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Guest editorial

Disease prevention guidelines put interprofessional collaboration to support healthy eating on the agenda

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In Sweden 50% of all women and 65% of all men are estimated to have one or more unhealthy lifestyle habits contributing to more than 20% of the total disease burden in the nation.[1] This has led to a reaction from the government and in 2011 the National Board of Health and Welfare published national guidelines for methods of preventing disease. The methods are evidence-based and designed to support patients in their efforts to change an unhealthy lifestyle habit. The foundation is that there is evidence for how we should be working, but there has not been uniform practice in the healthcare system.

The lifestyle habits that the guidelines discuss are:

- tobacco use
- hazardous use of alcohol
- insufficient physical activity
- unhealthy eating habits.

These habits are also among the risk factors that the World Health Organization (WHO) stresses in its European Strategy for the Prevention and Control of Non-Communicable Diseases.[2] According to the WHO, healthy lifestyle habits can prevent 80% of all diabetes and myocardial infarcts and 30% of all cancers.[3] In 2010 dietary related risk factors were the number one leading contributor for the burden of disease in Sweden according to the Institute for Health Metrics and Evaluation.[4] Tobacco use, physical inactivity and hazardous use of alcohol were secondary influences. At the same time overeating is considered the most difficult lifestyle habit to work with according to staff in the Swedish healthcare system.[5] In contrast, patients' eating habits receive less attention and knowledge of nutrition is generally poor, which can lead to significant cost increase in the area. To implement a national strategy for dietary prevention is certainly a shift of paradigm and a long awaited necessity for the status of lifestyle habits in primary and secondary care in Sweden.

Unhealthy eating habits refer to people who score low on a dietary index that the Swedish National Board of Health and Welfare developed during its work on the guidelines. The index is based on consumption of fruit, vegetables, fish and low nutritional food (such as sweets, chips, buns and cakes, and soft drinks). The evidence suggests that the method that has the most effect for changing is nutritional counselling that includes a pedagogic method. Out of the nine million people in Sweden, 20% are estimated to have significantly unhealthy eating habits. With a workforce of 850 dietitians in the healthcare system this is a challenging figure that requires clear pathways and substantial interprofessional collaborations.

The Swedish Association of Clinical Dietitians (DRF) has, together with five other professional associations, received a grant from the National Board of Health and Welfare for an implementation project to address the issue of health eating entitled 'Dietitians for healthy living'. The main aims of the project are to increase teamwork between dietitians and other healthcare professionals, to spread an increased understanding of the effect of eating habits on health and recognition that work on unhealthy eating habits and other lifestyle habits are acknowledged by politicians and other decision makers in the healthcare system. The vision is to improve health in the population through offering everyone in need an evidence-based method of support and treatment for their unhealthy eating habits.

One of the major challenges is to engage other professionals to focus on patients' eating habits, to

stress the effect of diet on the patient's overall health and to make the explicit connection with a manifest disease. The objective to work in teams to a greater extent than is the case in Sweden today will be important to meet this growing need. Medical doctors and nurses that have the first meeting with a patient must draw attention to diet and ask about eating habits as well as other lifestyle habits in order to identify people at risk of cardiovascular and other diseases associated with obesity. The next step will be to empower and motivate the patient to make healthy changes. When ready for action, someone with more competence in nutrition should see the patient for counselling and guidance towards a healthier eating pattern. Here, the dietitian has a key role in educating other staff, both in basic nutritional knowledge for putting diet on the agenda in the patient meeting, but also in tutoring other staff to feel more secure in basic nutritional advice for otherwise healthy patients. For patients with manifest diseases DRF recommends that the nutritional counselling should be given by dietitians, but we welcome more professionals to involve themselves in the dietetic area.

Public health projects that are running in parallel within the different professional associations have resulted in a shared view among healthcare professionals. We are all in agreement that lifestyle habits need to be on top of the agenda for all staff. Asking patients about their lifestyle habits is a relatively inexpensive way to improve health. Working with lifestyle changes is certainly more cost-effective than no action or simpler methods. The key message is that identifying the patients and guiding them in the right direction works: it is evidence-based.

Taking on the nation's eating habits

A questionnaire sent out in 2012 by the National Board of Health and Welfare suggests that 80% of healthcare professionals thought counselling with regards to unhealthy lifestyle is important. It has been estimated that 20% of the population has unhealthy eating habits so the dietetic project has investigated the readiness of Swedish dietitians. A questionnaire was sent to 1134 members of the professional body and returned by 413. Most dietitians who completed the questionnaire work in primary and specialist care with an orientation towards general medicine and cardiology. Most (98%) respondents thought that dietitians should be part of working with disease preventive methods. By the time of the questionnaire the guidelines had existed for two years and 97% of the respondents were aware of them, 61% had read the full document and 71% had been informed about them.

Although dietitians may seem a natural profession to involve in the structure for supporting patients to change their unhealthy eating habits, the availability in primary care is unequally distributed between the 22 healthcare regions in Sweden. In the region that has the most dietetic resources there is one dietitian for every 25 000 citizens. The corresponding number for the region with least resources is 150 000 citizens. One region does not have any dietitian in primary care, and two had only a part-time dietitian. This will leave many multidisciplinary teams incomplete and certainly affect the standard of preventive care. The aim for the DRF is to have one dietitian on every primary care unit. There is a long way to go to achieve this, but as disease preventive work is climbing higher on the agenda, so does the demand for specialised competencies.

There are many good examples of preventive work but we hope that more countries will involve themselves in national solutions for an equitable and more uniform health service. Having a healthy lifestyle makes a difference. There is evidence on methods and strategies, and there are competent and knowledgeable staff, but they need resources and collaboration to be effective. It has become very clear from the work to implement guidelines that there is a strong will from all medical and allied healthcare professionals to co-operate. We all see our different roles move forward in identifying, empowering and supporting patients. Preventive care has still got a lower status and does not get the attention, financial support and time it needs and deserves. But publication of the national guidelines has created a good foundation for a unified approach. Together with the public health projects run by all major professional bodies within the healthcare sector, there is a consensus that this is important for everyone and that we need to collaborate interprofessionally in order to optimise patient outcomes. We hope the work with disease prevention and unhealthy eating habits receives the status it deserves, and that medical teams have the opportunity to become complete with the range of competencies within healthcare in the future to aim for a better quality patient care. We all benefit from that as individuals, health service and population.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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