**HEALTH POLICY AND QUATERNARY PREVENTION**[1]

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*See at the bottom three questions for the on-line debate previous to the meeting.*

Health policy is a field of study and practice in which the priorities and values underlying health resource allocation are determined.

Health policy decision refers to selection of alternatives taking into account not only values and resources but the legitimate interest (and others) of many stakeholders. For example, health policy-making select in the public-private market best alternatives to give access and services for cataracts surgery (usually under-covered) and radical prostatectomy (usually in excess).

Health policy allows to decide about what services to be produced (for example, those needed to die at home) and the organization for accomplish the tasks (for example, skill mix of the professionals). When producing health services, the system try to answer health needs.

Health services could be individual (personal) or collective (population), complemented with inter-sectoral activities. Some health problems need the cooperation of all services, as obesity (clinical care, population interventions and inter-sectoral activities).

Health services production transform inputs into outputs and outcomes with the basic foundation of *primum non nocere*.

All services have adverse effects, all services might produce damage to health. A few services produce more benefits than harms in specific situations.

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Unnecessary and inappropriate services mainly produce harms, and few benefits if any.

Quaternary prevention is the prevention of unnecessary and/or inappropriate services and the prevention of over-medicalisation.

Quaternary prevention refers mainly to personal services, to clinical care, but collective services is not out of scope.

Unnecessary contact should be avoided. The risk of receiving unnecessary and/or inappropriate care depends upon having contact with the health system facilities-professionals.

Inappropriate contact should be also avoided. It is critical the question of contacting the right facilities-professionals only when needed, the appropriate professional at the right time, and where benefits could be expected to overcome harms.

So, one policy decision is to keep away healthy people of the health system (avoiding, for example, health check-up or health revisions), and to reduce preventive contacts and follow-up of chronic patients to a minimum (for example, stable diabetes patients every six months in routine situations and no contacts because screening of any cancer).

Complementary policy decision is to keep the contact according to needs, so organizing the services in such a way that the risk of receiving unnecessary and/or inappropriate care is proportionate to the complexity of health problems.

Quaternary prevention should be emphasized by health policies in risky critical situations which are typical 1/ in emergency care, 2/ when being care by an over-staffed facilities or by professionals with more/less specialization than needed, 3/ in the "transition" between "levels" (from hospital to community care and from home to nursing-home and vice versa, for example), 4/ when having more than a health problem (multi-morbidity) or being fragile (poor, elderly, handicapped, illiteracy, unemployed), and 5/ when adopting new technologies (organization, techniques and tools and diagnosis and therapeutic products). Health policy-making should take into account the need of quaternary prevention in these situations.

Person-focused care is better suited to addressing quaternary prevention than disease/risk factor-focused care. Person-focused care is global focused and take into account patients, families and communities perspectives and expectatives.

The "tyranny of diagnosis" increases the danger of harms as usually the implementation of guidelines and programs/protocols.

So health services need 1/ general practitioners who offer services with effective accessibility, comprehensiveness, person-focused care over time and able to coordinate care from other specialists, and 2/ the needed knowledge and organization to accomplish with the basic *primum non nocere.*

Because of the lesser exposure of the poor and other minority groups to medical interventions, when improving access and utilization health policy-making should take into account at the same time benefits and harms (avoiding when possible the later with specific actions of quaternary prevention, as limiting the exposure to radiology, for example).

Quaternary prevention is linked to transparency. So a health policy that promotes quaternary prevention should simultaneously promotes transparency. Transparency about the process of care and the outcomes in such a way benchmarking becomes a almost daily activity, for example.

Transparency refers, for instance, to information (by patients social class, and health care facilities, professionals, areas and regions) about use of statins in primary cardiovascular prevention, or adverse effects (of preventive, diagnostic, therapeutic and rehabilitation activities, as over-diagnosis of cancer, antibiotic resistance, and morbidity and morbidity of "medical origin").

Health policy is needed to promote leadership (clinical, managerial and political) about quaternary prevention.

**References**

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**Questions:**

1. **Health policy-making could make difficult quaternary prevention actions. Please, comment an example.**

2. **Select a few elements (inputs, as human resources, knowledge, technology, incentives and so on) that might improve at the meso (institutional) level diffusion and implementation of quaternary prevention.**

3. **In the case your must prioritize health policy-making about quaternary prevention, what and why you will select?**