Editorial

Why Hospitals Can, and Should, Do More to Help With Public Health

Shannon Sibbald, PhD; Ross Graham, MSc, CHE

The Canadian Medical Association's *Healthcare Transformation* initiative is an impressive example of the work being done to communicate the importance of the social determinants of health to the Canadian public.[1] The communication element of this work is critical, given widely held beliefs that downplay the importance of the social determinants of health: "Despite much research indicating that higher income levels and educational attainment are critical factors associated with better health, Canadians do not seem to understand this relationship or agree with it."[2] The system transformation element of the Canadian Medical Association's (and others) work is equally important, given the economic burden of chronic diseases and their common modifiable risk factors.[3] However, in our opinion, a commonly understated requirement for *true* system transformation is that of hospital administrators to take on larger local advocacy roles.[4] As we will explain, hospitals (particularly small community hospitals) have an opportunity to influence health by advocating locally for healthy communities and social justice. This editorial presents the rationale for (*a*) hospitals to take on a larger advocacy role and (*b*) for hospital advocacy to be reinstated as a requirement for health system transformation.

Thirty years ago, a cadre of international experts met in Ottawa to chart a course for improved health in industrialized countries. They discussed a future where hospitals have a "community conscience" and "move increasingly in a health promotion direction, beyond [their] responsibility for providing clinical and curative services."[5(p3)] This sentiment translated into the fifth principle of the Ottawa Charter for Health Promotion: Reorient Health Services.[5] The fifth principle aims to influence the foremost determinants of health: the social, economic, and built environments, which, by Canadian estimates, are responsible for 60% of health status. One's access to health care and personal biology are responsible for the remaining 25% and 15%, respectively.[6] The Charter's fifth principle acknowledges that the power to influence health status largely resides outside the health care sector and that "social justice—or lack thereof has a greater impact on the health of the population than the human genome, lifestyle choice, and medical treatment."[7(pvii)]

Influencing the determinants of health has arguably become of even greater importance, as chronic diseases outpace communicable diseases as the leading cause of death and disability in developed countries. Management of these chronic diseases requires an enormous share of health care resources and represents a significant amount of lost productivity.[3] A comprehensive health promotion approach to influence the determinants of health is required, given that chronic diseases share common modifiable risk factors.[8] Unfortunately, little has been done systemically in Canada to reorient health services toward health promotion and chronic disease prevention.[9] Soon after the Ottawa Charter's creation, Lalonde reported that Canadian hospitals ignored the pressure to embrace a health-promoting role, recounting their attitude as "let somebody else do it; we already have too much to do."[10(p38)] However, more recent research has demonstrated that some

Author Affiliations: School of Health Studies, and Department of Family Medicine & Schulich Interfaculty Program in Public Health, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada (Dr Sibbald); Vancouver Island Health Authority, Victoria, British Columbia, Canada (Mr Graham); and Centre for Health Services & Policy Research, University of British Columbia, Vancouver, British Columbia, Canada (Mr Graham).

Both authors contributed equally to the writing and editing of the manuscript.

The authors declare that they have no competing interests.

Correspondence: Shannon Sibbald, PhD, School of Health Studies, Department of Family Medicine & Schulich Interfaculty Program in Public Health, Schulich School of Medicine and Dentistry, Western University, Health Sciences Bldg, Room 334, London, ON N6A 5B9, Canada (ssibbald@uwo.ca).

DOI: 10.1097/PHH.0000000000000425

J Public Health Management Practice, 2016, 22(5), 433–435

Canadian hospitals actively engage in health promotion, such as community partnerships. However, this work often occurs at the grassroots or practitioner level and may be stifled by hospital policy and leadership, rather than encouraged.[11]

A discussion in the literature around hospitals as "anchor institutes" has recently begun.[12,13] Anchor institutes are "large public or non-profit organizations with significant spending and employment power."[12(p7)] Examples of anchor institutes include universities, cultural institutions, and sport venues.[14,15] As an anchor institution with sizable real estate and social capital, hospitals occupy a unique and influential place in communities by providing not only health services but also economic support to communities.[13] Anchor institutions are a powerful way to bolster local economies and also collaborate with communities and create partnerships that result in shared value for both. Shared value has been defined as:

> Policies and operating practices that enhance the competitiveness of a company while simultaneously advancing the economic and social conditions in the communities in which it operates . . . . Shared value is not social responsibility, philanthropy or even sustainability, but a new way to achieve economic success.[16(p64)]

In the United States, the recently passed *Patient Protection and Affordable Care Act* requires tax-exempt hospitals to conduct community health needs assessment every 3 years and implement a strategy to address identified needs.[17,18] Hospitals can meet this requirement by performing certain activities: (*a*) providing charity care, (*b*) discounting the cost of government-sponsored programs and health services, (*c*) engaging in "community health improvement," (*d*) donating to community groups, (*e*) conducting research, and (*f*) educating health professionals.[17] While many of these activities occur in Canadian hospitals, a similar requirement and acknowledgement of hospitals' responsibility for community health (ie, system transformation) do not exist. Instead, these areas are predominantly the responsibility of public health.

Although public health may mobilize other components of the health care system to advocate for social justice and healthy communities, the responsibility for improvement in these areas remains with public health. This is problematic for 3 reasons: First, the chronic disease endemic has significantly escalated the importance of advocacy in these areas:

> The requirement for public health advocacy is even more apparent today . . . . Today's chronic disease burden—cardiovascular disease, cancer, and diabetes—is attributable not to bacteria but to an array of risk factors embedded in community life.[19(p1204)]

Second, public health has significantly less funding compared with other components of the health system. The Canadian Institute for Health Information examined the total expenditure on health services. Public health initiatives receive approximately 5% of total health expenditures.[20] Despite consistent rhetoric about the necessity to increase funding for public health, such as in the First Ministers' Accord on Health Care Renewal,[21] public health funding has been stagnant.

Third, and most importantly, public health lacks the social status needed to best influence societal beliefs, which influence political decisions relating to healthy community design and social justice.[22,23] Health care providers have significantly higher social status. This is perhaps most evident for hospitals in their ability to fund-raise and the public outcry that precedes hospital closures. Hospital social status stems from their services that prevent imminent death, deliver babies, heal the sick, and care for the most vulnerable in society. Public health, in comparison, "poisons" drinking water with fluoride, forces "unsafe" vaccinations on children, closes restaurants, and advocates against "enjoyable pastimes" such as smoking and alcohol consumption. Furthermore, the "invisible" and complex nature of some public health work can be confusing, leading to further decreases in social status.[23] This creates a challenging scenario, where public health is accountable for chronic disease prevention, but has minimal leverage to influence societal beliefs.

It is time for Canadian hospitals to share the responsibility for chronic disease prevention by advocating for social justice and healthy communities. Consequently, it is imperative to build community wealth by leveraging local assets in order to foster job creation and promote the economic and social well-being of communities.

Furthermore, this role is perhaps most important for small community hospitals, which likely represent "the health system" to their community and local politicians.

> Hospitals are in a strong position within the health care system to be advocates for health promotion . . . . Although hospitals are the high temples of sick care, the extensive resources they command mean that even a small shift of focus has the potential to bring about an increase in resources dedicated to health promotion and, in time, health benefits to a community.[24(p282)]

To create the maximum shared value for cities and local communities, anchor institutions, nonprofit organizations, government and local business must acknowledge they are interdependent and they must work together. This is especially imperative for communities with limited economic opportunities.[19] Many hospitals are already adept at advocacy, although primarily as a mechanism to increase their funding.[25] Unfortunately,

this does little to impact the foremost determinants of health and may perpetuate incorrect societal beliefs about health. Lewis reports the Canadian "public has been persuaded of the value of increasingly specialized and sophisticated health care and health technology, despite the clear absence of effect on health status."[22(p2)] By using a framework that assesses hospital business needs in light of community needs, a community development agenda can be created that uses an "anchor institution" lens to both strengthen and build community wealth that results in shared value.

Conclusion

It is clear there are opportunities for hospitals to better support chronic diseases prevention in Canada. Local advocacy for social justice and healthy communities (in partnership with public health) represents a relatively simple, potentially high-return opportunity to capitalize on hospitals' social status and make good on the fifth principle of the Ottawa Charter. We acknowledge the challenges inherent to this approach, including funding, organizational readiness, and capacity. However, viewing hospitals as anchor institutions supports the ideas of garnering capital and human resources to build community wealth, improve health and social outcomes, as well as strengthen local economies.

REFERENCES

1. Canadian Medical Association. About health care transformation in Canada. https://www.cma.ca/En/Pages/health-care-transformation.aspx. Published 2013. Accessed April 14, 2016.
2. The Conference Board of Canada. *Canadians See Their Own Behaviour and Lifestyle as the Key to Their Health, Not Socio-economic Factors*. Ottawa, ON, Canada: The Conference Board of Canada; 2012. News Release 13-33.
3. Daar AS, Singer PA, Persad DL, et al. Grand challenges in chronic non-communicable diseases. *Nature.* 2007; 450(7169):494-496.
4. Hancock T. Advocacy: it's not a dirty word, it's a duty. *Can J Public Health.* 2015;106(3):e86-e88.
5. World Health Organization. Ottawa Charter for Health Promotion. www.phac-aspc.gc.ca/ph-sp/docs/charter-chartre/pdf/charter.pdf. Published 1986. Accessed April 2, 2015.
6. Standing Senate Committee on Social Affairs, Science and Technology. The health of Canadians—the federal role: final report. www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm. Published 2012. Accessed April 2, 2015.
7. Picard A. Foreword to redistributing health. In: McIntosh T, Jeffery B, Muhajarine N, eds. *Redistributing Health: New Directions in Population Health Research in Canada*. Regina, SK, Canada: CPRC Press; 2010:vii.
8. Public Health Agency of Canada. Preventing chronic disease strategic plan 2013-2016. www.phac-aspc.gc.ca/cd-mc/diabetes-diabete/strategy_plan-plan_strategique-eng.php. Published 2013. Accessed April 2, 2015.
9. Hancock T. Health promotion in Canada: 25 years of unfulfilled promise. *Health Promot Int.* 2011;26:263-267.
10. Lalonde M. Hospitals must become true health centres. *Dimens Health Serv.* 1989;66(8):39-41.
11. Poland B, Graham H, Walsh E, et al. Working at the margins" or "leading from behind:" a Canadian study of hospital-community collaboration. *Health Soc Care Community*. 2005;13(2):125-135.
12. Dragicevic N. *Anchor Institutions: The Prospective Province: Strategies for Building Community Wealth*. Toronto, ON, Canada: The Mowat Centre; 2015:8.
13. Zuckerman D, Sparks HJ, Dubb S, Howard T. *Hospitals Building Healthier Communities: Embracing the Anchor Mission*. College Park, MD: The Democracy Collaborative at the University of Maryland; 2013:1-2.
14. Birch E, Perry DC, Taylor HL. Universities as anchor institutions. *J Higher Educ Outreach Engagement.* 2013;17(3): 7-15.
15. Anchor institutions and urban economic development: from community benefit to shared value. *Inner City Insights.* 2011; 1(2):1-10.
16. Porter ME, Kramer MR. Creating shared value. *Harv Bus Rev*. 2011;89(1):62-77.
17. Young GJ, Chou CH, Alexander J, Lee SYD, Raver E. Provision of community benefits by tax-exempt US hospitals. *N Engl J Med.* 2013;368(16):1519-1527.
18. Singh SR, Bakken E, Kindig DA, Young GJ. Hospital community benefit in the context of the larger public health system: a state-level analysis of hospital and governmental public health spending across the United States. *J Public Health Manag Pract*. 2015;22(2):164-174.
19. Bassett MT. Public health advocacy. *Am J Public Health.* 2003;93(8):1204.
20. Canadian Institute for Health Information. *National Health Expenditure Trends, 1975 to 2015*. Ottawa, ON, Canada: Canadian Institute for Health Information.
21. First Ministers' Meeting. *First Ministers' Accord on Health Care Renewal*. Ottawa, ON, Canada: Health Canada; 2003.
22. Lewis S. Creating incentives to improve population health. *Prev Chronic Dis.* 2010;7(5):120-124.
23. Richardson AK. Investing in public health: barriers and possible solutions. *J Public Health.* 2012;34(3): 322-327.
24. Johnson A, Baum F. Health promoting hospitals: a typology of different organizational approaches to health promotion. *Health Promot Int*. 2010;16(3):281-287.
25. Johnson A. Public health advocacy—determining a role for staff of a public hospital. *Aust Health Rev.* 2001;24(2): 112-119.