Editorial

Can hospitals and health services do more for public health?

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Patients, staff, management, health care providers, and politicians should ask if the hospitals and health services (H&HS) are really playing their role in the public health improvement to the best of their abilities.

Although health promotion should ideally take place outside of hospitals and health services as an integral part of people's everyday domains – in families, communities, workplaces, schools – the reality is very different. The majority of patients have unhealthy lifestyles that influence their current treatment results short-term and their outcomes in the long term, whereas clinical health promotion (ClinHP) has the immediate opposite effect. Therefore, the need for ClinHP is exceedingly high and hospitals and health services (H&HS) are certainly part of the real life solution.

The facts are very clear and worrying: Approximately four out of five hospital patients lead an un-healthy lifestyle, which is of major importance to their treatment outcome, quality of life, and life expectancy. Furthermore, approximately three out of five patients have two or more risk factors and therefore would need combined and comprehensive ClinHP programs (1). But are H&HS actually acting on these needs?

Today, it is well-known that integration of ClinHP in treatment programmes can cause significantly better treatment results. For instance, they make it possible to reduce complications after surgery and improve the results of treatment for non-communicable diseases (NCD) in the short term - and in the long term provide a significant health gain, which in turn benefits public health considerably (2;3). However, in many H&HS, this major potential is not fully utilised yet.

The integration of health promotion in healthcare has become a core issue world-wide, especially after the member state of the United Nations and World Health Organization Europe have signed new declarations, strategies, and action plans such as: "Health 2020", "Preventing and Control of Non-Communicable Diseases", and "Strengthening Public Health Capacities and Services" (4;5). For the World Health Assembly last year, a key goal was the reduction by 25% in premature NCD mortality (cardiovascular and respiratory disease, cancer, and diabetes) by 2025.

What all of the above have in common is the fact that they revolve around the well-known core risk factors of global disease burden and injuries. These are: Smoking, alcohol, overweight/nutrition, and physical in- or low activity, which are in fact both preventable and treatable and key elements in ClinHP (6). Thus, to live up to the challenges at hand, hospitals and health services should consider it among their core functions to implement health promotion, especially when society at large still has a long way to go in this field.

Although the year of 2025 may seem far away, when it comes to reaching the 25% reduction in premature death from NCD, 2025 is just around the corner. The international declarations and frameworks need to be translated into real action at all levels, nationally and sub-nationally. Furthermore, such action plans need to be in place and adapted to local conditions within a few years from now if they are to work. They also have to include all relevant partners and stakeholders nec-

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essary for a successful result within the limited time-frame. This is where hospitals and health services can add value, because in addition to the community-based prevention and disease control efforts, the ClinHP can play an important part.

Surprisingly good results have been published on health promotion performed inside the hospitals and health services (2;3). Furthermore, by systematic integration of health promotion activities in H&HS, you can also reach out to the otherwise unreachable groups, the most vulnerable patients, and those who are hit the hardest by inequity in health.

ClinHP is easy. The validated and easy-to-use tools from the International Network of Health Promotion H&HS and the World Health Organization facilitate the integration and evaluation of ClinHP. Today, you can count ClinHP interventions in line with number of surgical interventions – and it is possible to follow-up for effectiveness and cost-effectiveness via international documentation codes and integration into the most used reimbursement systems, such as Diagnoses Related Groups (DRG). The bridging between primary and secondary health care has been given priority in the tools, so that actions in one sector can be followed in the other. There are plenty of practical examples, since several countries have already integrated important elements of the tools into their national models for quality management and accreditation models (7).

During the last decade, ClinHP has moved from talk and development to real and hugely effective implementation of evidence-based activities, capacity building as well as to making actions visible and widely known. This is all included in the "Preventing and Control of Non-Communicable Diseases" and "Strengthening Public Health Capacities and Services".

So really, today hospitals and health services can do a lot more for public health.

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