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From Prevention to Cure: Integrative Care Models Transforming General Medicine Practice

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Abstract—*The increasing burden of chronic and lifestyle-related diseases around the world has revealed the inherent constraints in healthcare systems that typically divide preventive and curative care. General medicine, being the point of first line care provision, plays a pivotal role in bridging this gap. A combination of preventive and curative care models provides a pathway that is strategic in enhancing the health outcomes of the population, patient experience, as well as system sustainability. This paper analyzes the principles of integrated care models, clinical applicability, and system-level translation of this concept in general medicine based on the evidence of both preventive and integrative medicine concepts and chronic care models. The review is a synthesis of models that are extant in integrating health promotion, early disease detection, clinical management, and long-term care in integrated service structures. It has a focus on patient-centred care, interdisciplinary teamwork, community involvement, and continuity of preventiontreatment continuum. The paper also addresses how primary care, integration of public health and emerging digital and precision-based strategies can be operationalized to integrate models. Critical issues are discussed in the context of workforce preparedness, health system fragmentation, equity and alignment of policy. The article suggests that the paradigm shift in general medicine should be to integrated, holistic, and value-based care by placing prevention and cure as complementary and not competing areas. The results emphasize the necessity to implement integrated care models in clinical practice and provide context-specific implementation strategies and supporting health policies. Increase in the presence of preventive and curative services should be strengthened to the problem of chronic disease complexity and contribute to the development of resilient healthcare systems.*

Index Terms— *Preventive medicine; Curative services; General medicine; Patient-centred care; Chronic disease management; Health system integration; Primary care; Public health.*

INTRODUCTION

The growing prevalence of chronic, lifestyle-related, and multimorbid conditions which require long-term, coordinated, and patient-centred care is now a challenge to the healthcare systems in various parts of the world. Conventional paradigms of medical practice have in the past separated prevention and cure as separate areas, which frequently leads to disjointed service delivery, slow intervention, and inefficient health outcomes. Certainly, general medicine, situated at the cross point between primary care and public health as well as between specialty services, can be instrumental in dealing with this fragmentation by providing both preventive and curative care in a single clinical setting (Hensrud, 2000; Cashman et al., 1999). Preventive medicine is aimed at promoting health, reducing the risk, and diagnosing in early stages whereas curative care aims at examining, treating, and managing the symptoms. There is growing evidence indicating that separation of these functions negatively affects continuity of care, especially with chronic illnesses that develop over time and need long-term clinical interactions (Glasgow et al., 2001; Wendimagegn and Bezuidenhout, 2019). The aim of integrated care models is to close this gap through pivoting preventive care with therapeutic intervention along the disease continuum to enhance efficiency, equity, and patient outcomes (Valentijn et al., 2013; Wulsin et al., 2006). Integrative medicine offers both conceptual and operational frameworks of such alignment combining conventional biomedical treatment with lifestyle modification, behavioural interventions and patient-centred approaches. Researchers emphasize that integrative medicine reinforces preventive care and improves the efficiency of curative care, in particular, in primary and general medicine (Ali and Katz, 2015; Templeman and Robinson, 2011; Maizes et al., 2009). Such a holistic orientation fits the modern understanding of the concept of healing and curing where health is viewed as a multidimensional construct that includes physical, psychological, social, and environmental determinants (Verma & Sharma, 2025).

The epidemic of the chronic disease has also spurred the integrated models. Medical conditions like diabetes, cardiovascular diseases, mental illness, and substance-related illnesses usually have a basis on modifiable risk factors and develop through preventable phases until it demands intensive medical care. There is an emphasis on better disease detection, community interventions, and continuity between the levels of care, which results in the disruption of the vicious cycle of disease evolution (Sun et al., 2026; Yach et al., 2004; Willison et al., 2005). Combined with experiences of other regions in the world and in India, it is proven that integrated programs could be used to enhance adherence, the number of hospitalizations, and quality of life across various populations and even vulnerable and underserved ones (Soni et al., 2025; Ashifa, 2019; Ashifa, 2021). In the systems perspective, integrated care is also reacting to calls of closer cooperation between medicine and public health. Community-based preventive medicine, which is based on community-responsive care, can help general physicians to mitigate social determinants of health, health inequities, and behavioural risks in addition to clinical management (Cashman et al., 1999; Airhihenbuwa et al., 2021). The relevance of the integration of prevention, chronic care, and palliative services into primary healthcare systems to establish continuity and sustainability is highlighted by international frameworks, such as those advocated by the World Health Organization (World Health Organization, 2018; Kearney et al., 2020). Even with the strong conceptual positioning, it is difficult to operationalize the concept of integrated preventive and curative care. Professional silos, lack of training in preventive competencies, resource limitations and policy misalignment are some of the barriers. To overcome them, medical education has to be reoriented, interdisciplinary collaboration and enabling governance systems that view prevention and cure as complementary functions but not prime competitors (Jani et al., 2015; Czerska and Skweres-Kuchta, 2021). It is in this background that the current paper analyzes the rationale, models, and practical implications of integration of preventive and curative care in general

medicine. It will use evidence based on integrative medicine, chronic care models, and global health policy to bring into the limelight of the pathways of strengthening patient centred, coordinated, and sustainable healthcare delivery.

PREVENTIVE AND CURATIVE CARE AS CONCEPTUAL MODELS OF GENERAL MEDICINE

The conceptualization of the integration of preventive and curative care in general medicine is based on the continuity, coordination, and patient-centredness throughout the health-disease continuum. Such models go further than episodic treatment to introduce longitudinal treatment pathways where prevention, early detection, treatment, rehabilitation, and palliative are interdependent functions and not isolated services (Valentijn et al., 2013; Wulsin et al., 2006). The Chronic Care Model (CCM) is one of the most influential models that inform this integration and was initially aimed at enhancing the outcomes of chronic diseases, by organizing the health system, and the community, facilitating self-management, the design of the delivery system, decision support and clinical information systems. It has been indicated that the CCM may be used as a model of preventive care as well, with the risks assessment, lifestyle counselling, and early intervention integrated into the standard clinical encounter (Glasgow et al., 2001; Adams et al., 2007). This model has been applied in general medicine to treat both upstream risk factors (poor diet, lack of exercise, and drug use) and underlying disease. In addition to the CCM, integrative medicine paradigms clearly connect disease prevention and therapeutic care by using holistic, person-centred methods. These systems include the use of biomedical treatment and behavioural modification, psychosocial support and complementary approaches, taking into consideration that both prevention and cure have common determinants and clinical outcomes (Ali and Katz, 2015; Maizes et al., 2009). Integrative models, in the context of primary and general care, are associated with shared decision-making and continuity in care, and should also consider social and environmental factors that impact health, and this strengthens preventive actions even when treatment is still ongoing (Templeman & Robinson, 2011).

Integrated care frameworks are at the system level, which creates a wider organizational prism to match preventive and curative services. According to Valentijn et al. (2013), one of the extensive frameworks is an integration of clinical, professional, organizational, and system-level functionalities with primary care as the coordinating platform. In this context, general medicine is a nexus through which preventive screening, health promotion, diagnosis, and treatment are provided in a unified manner across settings and throughout time. This kind of integration is especially applicable to multimorbid populations, in which partial care may worsen disease burden and healthcare expenses (Wendimagegn & Bezuidenhout, 2019). Public health-oriented models also enhance integration through connecting clinical care and community-based prevention programs. The medicine-public health program highlights the collective role of clinicians and of the public health practitioner to work on the problems of population health, with the focus on community involvement, health promotion, and policy-based interventions in addition to individual care (Cashman et al., 1999). The method is particularly significant within the context of low- and middle-income, where social determinants and access barriers have a critical role in disease progression (Sun et al., 2026). What emerges through the appearing models also is the meeting of preventive, curative, and palliative care throughout the life course. Instead of considering these domains as subsequent steps, modern models recommend their synchronous connection to enhance the quality of life and clinical outcomes, especially in cases related to chronic and life-limiting conditions (Spyra et al., 2018; World Health Organization, 2018). In general medicine, this life-course view can facilitate early preventive intervention and provide the appropriate level of therapeutic intensity and supportive care, as the conditions develop. All these conceptual models highlight the fact that the successful incorporation of preventive and curative care needs to be achieved beyond co-location of services. It requires the alignment of clinical care, education and health systems towards coordinated patient-centred care trajectories that extend between prevention and treatment. The next section will look how these models can be applied to real-life clinical scenarios in general medicine.

INTEGRATED PREVENTIVE–CURATIVE CARE AS APPLIED TO CLINICAL MEDICINE

To convert the concept of integrated preventive-curative models into daily general medical practice, operational strategies are needed to incorporate prevention as a part of daily diagnosis, treatment and follow-up. The general physicians have a unique role in the areas of clinical settings where they are the first point of contact and the long-term coordinators of care at the disease continuum (Hensrud, 2000; Rothman and Wagner, 2003). One of the clinical uses is the systematic process of integrating preventive risk assessment into curative encounters. Acute or chronic patients are increasingly assessed by behavioural, metabolic and psychosocial risk factors, and therefore clinicians can launch preventive counselling in addition to therapeutic intervention measures. It has been shown that this opportunistic prevention that is provided in the course of regular visits has a great impact on the detection of non-communicable diseases and modifiable risk exposures (Willett et al., 2006; Bauer et al., 2014). As an illustration, dietary, exercise, and tobacco cessation lifestyle counselling have become part of the general medicine management of hypertension, diabetes, and cardiovascular disease management (Gritz et al., 2007; Sadiq, 2023).

Another important use of integrated care is self-management support. Based on the models of self-management of chronic diseases, clinical workers prepare patients and provide them with skills, knowledge, and confidence to manage the symptoms, adhere to the treatment, and preventive behaviours at the same time (Lorig, 1996; Clark, 2003). This methodology in the general medical practice involves a change in the control of care towards provider-dominated decision-making to partnerships, which strengthens long-term prevention and maximizes the control of disease. These strategies are especially useful when the long-term change in behaviour is needed, such as in metabolic disorders and substance-related diseases (Ashifa, 2020a; Ashifa, 2020b). Clinical integration is further promoted through the interdisciplinary teamwork. Collaborative care teams that include nurses, dietitians, mental health workers, and community health workers provide an increasing number of general medicine-oriented care. Integrated care models prove that multidisciplinary collaboration leads to a better compliance with prevention guidelines, less hospitalization, and improved patient satisfaction, particularly in multimorbid people (Wulsin et al., 2006; Fortin et al., 2013). This team-based model is also applicable in the continuity of care both within a clinical and community environment making prevention more robust beyond the hospital or clinic walls.

The other realistic aspect of preventive-curative congruity is the integration of mental health and social care in general medicine. Mental illnesses and social stressors are frequently comorbid with chronic physical diseases affecting their onset, course, and response to therapy. Research points out that the treatment of the psychological well-being, occupational stress, and social vulnerability in the general medical care can help prevent and increase the efficacy of the treatment (Ranganathan et al., 2024; Zahoor et al., 2025). This whole person approach is compatible with the principles of integrative medicine where health is considered as a multidimensional construct (Maizes et al., 2009). Clinical integration is also supported by innovations at the technological and system levels. Risk stratification, preventive reminders and longitudinal monitoring of general practice are

achieved through the use of digital health tools, clinical information systems, and data-driven decision support. These tools empower the clinicians to monitor preventive indicators and disease markers, which encourages the timely intervention and care continuity (Devi et al., 2025; Catherine et al., 2025). Technology reinforced the preventive effect of regular clinical care without imposing an extra burden on the provider when it is associated with patient-centred communication. In general, the interventions of integrated preventive curative care in general medicine indicate that prevention and treatment do not oppose each other, but they support each other. Implementation of preventative measures into the process of therapeutic work may help general physicians to both meet the urgent clinical needs and decrease the burden of illnesses in the future. The following section discusses health system and policy implications required to maintain and expand such integrated models in different healthcare settings.

HEALTH SYSTEM AND POLICY IMPLICATIONS OF INTEGRATED PREVENTIVE -CURATIVE CARE

Clinical practice is the core of preventive-curative integration although it is long-term sustainable when it is designed and aligned with health system policy. The historical barriers between prevention and treatment have been fragmented financing, siloed services delivery, and disease-focus planning, which have limited the success of prevention and treatment (Cashman et al., 1999; Yach et al., 2004). The integrated care models need a systemic reorganization to understand prevention and cure as inseparable branches of the same continuum of health. One of the main policy implications is the restructuring of primary and general medicine towards formats of integrated care. The conceptual models of integrated care focus on coordination at the clinical, organizational, and population levels, which allow preventive services to be located in the curative pathways (Valentijn et al., 2013; Wendimagegn & Bezuidenhout, 2019). Stronger primary care policies which make it the center of prevention, early detection, treatment and long term follow up have been linked to better health outcomes and cost containment especially in chronic diseases (Rothman and Wagner, 2003; Gaziano et al., 2007). How integration is determined is determined by financing and reimbursement mechanisms. Fee-based systems tend to encourage episodic and curative care and underestimate preventive measures. Conversely, such financing schemes as value-based financing, bundle payment, and population-based funding motivate healthcare institutions to invest in prevention as a tool of enhancing long-term outcomes and preventing unnecessary consumption (Bauer et al., 2014; Sun et al., 2026). Such health systems that are reward-based on continuity, reduction of risk, and patient engagement have a higher likelihood of maintaining integrated preventive-curative practices.

Another determinant is the workforce policy. To achieve successful integration, competencies of preventive medicine, behavioural counselling, and interprofessional collaboration should be trained in clinicians. The reforms in the sphere of education that will introduce the principles of integrative and preventive medicine to the undergraduate and postgraduate level of medical education are necessary to train the general physicians to deliver holistic care (Jani et al., 2015; Ali and Katz, 2015). Professional development programs provide additional support to these competencies and provide an opportunity to ensure the competencies are relevant to the changing needs of population health. At the population level, community-responsive and public health-linked models of care develop preventive-curative integration outside of clinical contexts. The policies that encourage partnership between healthcare givers, community organizations, and public health agencies enable reaching vulnerable groups and working on the social determinants of health (Airhihenbuwa et al., 2021; Ashifa, 2021a). This integration is especially pertinent to the low-resource and rural setting, where community-based programs have proven to be effective in the prevention of chronic diseases and health promotion (Ashifa, 2019; Rasi and Ashifa, 2019). The policies of digital health and information governance also facilitate the integration, facilitate the sharing of data, continuity of care, and preventive observation across settings. Clinical records and preventive indicators can be connected, enabling the policy formulator and the providers to monitor the outcomes, reveal gaps, and create specific interventions (Devi et al., 2025; Shanthi et al., 2025). Nevertheless, equity of access, privacy of data and interoperability are critical considerations that are necessary in implementation of policies.

On an international scale, the international frameworks highlight integrated care as one of the strategic solutions to the increasing burden of chronic diseases and ageing as a significant factor. The World Health Organization promotes the policies that encompass prevention, curative services, rehabilitation, and palliative care as part of the primary health systems to enhance continuity throughout the life course (World Health Organization, 2018; Kearney et al., 2020). These insights are important around the world as the local health priorities must be balanced with evidence-based integration strategies in the form of adaptive and context-sensitive policies. The environments of health system and policy clearly decide whether preventive-curative integration will become a routine activity or the fragmented ideal. To scale up and sustain the models, it is important to align financing, workforce development, governance and community engagement with the principles of integrated care. These contributions are summarized by the next section where the future directions of advancement in the field of integrated preventive and curative care in general medicine and strategic priorities are considered.

FUTURE PERSPECTIVES AND CONCLUSION

Combination of preventive and curative care in general medicine is a key revolution in health care delivery prompted by increasing prevalence of chronic diseases and demographic changes and the increasing health care expenditures. The available clinical, behavioural, and population health evidence clearly indicates a lack of effectiveness in fragmented interventions (when prevention and treatment are conducted separately) to meet the modern health issues (Bauer et al., 2014; Yach et al., 2004). In contrast, integrated models integrate health promotion, early beings, treatment, rehabilitation, and palliation in a framework of continuous care and enhance individual outcomes and efficiency of the entire system. To move in the future, it is recommended to focus the development of institutionalization towards integrated care as a primary role of general medicine and not an auxiliary approach. This necessitates intensifying primary care systems that may act as the coordinating nexus of both preventive and curative services with the assistance of multidisciplinary teams and longitudinal patient interaction (Valentijn et al., 2013; Rothman and Wagner, 2003). This change will require increased integration of general physicians to provide preventive counselling, behavioural risk management and monitoring the health of the population.

Workforce development and education are still based. Integrative and preventative medicine skills should be incorporated in medical curriculum and training as a resident, with a focus on patient-centred care, shared decision-making, and intersectoral collaboration (Maizes et al., 2009; Jani et al., 2015). There should be an ongoing professional development initiative to enable clinicians to deal with multimorbidity, social determinants of health, and evidence-based preventive initiatives in everyday practice.

There are other possibilities of improvement of integration through technological innovation. When integrated with preventive objectives, digital health solutions, clinical decision support efforts, and data-driven population health can support the initial detection of a disease, enhance its prioritization, and can contribute to ongoing care (Devi et al., 2025; Shanthi et al., 2025). Nevertheless, future initiatives should focus on providing equality, ethical data control, and interoperability to prevent strengthening the existing health inequities. On the policy level, sustainable integration is based on harmonization of financing, governance and accountability mechanisms. Preventive-based clinical practice can be incentivized with the help of value-based payment models, outcome-based performance measurement, and community-linked care programs without reducing the quality of curative care (Sun et al., 2026; Gaziani et al., 2007). Inclusive policies aimed at vulnerable and underserved groups should also be a priority to policymakers, relying on the experience of community-based and publicly-specific health partnerships (Ashifa, 2019; Airhihenbuwa et al., 2021). The incorporation of preventive and curative care models in general medicine is not just a mere dream but a reality needed to ensure the realization of sustainable, equitable, and patient-centred health services. With the integration of clinical practice, education, technology, and policy in an integrated system, health systems will be able to better address the intricate and changing needs of communities. Further research, dynamic application, and collaboration across different sectors will be critical to the transformation of the integrated care principles into quantifiable changes in health outcomes and system resiliency.

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