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News

Screen all adults 45 or over for abnormal glucose, says US panel

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What to do about prediabetes and other prediseases in the context of health and economics

Prediabetes, prehypertension and pre-obesity/overweight are construed as intermediate health states, between ideal health and clinically-diagnosed conditions indicating elevated risks to health.¹ They are increasingly recognized as major risk factors for some of the leading causes of mortality among high-income and middle-income economies and are advocated as clinical entities deserving targeted identification and clinical intervention. Indeed, early intervention in cardiovascular disease (CVD) mortality has been proposed predicated on the diagnosis of prehypertension, prediabetes and pre-obesity as well as borderline hypertriglyceridemia (or prediseases).²⁻³ Acknowledging them as clinical entities is valuable to the extent that the “diagnosis” alerts individuals to act in order to prevent the worsening of risks and onset of disease.

While health information alone is no guarantee for the promotion of health, health-related behavioral changes, it should be noted, are contingent on health information and the understanding of such.⁴ Far from turning healthy individuals into or labeling them “patients” and pathologizing their health status, prediseases ought to be seen in the context of prevention and that their management and control, as with the prevention of hypertension, diabetes and obesity, is behavioral, non-pharmacologic and not confined to the clinic. The non-pharmacological and non-clinic management of individuals with prediseases is critical to avoid the repeat of the (increasing) capture of (primary and secondary) prevention efforts at present by the interests of pharmaceutical and medical devices industries with the (indirect and unintended, and in some cases, direct and unambiguous) support of practitioners.⁵ Otherwise, the challenge of overconsumption and overtreatment will remain, if not worsen.

Disease prevention and health promotion are activities that need not, cannot and should not be locked in within the confines of the healthcare system. This is not just a matter of costs but also of outcomes. Studies of interventions in primary prevention have shown the superiority of lifestyle interventions over drug-based treatment with a review of pharmacotherapy for mild hypertension among healthy adults finding no reduction in mortality or morbidity in randomized clinical trials.^{4,5} Meanwhile, clinic-based, preventative interventions have shown mixed results with regards to their effectiveness.⁶ The workplace, school and home are, most likely, the best candidates for carrying out these activities and by implication managing and controlling prediseases.

Pursuit of “Health in All Policies”, an approach that has health as an outcome of all policies is imperative.⁷ This involves investing in primordial prevention which focuses on the behavioral, cultural, economic,

environmental and social factors known to increase the risk of disease and multisectoral action. A macro level strategy can help facilitate action at the micro (i.e. individual) level which requires taking greater responsibility over one's health by being informed about vital health metrics through self-tracking and managing one's health. Strategy at the micro level can be achieved by leveraging mHealth, defined as medical services and health information delivered or enhanced through mobile communication and information technology, given the uptake of mobile technologies which transcends demographic groups, geographic areas and socio-economic levels and its potential.⁸

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