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Primary prevention in hospitals in 20 high-income countries in Europe – A case of not "Making Every Contact Count"?

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ABSTRACT

This article provides a snapshot of primary prevention activities in hospitals in 20 European high-income countries, based on inputs from experts of the Observatory's Health Systems and Policies Monitor (HSPM) network using a structured questionnaire. We found that in the vast majority of countries (15), there are no systematic national policies on primary prevention in hospitals. Five countries (Cyprus, Finland, Ireland, Romania and the United Kingdom) reported systematic primary prevention activities in hospitals, although in one of them (Cyprus) this was due to the fact that small hospitals in rural areas or less populated districts host providers of primary care. In two of the five countries with systematic national policies on primary prevention, there are no incentives (financial or otherwise) to provide these interventions. The remaining three countries (Finland, Romania and the United Kingdom) report the existence of incentives, but only two of them (Romania and the United Kingdom) provide financial incentives in the form of additional funding. Only two of the 20 countries (Ireland and the United Kingdom) make explicit use of the Making Every Contact Count (MECC) approach. Overall, it can be concluded that there is little focus on primary prevention in hospitals in Europe, which may be seen as a missed opportunity.

1. Background

This article explores whether European countries have implemented systematic national policies for primary prevention in hospitals and the methods for implementing these approaches, including through financial incentives and ways of motivating and training health professionals.

Primary prevention is understood here as actions that aim to avoid diseases from occurring. Examples are providing information on the harmful effects of smoking, alcohol consumption or unhealthy diets, or providing information on how to prevent cancer, cardiovascular or respiratory diseases. Primary prevention involves actions that aim to improve the general health of patients, rather than focus on the specific acute condition for which they are in hospital. These types of interventions are also called "health education interventions", "non-disease specific health promotion interventions" [1] or "clinical health promotion interventions" [1,2].

However, conceptual challenges regarding primary prevention interventions in hospitals have to be recognized. Primary prevention aims to address risk factors before health problems arise. As such, interventions that focus on smoking or alcohol consumption, which would be considered primary prevention when they occur in schools or universities, could be tertiary prevention when they are addressed to people with cardiovascular or respiratory diseases. In the same way, addressing harmful drinking in emergency departments might be considered secondary or tertiary prevention if health problems have already occurred, or as primary prevention if harmful drinking is considered a risk factor for the future occurrence of diseases. A similar challenge applies to obesity. According to whether it is considered a risk factor or a condition, the interventions to address it could be considered primary or tertiary prevention. It cannot be ruled out that there are different understandings in different countries as to what constitutes primary prevention.

One often-quoted approach for primary prevention in hospitals is the "Making every contact count" (MECC) initiative in England. The MECC approach was first developed by NHS Yorkshire and the Humber in 2009 as a key public health strategy on behaviour change methods to promote healthier behaviours among the population [3]. Reinforced by a competence framework on "Prevention and Lifestyle Behaviour Change" in 2010 [4], the MECC approach is now used across the UK and its content and use was clearly defined by NHS England in a consensus statement from the national bodies responsible for healthcare delivery, clinical training and public health in 2016 [5]. In Scotland, NHS Grampian has followed a related approach described as "Making Every Opportunity Count". Following a recent Delphi study, the UK Royal Society of Public Health endorsed a definition of MECC as "a person centred and opportunistic approach to health behaviour change that applies appropriate theory informed behaviour change techniques from behavioural science, delivered during every appropriate contact" [6], with potential topics of conversations including smoking, physical activity, healthy diet, alcohol, or mental health.

The MECC approach aims to capitalize on the routine interactions between providers and individuals by encouraging health and social care staff to engage with patients and/or relatives in conversations about their health-related behaviours [5]. The goal of this approach is to support individuals in making positive improvements to their health and well-being. The MECC approach is underpinned by the idea that not only internal events but also external, impact the choices and decisions of an individual. Hence, the objective of interventions based on the MECC approach is to trigger or push individuals' will for positive change by providing them with an increased understanding and knowledge of risky behaviours and their potential impacts on their health and well-being. Opportunities for health and social care staff to engage with individuals exist at all levels of the health system. The MECC model from the UK describes four levels of interventions:

- Very brief interventions: performed by anyone in direct contact with the general population
- Brief interventions: performed by health and social care staff that is in contact with at-risk individuals
- Extended brief interventions: performed by health and social care staff with longer and more frequent contact with higher-risk individuals
- High-intensity interventions: performed by specialist practitioners

The MECC approach can be used on a wide range of topics, the most common being the cessation of tobacco use, reduction of alcohol use, improvement of diet, and increase of regular physical activity [5]. It can also be used in a vast range of care settings, from community pharmacies

to hospitals, and may not only be used on patients but also on health workers. Furthermore, while it was mainly developed for routine interactions within health and social care, the MECC approach may be adapted to include broader determinants such as housing or debt management, further contributing to addressing the social determinants of health [7].

Following an evaluation of diverse behavioural change techniques based on an individual approach, the National Institute for Health and Care Excellence (NICE) recommended the use of MECC approaches at all levels, and recognised its cost-effectiveness in supporting individuals to better manage their tobacco and alcohol consumption, as well as their diet and physical activity [5,8]. Moreover, it is well recognised that the MECC approach has the potential to effectively contribute to public health goals, notably for non-communicable diseases (NCDs), at lower costs [9].

A national MECC advisory group has been established and produced resources and courses alongside Health Education England (responsible for training). There are also MECC working groups and partnerships in local areas. NHS England published in 2018 an implementation guide for the MECC approach [7], which presents eight steps to help providers, including hospitals, to plan and implement MECC, and in 2020 an evaluation guide for MECC programmes [10] to provide public authorities and providers guidance on how to evaluate the implementation of their MECC programmes.

A concept that is related to primary prevention in hospitals, but much wider in scope, is the approach of health-promoting hospitals. The concept of Health Promoting Hospitals (HPH) was first drawn up by the World Health Organization (WHO) in 1989 [11], and followed by the International Health Promoting Hospitals and Health Services (HPH) Network, initiated by the WHO Regional Office for Europe [12,13].

The concept of health-promoting hospitals builds on the fact that hospitals' healthcare staff see many patients every day, including a significant proportion of patients suffering from chronic disease, but also that during their hospital stay, patients might be more receptive to health counselling and behaviour advice [12]. Hence, hospital visits are seen as a relevant opportunity for health promotion interventions that empower people to self-care and improve the quality of their lives.

As far as the MECC approach is concerned, it seems to be understood mainly as an approach to trigger behaviour change, although its aim was initially broader. There are however many other types of interventions that contribute to primary prevention, such as interventions to support the attachment between a mother and her newborn, or to help a newly diagnosed or recently operated patient to cope with their condition, or to prepare families for transplantation in case of intra-familial organ donation, etc.

Differences between primary prevention and health promotion are sometimes blurry. Health promotion refers to a process of empowering individuals to take control over their health and adopt healthier behaviours. It thus incorporates both health education and disease prevention [12]. However, the concept of health promotion goes much further and includes a consideration of the social, political and commercial determinants of health, as well as a salutogenic perspective on increasing resources for health. This is why we decided to focus on primary prevention.

Despite the importance and potential impact of primary prevention in hospitals, there is a lack of information on its implementation in European health systems. Our study, therefore, aimed to answer the following research questions:

- Are there systematic nationwide primary prevention initiatives in hospitals in the countries covered?
- Are there incentives, including financial ones, for primary prevention initiatives in hospitals?
- Are countries following the Making Every Contact Count (MECC) approach that has been popularized in the UK?
- What conditions do hospitals have to meet to roll out primary prevention initiatives, in terms of staff training and health workers' time?
- Which healthcare or other professionals are involved in primary prevention initiatives in hospitals?
- Is the impact of primary prevention measures on patient health being assessed?
- Do primary prevention initiatives in hospitals focus on certain diseases or risks?

2. Methods

A structured data collection exercise was performed using a common template that was completed by national experts from the Observatory's Health Systems and Policy Monitor (HSPM) network [eurohealthobservatory.who.int/monitors/health-systems-monitor/]. The data collection instrument was developed based on expert input and a rapid review of the literature on primary prevention in hospitals in Europe. The HSPM network is an international group of country experts from high-profile institutions with a track record in health systems and policy analysis. The retrieved information was supplemented with information provided by additional experts with specialized knowledge of primary prevention in hospitals and a rapid review of the academic and grey literature. The rapid review was based on sources retrieved through Medline in November 2023 using the search terms "Making every contact count", "MECC", "health-promoting hospitals", "primary prevention" and "hospitals". The countries were selected to reflect the diversity of health systems in Europe in terms of geography, health financing and governance, although with a focus on European Union/European Economic Area member states. Data collection took place in November-December 2023.

Deductive thematic analysis [14] according to pre-defined themes was used to categorize and analyse the information provided by national experts. The results are presented below in table and narrative form. The country experts (co-authors of this article) cross-checked the national information after it had been categorized and analysed and provided inputs into the comparative analysis and discussion.

The article does not consider primary prevention activities such as vaccination, some of which are routinely given in hospitals, such as for newborns. Interventions for secondary prevention (screening for medical conditions) and tertiary prevention (treatment of diagnosed conditions, self-management support, and patient education) were also excluded, as were interventions targeting health workers in hospitals, infection prevention and control measures and measures for ensuring hospitals are smoke-free.

3. Results

We received information from experts in 20 European high-income countries, including 18 European Union (EU) member states, as well as Switzerland and the United Kingdom. The findings from our literature search complemented this information, in particular with regard to the MECC approach and the health-promoting hospitals initiative, which are both well covered in the academic literature.

3.1. Systematic national policies on primary prevention in hospitals

In the vast majority of countries (15), there are no systematic national policies on primary prevention in hospitals. Five countries (Cyprus, Finland, Ireland, Romania and the United Kingdom) reported systematic primary prevention activities in hospitals (Table 1).

However, in one of them, **Cyprus**, this was mainly due to the fact that small hospitals in rural areas or less populated districts host primary prevention services because they host Personal Doctors who are providing primary care. They thus support the delivery of patient care that would ordinarily be provided by frontline primary care facilities

Table 1
Systematic primary prevention initiatives in hospitals in Europe.

	Systematic primary prevention initiatives in hospitals	Incentives	Financial incentives	Following MECC approach
Belgium	No	No	No	No
Bulgaria	No	No	No	No
Croatia	No	No	No	No
Cyprus	Yes	No	No	No
Denmark	No	No	No	Yes, implicitly
Finland	Yes	Yes	No	No
France	No	No	No	No
Germany	No	No	No	No
Hungary	No	No	No	No
Ireland	Yes	No	No	Yes
Italy	No	No	No	Not explicitly
Latvia	No	No	No	No
Lithuania	Generally no, but mandatory for geriatric day care facilities (units of hospitals)	Yes	15 days of day care per patient /indication per year are paid by the Compulsory Health Insurance Fund	No
Netherlands	No	No	No	No
Poland	No	Yes	Additional funding from National Health Fund	No
Portugal	No	No	No	No
Romania	Only in several hospitals, named by the Ministry of Health Order 964/2022 on the approval of technical norms for national implementation of public health programmes	Yes	Preventive national programmes pay a certain amount for each intervention (counselled patient)	No
Slovenia	No	No	No	No
Switzerland	No	No	No	No
England (United Kingdom)	Yes	Yes	No specific financial incentives at national level, but some regions provide financial incentives.	Yes

Source: country correspondents.

because of gaps or deficiencies in primary care at the community level.

In **Lithuania**, there are no systematic primary prevention activities in hospitals, but they are mandatory for geriatric day care facilities, which are units of hospitals.

On a smaller than national scale, several experts reported about the involvement of their countries in the health-promoting hospitals initiative, although, given the much wider scope of this initiative, this may not necessarily mean per se that these hospitals are involved in primary prevention activities.

Finland has been a part of the International Network of Health Promoting Hospitals and Health Services (HPH) since 2001. At present, 13 counties (of the country's 21) are members of the Finnish Network of health promoting hospitals and health services. The Finnish network focuses on promotion and support of smokefree hospitals and nutritional health promotion in social services and health care organizations.

In **France**, healthcare facilities do not systematically implement primary prevention programmes. However, some establishments carry out actions targeting specific audiences (expectant mothers, young parents, adolescents, older people, etc.) focused on certain health determinants, mainly tobacco. These programmes can also be conducted for the facility's professionals, as part of a certification process (e.g., tobacco-free hospital); they can be supported by the Regional Health Agencies within the priorities of Regional Health Projects. The government's current intention is to extend the primary prevention policy to all healthcare providers, as recommended in several recent public health reports.

Slovenia started in 2011 to establish three and later five health-promoting hospitals and a national HPH network. After years, due to costs arising from HPH activities and some other reasons (e. g. changes of hospital managements, different priorities, the COVID-19 pandemic), the HPH network was discontinued.

Several hospitals in **Poland** are formal members of the Polish Network of Health Promoting Hospitals (which is a member of the International Network of Health Promoting Hospitals and Health Services). As of April 2021, 18 Polish hospitals had an active certificate of being health-promoting hospitals. There are no financial incentives to participate in the network. The decision to pursue the certification is voluntary and requires additional resources. Depending on how hospitals are defined, there are approximately 800–1000 hospitals in Poland, which means that the proportion of health-promoting hospitals is very small, comprising only 1.8–2.3 % of all hospitals in the country. The situation seems similar in many other European countries.

3.2. Incentives (including financial ones) to provide primary prevention in hospitals

Tellingly, in two of the five countries with systematic national policies on primary prevention, there are no incentives (financial or otherwise) to provide these interventions. The remaining three countries (Finland, Romania and the United Kingdom) report the existence of incentives, but only two of them (Romania and the United Kingdom) provide financial incentives in the form of additional funding. Finland plans to introduce additional funding for the promotion of health and wellbeing from 2026 onwards, with some of the funding based on counties' population size and some determined by criteria for health and wellbeing performance. One country without systematic national policies on primary prevention, Poland, also provides incentives, including financial ones.

In England, certain MECC-related activities are listed in the 2023/24 NHS Standard contract, such as referral to smoking cessation services. However, no specific national financial incentives are listed in the 2023/24 indicator specifications. Funding to local health systems is given upfront with broad expectations around delivery of services, rather than them being rewarded with financial incentives upon delivery of services. While thus no specific financial incentives exist nationally, some regions have incorporated MECC activities into service specifications.

3.3. Countries following the MECC approach

Only two of the 20 countries (Ireland and the United Kingdom) make explicit use of the Making Every Contact Count (MECC) approach. In Denmark and Italy the approach is used implicitly, although Denmark does not have systematic nationwide policies on primary prevention in hospitals.

Apart from England, only **Ireland** explicitly adopted the use of the MECC approach as such. The Health Service Executive (HSE) published in December 2016 a framework for health professionals to implement MECC programmes across health services [15]. The Irish plan focuses on the first three levels of the MECC approach (very brief, brief, and extended brief interventions) and specifically targets the prevention of

chronic diseases through four main risk factors: alcohol and tobacco consumption, low physical activity, and unhealthy diet [15,16].

Following the MECC framework, Ireland launched in 2017 a first national undergraduate curriculum, which aimed to train a wide range of future health professionals, including nurses, midwives, and allied healthcare staff, on the use of the MECC approach in their routine practice [3,16,17]. A strategy to optimise the uptake of MECC in Ireland is under development [18].

Table 2
Details of primary prevention initiatives in hospitals in Europe.

	Conditions for implementing primary prevention	Professionals involved	Monitoring and evaluation	Focus on certain diseases or risks
Belgium	No national guidelines or regulations	Primarily nurses and doctors	Ad-hoc monitoring and evaluation as part of wider international accreditation and quality improvement systems (e.g. baby friendly hospital, smoke-free hospital, health-promoting hospital).	Mental health with the presence of a psychologist when there is a multidisciplinary health care team for complex somatic conditions, as well as access to spiritual care with representatives from different religions, or well-being and sex therapy initiatives in oncology
Bulgaria	n.a.	n.a.	n.a.	n.a.
Croatia	n.a.	n.a.	n.a.	n.a.
Cyprus	Continuous professional development	Mainly Personal Doctors who are part of the primary care sector but do practice in small hospitals and some other health personnel like nurses	No	Obesity, diabetes, smoking, sexual education for adolescents, protection from sun exposure, alcohol consumption, promotion of breastfeeding
Denmark	No national guidelines or regulations (although the Danish Health Authority has developed information material about prevention to hospital managers and staff)	Primarily nurses and doctors	No	Individual preventive activities likely to focus on smoking and alcohol consumption. At some departments, treatment of malnutrition.
Finland	General medical training and continuous professional development courses.	In general, the registered nurses in collaboration with other health care professionals, e.g. doctors, physiotherapists, and practical nurses	Evaluation of specific interventions and use of best practices based on national recommendations for health promotion and disease prevention	Smoking cessation intervention prior to surgery, pressure ulcer prevention, prevention of falls, prevention and treatment of malnutrition, screening of addictions such as alcohol and tobacco and brief interventions
France	n.a.	n.a.	n.a.	Actions may be carried out in certain maternity hospitals, targeting expectant mothers, young mothers, and young parents, related to the main health determinants (tobacco, alcohol, nutrition, etc.)
Germany	n.a.	n.a.	n.a.	n.a.
Hungary	No specific national regulations or guidelines for primary prevention in hospitals	Non-medical health professionals, such as dieticians, physiotherapists, psychologists	No	n.a.
Ireland	Unclear	All healthcare professionals can undertake training in MECC	There are resources for evaluation and some studies	smoking cessation
Italy	No	Internal medicine doctors, paediatricians, cardiologists, obstetricians and gynaecologists, general practitioners, physician assistants, hygienists, infectious disease specialists, nurses, nurse practitioners, caregivers, health economists	Examples of monitoring the effectiveness of primary prevention in hospitals include the PREVITAL project, a Cardiology Network of 14 Clinical Research Hospitals	Cardiovascular diseases, diabetes, tobacco and alcohol consumption, dietary risks
Latvia	n.a.	n.a.	n.a.	n.a.
Lithuania	Professional development courses on geriatric care	Physicians, nurses, and other professionals	n.a.	Not exactly but geriatric syndromes and/or eating disorders and/or polypathology and/or falling risks are mentioned among the indications
Netherlands	n.a.	n.a.	n.a.	n.a.
Poland	No, mostly voluntary	Mainly nurses	n.a.	Voluntary programmes (e.g. promotion of breast-feeding, healthy hospital diet)
Portugal	n.a.	n.a.	n.a.	n.a.
Romania	Hospital staff involved in delivering services under the disease prevention programmes receive specific training	Physicians, nurses	No	Smoking, alcohol consumption
Slovenia	n.a.	n.a.	n.a.	n.a.
Switzerland	n.a.	n.a.	n.a.	n.a.
England (United Kingdom)	In England some training is required through the short courses on MECC provided	Primarily nurses and doctors	A number of evaluations of implementing MECC in England exist	Obesity, alcohol use, and smoking cessation are the main priorities.

Source: country correspondents.

3.4. Conditions for the provision of primary prevention in hospitals

Most countries do not report any specific conditions in terms of staff training or health workers' time for the provision of primary prevention activities in hospitals beyond general medical training and continuous professional development (Table 2).

In **England** some training is required through short courses on MECC, while in **Ireland**, all healthcare professionals can undertake training in MECC, but it is unclear whether this training is a requirement for providing primary prevention. In **Romania**, hospital staff involved in delivering services under the disease prevention programmes receive specific training.

3.5. Health workers involved in primary prevention in hospitals

In most countries that report primary prevention initiatives in hospitals, these are undertaken mainly by nurses and doctors. The exception is Hungary, where non-medical health professionals, such as dieticians, physiotherapists, psychologists are involved in such activities. The information provided from our country experts on **Hungary** could well reflect the situation in many other European countries:

> "Typically, healthcare workers are extremely overworked, have a strong focus on curative care with no or very low priority given to prevention. They typically lack the knowledge and skills to carry out primary prevention activities. As the primary prevention activities are not centrally organized, the hospitals do not employ dedicated healthcare professionals or establish prevention units or departments."

3.6. Monitoring and evaluation of primary prevention initiatives in hospitals

Monitoring and evaluation of primary prevention measures in hospitals are only reported in four of the 20 countries (Finland, Italy, Ireland, United Kingdom). However, even in these countries, the assessment of interventions seems to be sporadic.

In **Finland**, a new practice started in 2019 where specific interventions are evaluated and there is a best practice portal for health promotion and disease prevention interventions [19]. Examples of interventions that have been evaluated are healthcare clowning for child patients and a programme to prevent cognitive decline, although neither of these interventions are widely used. Other primary prevention interventions that have been studied are a smoking cessation intervention prior to orthopaedic surgery [20] and nursing interventions in preventing pressure injuries in acute inpatient care [21].

In **Italy**, examples of monitoring the effectiveness of primary prevention in hospitals include the PREVITAL project, a Cardiology Network of 14 Clinical Research Hospitals that aims to assess the effectiveness and feasibility of an innovative digital way of carrying out primary cardiovascular prevention [22].

In Ireland and the United Kingdom, a number of evaluations of the MECC approach have been undertaken. In the **United Kingdom**, the systematic use of the MECC approach remains quite recent, and most studies published in the scientific literature focus on staff training and acceptance. While in most studies healthcare staff found the concept of the MECC approach acceptable [23,24], training remains key, as the lack of confidence and training are among the most commonly reported barriers to implementing the MECC approach in daily practice [25]. Other common barriers reported include the lack of time, difficulties in identifying physical opportunities and divergences in the perception of staff responsibility towards MECC activities [25,26], suggesting the importance of national and harmonised guidance for the development and use of the MECC approach. Within organisations, high-level strategic commitment and the involvement of patients and the public can be crucial, but are often lacking [27]. Furthermore, the lack of real-life evidence on the effectiveness of the MECC approach was found to be a common barrier to acceptance and implementation [23,25,26].

In a recent study on **Ireland**, Meade et al. (2023) reported a relatively high rate of trained healthcare staff who delivered at least one MECC intervention in their routine practice [28]. According to the findings, the main enablers were the role of the health professionals and their goals, while the main barriers were the belief in the efficacy of MECC interventions and prioritisation choices against MECC interventions [28].

3.7. Focus on certain diseases or risks

Among those countries that report a specific focus of primary prevention activities in hospitals, smoking cessation and alcohol use are the most commonly mentioned, followed by obesity and dietary risks.

In **Italy**, a number of initiatives aim to tackle alcohol consumption, although some of them can be categorized as secondary or tertiary rather than primary prevention. Short interventions lasting 10–15 min aimed at reducing risky or harmful (but not alcohol-dependent) drinking are reported to be effective and cost-effective. In contrast, extended interventions (with longer times and/or multiple sessions) do not appear to have greater effectiveness than short interventions. Health professionals have a responsibility to identify and intervene by informing patients of the risks of high alcohol consumption that adversely affects health status. This method helps to promote the development of specific prevention campaigns. In addition, throughout the province of Trento and at Careggi Hospital in Florence, the figure of the "ward alcohology referent" has been introduced, typically an appropriately trained nurse with the task of early identification of risky or harmful alcohol consumption and alcohol dependency.

Specific interventions are also carried out in Italy to prevent smoking, supporting the creation of smoke-free hospitals. They cannot only provide a strong health message and protect patients, but also reduce the economic loss caused by staff absence and the economic costs for environmental hygiene and fire prevention. There are also cultural initiatives, such as photo exhibitions with graphic pictures and captive slogans related to tobacco consumption. Placed in the hospital, they aim to promote cultural change and prevent smoking [29].

In **Romania**, hospitals are required by the National Agency for Hospital Accreditation standards to provide written health promotion and disease prevention materials available for patients and easily accessible, mainly displayed on their websites. As in many other European countries, maternity wards have to have the capacity to provide mothers with breastfeeding counselling, supported by a breastfeeding policy and trained personnel.

In **England**, key current initiatives are outlined in the 2019 NHS Long Term Plan and comprise primary, secondary and tertiary prevention activities. These include the offer of NHS-funded tobacco dependency treatment to all smokers admitted to hospital, and alcohol care teams for those dependent on alcohol. NHS England also has an "area of work" around evaluating and encouraging hospital staff to discuss obesity with patients in all settings and refer appropriately. In **Scotland**, a notable specific initiative is Alcohol Brief Interventions. Defined by Public Health Scotland, this is a programme for consistent brief and non-confrontational conversations around harmful and hazardous drinking; emergency departments have been a priority setting for this. However, as this programme is aimed at identifying and addressing harmful and hazardous drinking, it could be categorized as secondary or tertiary prevention.

In **Hungary** two institutions stand out for their preventive activities, which, due to their character, focus on the prevention of specific diseases and on specific age groups.

- National Korányi Tuberculosis and Pulmonological Institute: Their prevention activities focus mainly on smoking cessation and smoking-related diseases. However, in 2018–2021 under the

professional leadership of the Institute operated a wider award-winning programme called Buda Region Health Programme. This partnership-based health programme for children was a cooperation of local and national actors of the education and health sectors [30].
- Bethesda Children's Hospital: They have been carrying out primary prevention activities to protect and improve children's health for many years, mainly in the field of health education and health communication. They address issues which have a high public health priority and are deemed necessary based on hospital practice [31].

In both places, based on local incentives, there is a designated prevention unit integrated into the hospital.

4. Discussion

This article explored primary prevention activities in hospitals in Europe, drawing on a structured data collection exercise involving 20 high-income countries. We found systematic national policies on primary prevention in hospitals in only five of these countries (Cyprus, Finland, Ireland, Romania and the United Kingdom), but those in Cyprus were mainly due to primary care staff being hosted in small hospitals in rural areas or less populated districts, so that effectively only four of 20 countries had systematic national policies on primary prevention in hospitals. Only two of the 20 countries (Ireland and the United Kingdom) make explicit use of the Making Every Contact Count (MECC) approach.

When considering the existence of incentives (financial or otherwise) to provide these interventions, the number of countries declined further. Only three countries (Finland, Romania and the United Kingdom) reported the existence of incentives, and only two (Romania and the United Kingdom) provide financial incentives in the form of additional funding, although Finland plans to introduce financial incentives in 2026.

It is difficult to relate the existence of national policies and incentives to health system characteristics. One could surmise that countries with a national health system and medical specialists primarily employed by hospitals have better conditions to implement primary prevention in hospitals and that in social health insurance systems more hurdles might exist to implement such policy innovations. In social health insurance systems, the costs of primary prevention in hospitals have to be paid for in the present by social health insurance funds (who often compete each other), while the benefits will accrue in the future and fall potentially to other social insurance funds or outside the health system. Indeed, Finland, Ireland and the United Kingdom have taxation-based health systems and Romania is the only country with national policies that has a social health insurance system. More in-depth analysis, however, would be needed to corroborate these assumptions.

Monitoring and evaluation of primary prevention measures in hospitals are only reported in four of the 20 countries (Finland, Italy, Ireland, United Kingdom). However, even in these countries, the assessment of interventions seems to be sporadic, although there is reportedly evidence on the effectiveness and cost-effectiveness of brief interventions to address tobacco smoking and alcohol consumption. In studies on the MECC approach in England, the lack of real-life evidence on the effectiveness of the approach was identified as a common barrier to acceptance and implementation [23,25,26]. This scarce information is mirrored by a very limited number of studies on primary prevention in hospitals in general. A systematic literature review on non-disease-specific hospital-based intervention designed to promote general health in chronically ill teenagers could only identify four relevant studies [1].

The little emphasis on primary prevention in hospitals in Europe is also reflected in the limited scope of the health-promoting hospitals approach. While in Poland only approximately 1.8–2.3 % of all hospitals in the country were certified as being health-promoting, in Slovenia the HPH network was discontinued altogether. The situation seems similar in many other European countries. In recent years, the international HPH network has shrunken slightly, which may be due to the economic crisis, a lack of human resources to lead the change, and the consequences of the COVID-19 pandemic [11]. As far as the HPH network is concerned, its scope extends well beyond primary prevention to encompass all the tertiary prevention activities meant to enhance a patient's understanding of their condition and strengthen their capacity to self-monitor and manage their condition, as well as making adaptations when necessary.

While outside of Europe, developments in Canada are noteworthy, the country where the 1986 Ottawa Charter for Health Promotion was adopted. In 2019, a eulogy for the health-promoting hospitals movement in Canada was written [32]. Health-promoting hospitals in Canada struggled with longstanding financial and accountability disincentives within provincial/territorial health systems. Notably, in 1986, the same year in which the Ottawa Charter for Health Promotion was published, the provincial Deputy Ministers of Health unanimously indicated that hospitals would not be reimbursed for health promotion activities, because this was regarded as the responsibility of public health [32]. Marc Lalonde, the former Minister of National Health and Welfare and known as author of the 1974 Lalonde report that recognized the importance of disease prevention and health promotion, characterized the response of Canadian hospitals to health promotion as "let somebody else do it; we already have too much to do" [32].

Resource and time constraints were also identified in the literature on the MECC approach in England as a significant limitation. Common barriers reported include the lack of time, difficulties in identifying physical opportunities and divergences in the perception of staff responsibility towards MECC activities [25,26]. These factors help to explain why even in those countries that have formally embraced primary prevention in hospitals, implementation is far from straightforward.

Our study has several policy implications. Numerous national and European health policies have recognised the burden of ill health due to behavioural risk factors and there is a strong economic case for prevention, as it is much more costly to societies to address health problems once they become manifest. The MECC approach offers one potentially cost-effective option for embedding preventive activities into the contacts of patients with the health system. Our study indicates a number of available policy options to make use of this approach. First, countries without national policies on primary prevention in hospitals should consider adopting them. Second, they need to make sure that appropriate structures, resources and incentives (including financial ones) exist for policy implementation. Third, health workers need to be appropriately trained to provide the interventions. Finally, initiatives will need to be monitored and evaluated, with results feeding back into the way initiatives are being implemented, including with regard to which areas they should focus on.

4.1. Strengths and limitations

Our study provides new empirical evidence on the existence of primary prevention activities in hospitals in Europe. A structured data collection instrument and an established expert network helped to collect data systematically, enabling cross-country comparison and analysis.

However, there are also some limitations. One is that the scope of primary prevention in hospitals is somewhat blurred (see the Introduction section). Another is that, although a structured data collection instrument was used, no systematic country-wide data collection took place and many initiatives from individual hospitals may have been overlooked. However, since the focus was on national-level policies, this limitation was taken into account.

5. Conclusion

Overall, it can be concluded that there is very little focus on primary prevention in hospitals in Europe. Most of the 20 countries we considered do not have nationwide policies on this, even fewer (4) have any incentives, and fewer still (3) have any financial incentives to reimburse hospitals for the efforts taken. It fits this picture that very few targeted staff education initiatives seem to be in place and that there seems to be a lack of evidence on the effectiveness of primary prevention initiatives in hospitals. At the same time, a myriad of other demands are placed on health workers in hospitals, so it may come as little surprise if the main focus is on curative care for the condition for which the patient was admitted to hospital.

The underlying aspiration of the MECC approach is to use every contact with the health system as an opportunity to improve the general health and well-being of the population, including in hospitals. Very little of this aspiration seems to be realised in practice so far in most of the countries we considered here. This may be seen as a missed opportunity.

CRediT authorship contribution statement

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Declaration of competing interest

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Supplementary materials

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