quality of general practice is part of primordial prevention. It contributes to a performant primary healthcare system and is associated with better population health outcomes [10,11]. Research also shows that continuity of care in GP/FM is associated with reduced mortality and acute hospitalisations [12]. Accessible, good quality, evidence-based care also means people get timely help for their health problems with the best possible prognosis (tertiary prevention), and it reduces the risk of unnecessary, harmful interventions (quaternary prevention).

Become knowledge experts in evidence-based prevention

GP/FDs should know the available research underpinning prevention and be able to decide what is worthwhile and how to implement it [13]. Most medical prevention happens in primary care, yet evidence of the effectiveness of prevention is rarely generated within the primary care setting. Research done in primary care often shows surprising results and calls for cautious deliberation before adopting preventive interventions [14,15]. Moreover, organ specialist organisations regularly issue recommendations that largely affect primary care, yet with no or only a few GP/FDs involved in the guideline author group [16]. Despite shared patients and objectives, general practice differs substantially from organ specialist care. In theory, organ specialists are only responsible for offering tertiary prevention in their specific speciality. They care for a selected population of often very sick, high-risk patients with a probably higher motivation to adopt the proposed prevention and for whom preventive interventions will have a more favourable benefit-to-harm balance [17]. These high-risk patients are also part of the general practice population, but GP/FDs care for many more patients, most with much lower risk. Hence, this selective evidence and expertise from organ specialist care cannot be transferred to general practice. Prevention GP/FM requires thoughtful translation of the best available external evidence into realistic and feasible recommendations. GP/FDs have to take the lead in writing their preventive guidelines without having to rely on organ specialists' guidance.

Avoid prevention not based on high-quality evidence

Prevention requires robust, high-quality evidence demonstrating a beneficial effect that outweighs the potential harm. In other words, prevention that makes a relevant clinical or public health difference. The moral obligation to provide a strong evidence base is high because prevention is typically offered to healthy people at the health system's initiative [18]. It is hard to make a healthy person healthier. Although patients targeted for prevention are not necessarily entirely healthy (e.g. tertiary prevention is offered to symptomatic people), they are considered healthy in relation to the future condition we aim to prevent. Individualised prevention will, at best, result in only modest health improvements and may inflict harm on people who were previously healthy [13,19].

Yet, many preventive interventions in GP/FM have no solid evidence–some examples. No evidence supports the popular health checks in asymptomatic people [20]. Cardiology guidelines advocate for a resource-intensive treat-to-target approach for lipid-lowering without proof that this approach would result in better health outcomes than the well-established fire-and-forget strategy of prescribing statins based on a patient's cardiovascular risk [21]. Similarly, recent research found little to no evidence to support most recommendations for addressing lifestyle in general practice [22]. Further, even when research shows a statistically significant effect, this does not necessarily mean the intervention is worthwhile. Many screenings, such as screening for breast cancer or aortic aneurysm, show a slight reduction in disease-specific mortality but no reduction in all-cause mortality. They also result in substantial harm like overdiagnosis, emotional distress and cascade medical exams due to false positive testing [23–25].

Appreciate the value of structural prevention

The opportunity to prevent health problems through structural prevention is often undervalued. We define structural prevention as practice-level measures that modify the healthcare environment to improve health outcomes, with no or little need for active patient participation. Examples are disinfectant and sterilisation

protocols, appropriate antibiotic and cautious opioid prescribing, effective triage systems, and refraining from harmful screening practices. Structural interventions may require substantial preparatory efforts but have several advantages. Once they are in place, they apply to the whole practice population without needing to engage each patient separately. They often have spill-over effects on other practice situations and people. Structural prevention in GP/FM frequently aligns with de-implementation of low-value care and falls under quaternary prevention [26]. In this way, structural prevention protects patients from medical harm, saves GP/FDs' time for valuable work, and enhances the sustainability and equity of healthcare.

Symptomatic and high-risk patients have priority

GPS/FDs can maximise the health benefits of their preventive efforts by focusing on symptomatic patients and people at high risk of developing a problem.

As outlined in the first principle, accessible, high-quality care for sick patients improves their prognosis and forms the foundation of effective prevention [27]. It also enables targeted tertiary prevention tailored to the conditions patients consult for. Some examples are: adequate treatment of heart failure improves survival, as does smoking cessation in patients with COPD; a supervised walking program delays new episodes of acute back pain; and pharmacological prevention after a timely recognised vertebral fracture reduces the risk of hip fractures. This form of prevention is easy to offer, as it is closely linked to the patient's RFE. Doctors do not have to wait for a dedicated preventive consultation to introduce prevention. Many consultations provide an excellent opportunity to discuss tertiary prevention or prevention for high-risk asymptomatic people, the so-called 'teachable moment'.

For asymptomatic people, the benefit of preventive interventions will be higher for patients with higher baseline risks, whereas the harmful side effects tend to be more independent of baseline risk [17]. This implies that the benefit-to-harm ratio will be more favourable in patients with higher risk profiles. For example, statin therapy in patients with existing coronary heart disease has an NNT of 48 to prevent one death, whereas in primary prevention, four times as many high-risk persons must be treated to save one life (NNT = 200) [28,29]. Similarly, only five patients with moderate to severe COPD need a flu shot to prevent one COPD exacerbation, whereas 167 healthy adults must be vaccinated to avoid one flu episode [30,31]. This does not contradict Rose's prevention paradox, which states that on a population level, there will be more health benefits by approaching the large group with moderate risk than by focusing on the small group with high risk [32]. After all, if this improvement in public health is to be achieved through individual interventions, many more moderate-risk people will need to be 'treated'. For most of them, this will be without any benefit [17].

Proportionate universalism: Extra efforts for socially disadvantaged patients

Socially disadvantaged patients will benefit more from all the steps described above: accessibility, continuity of care, and no waste of time and money on unproven interventions. The harder people's socio-economic circumstances are, the higher their health risks are, and the more challenging it is for them to engage in prevention (Figure 2). This is true for nearly all health outcomes [33]. No form of medical prevention can compensate for this health inequality. This should be addressed through primordial prevention, and is a political and public health responsibility. Medical prevention can only achieve some attenuation of the deleterious effects of social inequalities on health outcomes. However, this does not mean GP/FDs could not make a meaningful difference. First, GPs can be aware of this socio-economic health inequality, advocate for their patients, and speak up publicly about the need for adequate primordial prevention whenever relevant. Second, GPs who treat people with respect and compassion can be trustworthy companions throughout people's health journey. Third, GP/FDs can support their patients in achieving prevention, or – to stay in the metaphor of Figure 2 – help them push the heavy rock of prevention.

Sir Michael Marmot coined the principle of proportionate universalism to respond to the observed socio-economic health gradient, even in wealthy societies. It states that '*interventions to reduce inequalities in health must be universal but with a scale and intensity that is proportionate to the level of disadvantage*' [33]. The Marmot report does not refer to medical prevention but emphasises the necessity of societal interventions to address health inequity. Nevertheless, we gratefully borrow the principle of proportionate universalism to apply to prevention in primary care and propose that GP/FDs proportionately invest more in supporting patients in socially difficult situations to help them realise the prevention they would like.

Start low and go slow

All preventive interventions can harm. Some do good as well, and of these, some do more good than harm [35].

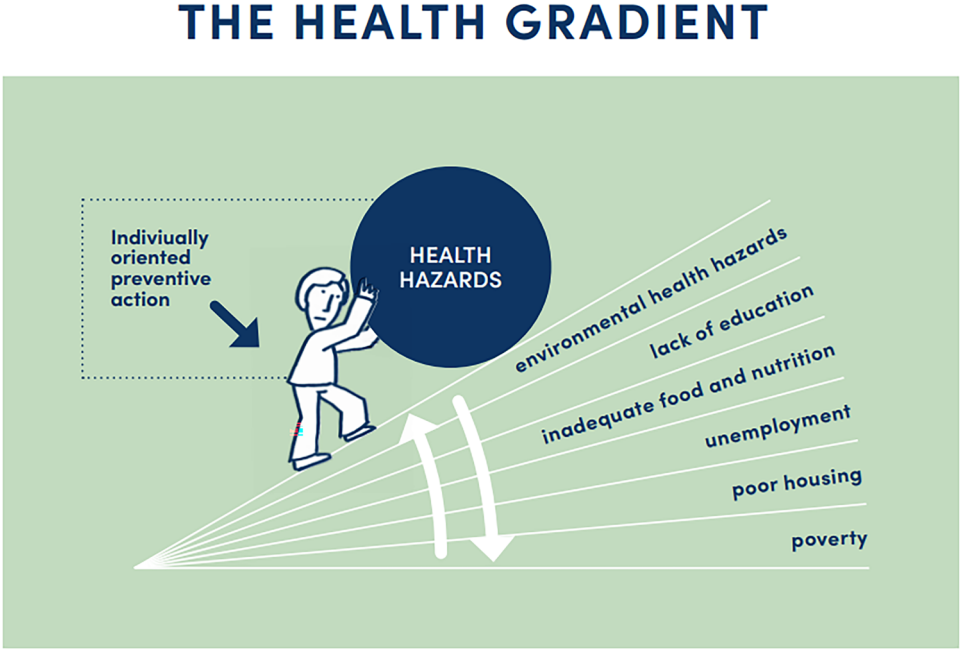

Figure 2. The health gradient [34].

The preventive field is tremendously large, and it is impossible to implement all preventive interventions well. Instead of trying to achieve the impossible, GP/FDs may start with a few priorities, get comfortable with these, re-evaluate if necessary and expand later on. Meanwhile, patients will be grateful for the ongoing, exceptionally good care they receive from their trusted GP/FDs [11].

Conclusion

These seven strategies to strengthen prevention emphasise that providing accessible, safe, and high-quality primary care is the strong structural foundation of prevention. They also encourage GP/FDs to make deliberate choices for safe, evidence-based prevention with clinically meaningful benefits for those most likely to benefit. This will free up time and mental space to focus on the core task of primary care: to help people with various health problems and provide continuity of care.

Acknowledgements

We thank Dr Jasmine Pawa and Dr Florian Stul for their proofreading and valuable comments. We used the following AI applications for writing and language support: Grammarly, an add-in application for writing assistance (grammar, syntaxis); Deepl, to translate specific challenging sentences into the author's native language and back into English to verify that the intended message was effectively conveyed; and ChatGPT, to rephrase specific paragraphs more concisely.

Authors contributions

This position statement expresses the shared vision of EUROPREV's delegates. It has been developed through exchange and debate during EUROPREV's annual Forum, delegates' meetings, and workshops at WONCA Europe's yearly conference. VP drafted the first version of this manuscript and shared it with the delegates. LRB, SO, CM and JBB contributed with essential comments and suggestions for changes. All authors accepted the final version of the manuscript. VP is the guarantor of the article. The final version of the article was presented to all the delegates for approval.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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