Primary Prevention And Promoting Well-Being

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Introduction

Prevention covers a wide range of policies, services, facilities, information, and community resources intended to maintain health, promote well-being, reduce risk, identify problems early, and lessen the impact of established illness or disability. It complements treatment rather than replacing it. Modern prevention recognises that health is shaped not only by medical care but also by housing, income, education, social connection, safety, transport, environment, discrimination, and access to supportive services (World Health Organization [WHO], 2025).

Prevention is commonly described at three levels:

- Primary prevention aims to prevent a disease, injury, or care need before it develops.
- Secondary prevention identifies elevated risk or early disease and intervenes promptly to prevent deterioration.
- Tertiary prevention reduces disability, complications, and loss of independence among people with established conditions.

The categories are useful but not absolute. A single service may operate at more than one level. Exercise can promote general well-being, reduce fall risk, support rehabilitation, and help manage chronic disease. The Care Act statutory guidance therefore treats prevention as an ongoing responsibility rather than a one-time activity and applies it to adults with no current care needs, adults already receiving care and support, and carers (Department of Health and Social Care [DHSC], 2025).

Primary Prevention and Promoting Well-Being

Primary prevention aims to help people maintain health, independence, resilience, and social participation before significant needs arise. It may be universal, such as public information and safe neighbourhood design, or targeted toward groups experiencing greater exposure to risk.

Examples include:

- accessible information about health, care, benefits, housing, and community services;
- physical activity, nutrition, vaccination, smoking cessation, and alcohol-harm reduction;
- safe housing, transport, streets, and public spaces;

- social groups, befriending, volunteering, and community activities;
- support for financial security, digital inclusion, and access to education;
- carer information, peer support, and early planning;
- hearing, vision, dental, and medication reviews; and
- measures addressing abuse, neglect, ageism, discrimination, and social exclusion.

Primary prevention should not be reduced to telling individuals to make better choices. People cannot exercise safely without suitable spaces, eat well without affordable food, remain socially connected without transport or accessible activities, or manage health information they cannot understand. Effective prevention therefore combines individual support with population and environmental change.

Well-Being Under the Care Act

The Care Act 2014 places individual well-being at the centre of adult social care in England. Relevant dimensions include:

- personal dignity;
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control over day-to-day life and care;
- participation in work, education, training, and recreation;
- social and economic well-being;
- domestic, family, and personal relationships;
- suitability of living accommodation; and
- contribution to society.

Promoting well-being therefore requires person-centred assessment rather than applying the same service to everyone. The person's goals, strengths, culture, communication needs, relationships, risks, and preferred outcomes should shape planning. Local authorities must also consider how services can prevent, reduce, or delay needs and how they can work with health services, housing, voluntary organisations, communities, carers, and individuals themselves (DHSC, 2025).

Social Connection and Loneliness

Social isolation is an objective lack of social contact, while loneliness is the distressing feeling that one's relationships are inadequate. They can occur together or separately. Both can affect people of any age, but retirement, bereavement, disability, sensory loss, caregiving, poverty, inaccessible environments, and poor transport may increase risk in later life.

WHO's Commission on Social Connection describes loneliness and social isolation as important public-

health issues associated with poorer physical and mental health and increased risk of premature death. Solutions can include social infrastructure, inclusive communities, transport, digital access, community groups, psychological approaches, and opportunities for meaningful participation. Programmes should be designed with participants, because merely placing people in a group does not guarantee belonging or supportive relationships (WHO, 2025).

Primary prevention may involve libraries, parks, community centres, intergenerational programmes, volunteering, accessible faith or cultural activities, and social prescribing. Targeted support may include befriending, bereavement services, peer groups, telephone contact, digital-skills training, and transport assistance. Services should avoid assuming that all older people are lonely or that digital contact is an adequate substitute for preferred face-to-face relationships.

Healthy and Active Living

Physical activity can support cardiovascular health, strength, balance, mobility, mood, sleep, cognition, and social participation. Prevention programmes should offer activities that are safe, affordable, culturally acceptable, accessible to people with disabilities, and adaptable to different levels of ability.

Nutrition support may include income assistance, meal programmes, community kitchens, food-delivery services, dental care, swallowing assessment, and treatment of conditions that affect appetite. Advice alone will not address malnutrition when people face poverty, isolation, inability to shop or cook, medication effects, or illness.

Primary prevention also includes vaccination, screening where evidence supports it, reduction of tobacco and harmful alcohol use, management of blood pressure and cholesterol, protection from head injury, hearing support, and action on air pollution. These measures can affect several chronic conditions simultaneously.

Planning for Future Care and Support

Early conversations can help people and families prepare for possible changes without assuming decline is inevitable. Topics may include:

- housing suitability and possible adaptations;
- financial and legal planning;
- advance care planning;
- future caregiving responsibilities;
- transport and social support;
- technology and emergency contact arrangements; and
- preferences concerning care and independence.

Planning should be voluntary, understandable, and sensitive. It should strengthen autonomy rather than pressure people to accept services or decisions they do not want.

Secondary Prevention and Early Intervention

Secondary prevention targets people who have elevated risk, early symptoms, emerging functional difficulty, or a change that could lead to crisis. The aim is to detect problems early and intervene before they become more serious.

Examples include:

- screening and assessment after a fall;
- medication review;
- home-safety assessment and adaptations;
- early identification of malnutrition, frailty, depression, sensory loss, or cognitive change;
- short-term equipment or mobility support;
- telecare and alarm services;
- rapid response after hospital discharge;
- early support for carers; and
- targeted programmes for people with known risk factors.

Secondary prevention should not become indiscriminate screening. A screening programme is valuable only when the condition is important, the test is sufficiently accurate, effective follow-up is available, harms are considered, and the people invited can make an informed choice.

Falls Prevention

Falls are common and can lead to fractures, head injury, fear of falling, reduced activity, loss of confidence, hospitalisation, and loss of independence. Risk is usually multifactorial and may involve muscle weakness, balance problems, medication, vision, footwear, hazards in the home, postural hypotension, alcohol, pain, cognition, and acute illness.

The CDC's 2025 compendium identifies effective community interventions, including strength and balance exercise, home modification, clinical interventions, and multifactorial programmes. Effective practice involves screening, assessment, and intervention rather than assuming that falls are an unavoidable part of ageing (Centers for Disease Control and Prevention [CDC], 2025).

A fall clinic or coordinated service may review:

- previous falls and circumstances;
- gait, strength, and balance;

- medicines that increase dizziness or sedation;
- vision, hearing, feet, and footwear;
- blood pressure and cardiovascular causes;
- osteoporosis and fracture risk;
- home hazards; and
- fear of falling and confidence.

Interventions should be tailored. Restricting movement out of fear can worsen weakness and increase future risk.

Housing Adaptations and Practical Support

Minor repairs, handrails, improved lighting, safer flooring, grab bars, ramps, accessible bathrooms, and heating improvements can help people remain independent. Handyperson services may be particularly valuable for people who cannot safely complete repairs or afford commercial assistance.

Adaptations should follow assessment and involve the person. Poorly selected equipment may be unused or create new risks. Housing services, occupational therapists, social-care teams, landlords, and health professionals may need to coordinate.

Aging in place also depends on more than the physical home. Access to shops, healthcare, transport, social contact, emergency assistance, and reliable care is essential. The U.S. National Institute on Aging notes that home-based independence often requires planning for personal care, household support, transport, home safety, and respite for carers (National Institute on Aging [NIA], 2023).

Telecare and Assistive Technology

Telecare and assistive technology can include personal alarms, fall detectors, medication reminders, automatic lighting, environmental sensors, video communication, accessible phones, and remote monitoring. Potential benefits include faster response, confidence, support for carers, and reduced avoidable hospital use.

Technology is not automatically preventive. It may fail because of poor connectivity, inaccessible design, false alarms, battery problems, lack of training, or services that cannot respond. It may also create privacy, consent, surveillance, and data-security concerns. Technology should support—not replace—human care and social contact. People should understand what is monitored, who receives information, how long data are stored, and what happens when an alert is triggered.

Dementia Risk Reduction and Early Support

Age and genetics are important non-modifiable risk factors for dementia, but several modifiable factors operate across the life course. The 2024 Lancet Commission update identified high LDL cholesterol and untreated vision loss in addition to previously recognised factors such as less education, hearing loss, hypertension, smoking, obesity, depression, physical inactivity, diabetes, excessive alcohol use, traumatic brain injury, air pollution, and social isolation. The Commission estimated that addressing modifiable risks could delay or prevent a substantial proportion of dementia cases at the population level (Alzheimer's Society, 2024).

Risk reduction does not guarantee prevention for an individual and should not create blame. Many factors require societal action, including education, clean air, safe work and transport, access to hearing and vision care, affordable healthy food, and reduction of inequality.

Early identification of cognitive concerns can allow assessment for reversible causes, planning, support, treatment of co-occurring conditions, and access to services. Screening without follow-up or consent can cause anxiety and stigma, so pathways must be clearly established.

Tertiary Prevention

Tertiary prevention aims to reduce complications, disability, distress, and loss of participation after a condition or care need is established. It supports recovery, adaptation, and the best possible quality of life rather than merely preventing death.

Examples include:

- rehabilitation after stroke, fracture, surgery, or serious illness;
- reablement following functional decline;
- management of chronic disease and pain;
- vision and hearing rehabilitation;
- multidisciplinary support for dementia or complex needs;
- assistive equipment and home adaptation;
- carer training, respite, and peer support;
- palliative and end-of-life care; and
- prevention of pressure injuries, infections, falls, and medication harm.

Reablement and Intermediate Care

Reablement is short-term, goal-oriented support intended to help a person regain or maintain skills and confidence in everyday activities. Rather than completing every task for the person, staff work

with the individual to practise activities such as washing, dressing, preparing food, moving safely, using transport, or managing routines.

NICE recommends person-centred intermediate care and reablement with agreed goals, timely access, multidisciplinary working, regular review, and a transition plan for the end of the service. Decisions should consider what matters to the person and should not exclude people merely because of age, diagnosis, dementia, or living arrangement (National Institute for Health and Care Excellence [NICE], 2017).

Reablement is not suitable as the only response when a person needs long-term care, urgent medical treatment, safeguarding, or specialist rehabilitation. Success should be measured through meaningful outcomes such as independence, confidence, participation, carer impact, and reduced avoidable service use—not only whether formal care hours decline.

Integrated Care for Complex Needs

People with multiple conditions may receive fragmented services from primary care, hospitals, mental-health teams, social care, housing, pharmacies, rehabilitation, and voluntary organisations. Separate assessments and conflicting plans can burden individuals and carers.

Integrated care may include:

- a named coordinator;
- a shared, person-centred plan;
- multidisciplinary review;
- medication reconciliation;
- rapid communication during transitions;
- clear responsibility for follow-up; and
- involvement of the person and carer.

Integration should not mean sharing information without consent or removing individual choice. It should reduce duplication and gaps while maintaining privacy and accountability.

Support for Carers

Carers may experience physical strain, sleep disruption, financial pressure, social isolation, anxiety, depression, and loss of employment or education. Prevention must therefore address the carer's well-being independently of the cared-for person's needs.

Support may include:

- information and training;

- carer assessment;
- respite and replacement care;
- peer support and dementia cafés;
- counselling and psychological support;
- flexible work and financial advice;
- emergency planning; and
- involvement in care planning with the person's consent.

Respite should be reliable and acceptable to both the carer and the person receiving care. A service that causes distress or is unavailable when needed will not provide meaningful relief.

Planning and Evaluating Prevention

Local prevention strategies should be based on population needs, inequalities, community assets, service gaps, and evidence. Planning should involve people who use services, unpaid carers, communities, and frontline workers.

Evaluation should consider:

- who is reached and who is excluded;
- changes in health, independence, and well-being;
- loneliness and social participation;
- falls, hospital admissions, and care-home admission;
- carer outcomes;
- user experience and dignity;
- costs across health, social care, housing, and families; and
- unintended harms.

Prevention may require investment before savings appear, and benefits may occur in a different organisation from the one paying for the intervention. Short-term financial measures should not obscure improvements in quality of life, autonomy, or equity.

Conclusion

Primary prevention promotes health, independence, social connection, and safer living before substantial needs arise. Secondary prevention identifies emerging risk and intervenes early through services such as falls assessment, home adaptation, assistive technology, and targeted support. Tertiary prevention reduces the impact of established illness and disability through rehabilitation, reablement, integrated care, equipment, and support for carers.

The three levels should not be treated as isolated programmes. Prevention is a continuous, person-

centred responsibility across communities, public health, healthcare, social care, housing, and voluntary services. The strongest approach combines individual choice and support with action on social and environmental conditions. Its success should be judged by whether people maintain dignity, relationships, participation, health, safety, and control over their lives—not simply by whether they use fewer services (DHSC, 2025; WHO, 2025).

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