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Hospital-Based Evidence on the Burden of Lifestyle-Associated Disorders: Patterns, Determinants, and Health Implications

[1]Dr. Gaurav Aggarwal, [2]Mrs. Sangeeta Sharma, [3]Dr. Rashmi Sharma,

[1]Professor, Department of General Medicine, Saraswathi Institute of Medical Sciences, Hapur

[2]Associate Professor, Community Health Nursing (CHN), Saraswathi College of Nursing, Hapur

[3]Professor, Department of Pharmacognosy, Saraswathi College of Pharmacy, Hapur

Abstract: Disorders that are lifestyle related are a significant and increasing burden to healthcare systems and especially in hospital settings where complicated and severe levels of disease are common. The dietary patterns, low physical activity, substance consumption, work pressures, and psychosocial aspects have also led to the increased occurrence of metabolic, cardiovascular, renal, eye, and cancer diseases. Hospital based research offers many insights regarding the pattern of diseases and the determinants linked to the diseases, as well as the clinical implications of risk exposures related to lifestyles. This is a review of epidemiological studies in hospitals that utilizes evidence on the burden of lifestyle-associated disorders and their patterns of presentation, socio-behavioural and clinical determinants, and implications on patient outcome and healthcare provision. The results of various clinical environments demonstrate that the prevalence of metabolic syndrome, diabetes-associated morbidity, and chronic kidney disease, lifestyle-associated cancers, cataracts, and oral disease are high, and they are commonly associated with social vulnerability and work exposure. It is always possible to identify educational level, substance abuse, physical exercise, and mental health as the determinants of disease occurrence and development. The review underlines the significance of patient-centred interventions, preventive strategies and lifestyle medicine implementation into normal practice in hospitals. To address disease burden and lower long-term healthcare expenditures, it is necessary to strengthen the hospital-based screening, multidisciplinary care, and health promotion efforts. The results highlight the necessity to implement context-specific public health policies and hospital-level interventions that would both address the behavioural risk factors and social determinants of health.

IndexTerms **-** Lifestyle-associated disorders; Hospital-based studies; Metabolic syndrome; Chronic diseases; Social determinants of health; Lifestyle medicine; Non-communicable diseases.

INTRODUCTION

The burden of disease has grown to be dominated by lifestyle-associated conditions with significant implications on morbidity, mortality and the use of healthcare services. The rapid change in diets, decreased physical exercise, augmented drug use, work pressures, and psychosocial tension have changed the pattern of diseases across the globe leading to a significant increase in non-communicable diseases that are chronic. The cumulative impact of these lifestyle exposures in the form of advanced disease, complications, and multimorbidity is increasingly concentrated in the hospitals. Studies in hospitals present important information on the actual burden of lifestyle-related conditions as they are important in capturing cases that are clinically significant, and they are usually underrepresented in the community surveys. However, hospital data indicate the severity of the disease, the complexity of treatment and the demand of healthcare resources, unlike population-based research, which focuses more on prevalence. There is consistent evidence of high-burden metabolic syndrome, diabetes-related complications, chronic kidney disease, cataracts, chronic respiratory disease and lifestyle-related associated cancers in secondary and tertiary care facilities, which directly identifies the importance of clinical effects of modifiable behavioural factors (Tachang et al., 2012; Bharathi et al., 2022; Olaomoju and Oniye, 2025). The number of lifestyle-related hospital admissions due to metabolic disorders comprises a significant percentage. Investigations in the patient population of the hospital and the staff members indicate an extremely high level of obesity, hyperglycaemia, dyslipidaemia, and hypertension, which are the results of sedentary lifestyle, dietary changes, and work stress that are inherent to the modern way of life (Tachang et al., 2012; Bharathi et al., 2022). These metabolic disorders often go together and increase the progression of cardiovascular disease, kidney dysfunction, and other long-term complications that require a long hospital stay.

Lifestyle related behaviours are also the major cause of organ specific diseases, which are prevalent in hospitals. Renal dysfunction in diabetes and undesirable lipid profiles are recorded in hospitalized patients, which testify to the pathogenesis in the long-term effects of inadequate glycaemic regulation and an unhealthy diet (Lopez et al., 2026). The ophthalmic literature indicates that this is due to the strong links between lifestyle factors, including smoking, metabolic dysregulation, and nutritional status with the progression of nuclear and cortical cataracts that lead to preventable visual impairment (Mamatha et al., 2015). Equally, chronic obstructive pulmonary disease has been closely associated with tobacco consumption and exposure to the environment and this has substantiated the preventability of a significant proportion of respiratory morbidity observed in clinical practice (Kant & Gupta, 2008). More evidence about the role of lifestyle and social determinants in burden of disease is provided by hospital-based oncological research. According to retrospective cohort studies, there are high levels of oral cancer in associations with substance use, education level, and socioeconomic status (Alzahrani, 2023). The risk of colorectal cancer has also been associated with low level of education via diet, physical inactivity and other lifestyle related factors (Puspitaningtyas et al., 2025). These results are in

line with the general epidemiological data that suggest an increasing cancer burden of the low- and middle-income environments with rapid lifestyle changes (Mghanga & Seth, 2025; Tuck et al., 2023).

In addition to the behavioural risk determinants, social and psychosocial determinants play a significant role in influencing the patterns of lifestyle-related diseases in hospitals. There is evidence to show that people with substance abuse issues, mental conditions, job stress, and social exclusion are at high risk of physical health, which further complicates the disease process and hinders its clinical management (Ashifa, 2020a; Ashifa, 2020b; Ashifa, 2022). Disproportionate disease burden is observed among vulnerable groups, such as the elderly, tribal groups, and women working in hazardous jobs because of limited access to preventive services and lack of ability to maintain a long-term lifestyle change (Ashifa, 2019; Ashifa, 2021a; Ashifa and Ramya, 2019). Hospitals thus act as both the terminals of the path of diseases due to lifestyle and places of intervention. The growing interest in implementing lifestyle medicine in hospitals has become an issue of growing attention as a way of treating the modifiable risk factor in addition to standard clinical care. There are indications that lifestyle counseling, multidisciplinary care, and patient education can be included in the general work of the hospital and will be effective and feasible in reducing the burden of diseases and improving long-term outcomes (Petersen et al., 2021). It is against this background that this review studies evidence on the burden of lifestyle-related disorders conducted in hospitals, and the emphasis given to the disease pattern, underlying determinants, and implications to health. The article will help clarify how lifestyle behaviours and social determinants intersect in hospital settings to determine disease burden and to make available prevention and health promotion opportunities at the institutional level by synthesising the findings of numerous clinical settings.

PATTERNS OF LIFESTYLE-ASSOCIATED DISORDERS IN HOSPITAL SETTINGS

Based on studies at hospitals, reliably, lifestyle related pathologies are a significant percentage of the case load at inpatient and outpatient level in any medical specialty. Hospital data unlike community surveys reflect clinically significant disease burden, complications, and multimorbidity due to the long-term exposure of behavioural and socio-environmental risk factors. The results of various hospital settings show that there are common trends of metabolic disorders, kidney dysfunction, eye disease, respiratory disease, and lifestyle-associated cancers.

Patterns of Metabolic and Cardiovascular risk

Metabolic syndrome and its three constituents, which include central obesity, hyperglycaemia, dyslipidaemia, and hypertension are becoming prevalent trends in the studies conducted in hospitals. Research in African and Indian secondary and tertiary care settings figures a high prevalence of metabolic syndrome among both patients and even hospital staff, with occupational stress, physical inactivity, and dietary changes identified as the primary factors of the syndrome (Tachang et al., 2012; Bharathi et al., 2022; Olaomoju and Oniye, 2025). All these metabolic abnormalities often come together, exposing the individual to the risk of cardiovascular disease, stroke, and renal complications, thus magnifying the unit of health care usage.

Renal and Lipid Abnormalities of Diabetes

Chronic kidney disease (CKD) is one of the most significant lifestyle diseases that are found in hospitals, especially in those patients with long-term type 2 diabetes mellitus. Several biochemical investigations in hospitals indicate that diabetic patients have compromised kidney functioning and are exposed to poor lipid profiles, which highlight the accumulation of the effect of their dietary patterns, physical inactivity, and inadequate glycaemic control (Lopez et al., 2026). Qualitative data also show that patient decision making, health literacy and access to supportive care play a key role in disease progression and treatment compliance in CKD (Morton et al., 2010).

Vision and respiratory diseases

Smoking, nutritional deficiencies, metabolic imbalances and environmental exposure are lifestyle factors that are highly correlated with ocular and respiratory disorders that are experienced within hospitals. According to hospital-based ophthalmic researchers, diabetes, tobacco intake, and nutritional condition are major risk factors of nuclear and cortical cataracts that lead to the avoidance of visual disability (Mamatha et al., 2015). In the same vein, chronic obstructive pulmonary disease (COPD) is still strongly associated with tobacco use, indoor air pollution, and work-related exposure and therefore, the modifiable lifestyle determinants in respiratory morbidity (Kant and Gupta, 2008).

CANCERS THAT ARE LINKED TO LIFESTYLES BY THE HOSPITAL POPULATIONS

Increasingly, oncological trends based on hospital-based research are trending towards lifestyle-related factors. Retrospective cohort studies indicate that there are strong correlations between oral cancer and the use of substances, education level, and social deprivation (Alzahrani, 2023). Low education level has also been meditated with colorectal cancer by way of diet, lack of physical activity and other lifestyle issues (Puspitaningtyas et al., 2025). Greater epidemiological studies focus on the increasing cancer burden in the low- and middle-income conditions, whose lifestyle change is combined with health inequities (Mghanga et al., 2025; Tuck et al., 2023).

Patterns of psychosocial and Social Vulnerability.

The interaction between lifestyle behaviours and the psychosocial vulnerability is further emphasized upon by the hospital-based evidence. Research records increased physical health risks of people having a mental illness, substance abuse, occupational stress, and social marginalization, which all worsen morbidity related to lifestyle (Ashifa, 2020a; Ashifa, 2020b; Ashifa, 2022). This disproportionately affects populations of elders, tribal populations, and women who are working in high-risk jobs because of low access to preventive care and low ability to change their lifestyle (Ashifa, 2019; Ashifa, 2021a; Ashifa and Ramya, 2019).

Table 1. Common Lifestyle-Associated Disorders Identified in Hospital-Based Studies

Condition Category	Key Lifestyle Determinants	Hospital-Based Evidence	Representative References
Metabolic syndrome	Poor diet, inactivity, stress	High prevalence among patients and staff	Tachang et al. (2012); Bharathi et al. (2022); Olaomoju & Oniye (2025)
Diabetes-related CKD	Diet, inactivity, glycaemic control	Renal dysfunction and dyslipidaemia	Lopez et al. (2026); Morton et al. (2010)
Cataracts	Diabetes, smoking, nutrition	Nuclear and cortical cataracts	Mamatha et al. (2015)

COPD	Tobacco use, pollution	Chronic respiratory morbidity	Kant & Gupta (2008)
Oral & colorectal cancers	Substance use, diet, education	Lifestyle-linked oncological risk	Alzahrani (2023); Puspitaningtyas et al. (2025)
Psychosocial vulnerability	Stress, substance use, occupation	Elevated morbidity in vulnerable groups	Ashifa (2020a); Ashifa (2022)

Generally, the hospital-based trends indicate that the disorders that are related to lifestyle hardly appear in isolation. Rather they are pooled in metabolic, organ, and psychosocial area, which represent cumulative exposure to behaviour and social vulnerability. This trend shows that urgent screening, integrated care pathways, and lifestyle-based interventions are needed at the hospital level to reduce the progression and the burden of diseases on the long-term health.

Determinants of Lifestyle-Associated Disorders in Hospital Populations

Lifestyle-related disorders experienced in hospitals are a complicated combination of behavioural, biological, social, and environmental factors. Evidence-based in the hospitals indicates that such disorders are seldom due to individual risk factors, but rather a result of cumulative exposure to unhealthy lifestyle behaviours and aggravated by social vulnerability and health system limitations. These determinants should be understood in order to create effective hospital-level prevention and intervention strategies.

BEHAVIOUR AND LIFESTYLE DETERMINANTS

The most proximate determinants of lifestyle-related morbidity among populations in hospitals are the behavioural factors. Essentially, unhealthy eating habits, lack of exercise, smoking and abuse of drugs are always cited in the growth and progressions of metabolic disorders, chronic kidney disease, respiratory diseases and cancers that are related to life styles. The studies that are based in the hospital reveal that patients, who come presenting with metabolic syndrome, complications related to diabetes, and chronic respiratory disease, often report that they have been exposed to sedentary behaviour, unhealthy nutrition, and substance use long-term (Tachang et al., 2012; Bharathi et al., 2022; Kant and Gupta, 2008). Substance use turns to be a rather significant determinant in various disease categories. There is evidence that the use of alcohol and tobacco is not only related to metabolic and respiratory diseases but also oral cancers and the overall health of the body, putting people at higher risk of hospitalization and more complex treatment (Alzahrani, 2023; Ashifa, 2020a). Such behaviours are usually synergistic, increasing the risk of diseases.

Socio-Demographic and Educational Determinants

Studies and reports published by hospitals always underscore the effect of socio-demographic factors on the burden of lifestyle-associated diseases. The health literacy, lifestyle choices, and access to preventive care are determined by educational attainment, occupation, and socioeconomic status. The role of lifestyle behaviours like diet, physical inactivity, and substance use that mediate the relationship between low education levels and the risk of colorectal and oral cancer is supported by studies (Puspitaningtyas et al., 2025; Alzahrani, 2023). Risk exposure is also altered due to occupational context. Hospital staff and industrial workers prove that metabolic syndrome, stress disorders, and physical health disorders are higher with the sedentary working pattern, irregular work schedules, and occupational stress (Tachang et al., 2012; Ashifa and Ramya, 2019). These results suggest that lifestyle risks are entrenched in the wider socio-economic framework as opposed to being individual decisions.

Mental Health and psychosocial Determinants

Anxiety and psychological stress have a major role in the patterns of lifestyle-related diseases among hospital patients. People who have chronic stress, psychiatric disorder or social isolation tend to have increased rates of unhealthy behaviours, low commitment to treatment and worse health outcomes. Evidence-based records in the hospital indicate that physically, the patients with schizophrenia and substance use disorders have high risks, which is bidirectional between mental illness and lifestyle-related morbidity (Ashifa, 2020b; Ashifa, 2022). Within the elderly groups, there is the issue of psychosocial vulnerability which increases the burden of the lifestyle disease through loneliness, lack of mobility, and lack of social support. The admission to hospital by older adults is often a manifestation of compounded ageing, exposure to risk behaviour, and substandard preventive care (Ashifa, 2022).

Health System and Environmental Determinants

The burden of lifestyle-associated disorders in hospitals is also influenced by the factors of the health system. Late diagnosis, restricted access to prevention services, and disjointed care processes are the causes of presented disease at an advanced stage. Additional interactions of environmental exposures with lifestyle behaviours escalate the risk of disease, especially diseases of the respiratory and metabolic system (Kant and Gupta, 2008). The studies at the hospital indicate that lifestyle medicine is not well-integrated into the regular clinical care, thus restricting the chance of the early intervention. Nonetheless, there is evidence that it is also possible to integrate lifestyle-oriented counseling and multidisciplinary interventions in the hospital to allow focusing on modifiable determinants more efficiently (Petersen et al., 2021).

Table 2. Key Determinants of Lifestyle-Associated Disorders Identified in Hospital-Based Studies

Determinant Category	Specific Factors	Associated Conditions	Representative References
Behavioural	Poor diet, inactivity, tobacco, alcohol	Metabolic syndrome, CKD, COPD, cancers	Tachang et al. (2012); Kant & Gupta (2008); Ashifa (2020a)
Socio-demographic	Low education, occupation, SES	Colorectal & oral cancer, metabolic disorders	Puspitaningtyas et al. (2025); Alzahrani (2023)
Psychosocial	Stress, mental illness, social isolation	Multimorbidity, poor adherence	Ashifa (2020b); Ashifa (2022)
Occupational	Sedentary work, job stress	Metabolic syndrome, musculoskeletal issues	Bharathi et al. (2022); Ashifa & Ramya (2019)
Health system	Limited prevention, late diagnosis	Advanced disease presentation	Petersen et al. (2021)

Factors that determine lifestyle-related disorders among hospital populations are not limited to individual behaviour to include social structure, mental health, work environment, and health system performance. These interacting factors are the reasons why hospitals are faced with complex and clustered disease manifestations and the reason why integrated, determinant-oriented interventions are required to minimize lifestyle-related morbidity and health care burden.

HEALTH IMPLICATIONS AND CLINICAL BURDEN OF LIFESTYLE-ASSOCIATED DISORDERS

Lifestyle related diseases have a heavy clinical and systemic burden to the hospital services, and affects trends of morbidity, multimorbidity, health care utilization, and patient outcomes. Evidence in the hospital has provided consistent results to indicate that the disorders are factors that are not merely increasing the rate of admission but also leading to long hospitalization, complicated treatment procedures, and high chances of complications. The accrual impact can be significant on the healthcare systems, especially in the low- and medium-income environments with a very high rate of lifestyle changes.

Clinical Morbidity and Multimorbidity

One of the salient characteristics of the lifestyle-associated conditions of hospital populations is the clustering effect, leading to multimorbidity. Metabolic syndrome is often associated with diabetes, hypertension, dyslipidaemia, and obesity, which expedites the development of cardiovascular disease and chronic kidney disease. Biochemical and clinical researches involving patients in a hospital reveal serious renal dysfunction and lipid disorders among diabetics, indicating the presence of severe forms of the disease, which need intensive care and the intervention of multiple specialists (Lopez et al., 2026). Such comorbidities complicate the diagnosis and risk the development of negative clinical outcomes. Sensory and functional impairment is also caused by lifestyle-linked conditions to a significant degree. Hospital-based ophthalmic evidence classifies cataracts related to metabolic dysregulation and smoking as one of the significant causes of avoidable visual impairment, which has its effects on the quality of life and productivity (Mamatha et al., 2015). Likewise, other chronic respiratory diseases like chronic obstructive pulmonary disease are also associated with frequent hospital visits, loss of functional capacity and even death, much of which could be attributed to tobacco consumption and exposure of the environment (Kant and Gupta, 2008).

Oncological and Long-term health consequences

The burden of disease within hospitals due to lifestyle-related cancer remains on the rise. Hospital-based cohort studies provide evidence of high correlations between oral cancer and substance use, low educational levels, and social deprivation, which in most cases leads to late-stage appearance and low survival chances (Alzahrani, 2023). The lifestyle and education-related risk of colorectal cancer provide further stress on the long-term outcomes of life-long accumulated behavioural exposures (Puspitaningtyas et al., 2025). Such cancers require resourceful treatment, long-term follow-ups and supportive care which increases healthcare expenses and patient suffering.

Psychosocial Effect and Quality of Life

Other than physical morbidity, the psychosocial impact of lifestyle-related disorders is huge on patients and caregivers. Qualitative and hospital-based evidence has suggested that chronic kidney disease, metabolism, and cancer influence the decision-making, emotional, and adherence to treatment in a significant way (Morton et al., 2010). Mental illnesses and drug use are also additional factors that contribute to disease impact, as they reduce self-care abilities and make people more susceptible to complications (Ashifa, 2020a; Ashifa, 2020b). In the population of the elderly, lifestyle-related morbidity is overlapped with social isolation and functional deterioration, which leads to a reduced quality of life and higher dependence on institutional services (Ashifa, 2022).

Resource Utilization and Burden in Health System

The medical cost of lifestyle-related diseases is directly converted to the extent of healthcare use. The advanced metabolic disease, renal failure, respiratory illness, and cancer hospital admissions may be attributed to long-term hospitalization, recurring investigations, and long-term pharmacological therapy. The examples of hospital settings include evidence that supports the claim that delayed diagnosis and the lack of preventive care increase the costs of treatment and the ineffectiveness of care provision (Petersen et al., 2021). Moreover, the lifestyle-related diseases in the healthcare workers themselves, including metabolic syndrome and stress-related disorders, are an extra problem because they impact the workforce health and productivity (Tachang et al., 2012; Bharathi et al., 2022).

PUBLIC HEALTH AND EQUITY IMPLICATIONS

The patterns occurring in hospitals demonstrate that the socially and economically vulnerable population is disproportionally affected by lifestyle-related diseases. Tribal communities, women working in the high-risk workplaces, and people with low levels of education have more morbidity and poor outcomes because they have limited access to preventive measures and support with lifestyle changes (Ashifa, 2019; Ashifa, 2021a; Ashifa and Ramya, 2019). These disparities support the necessity to implement approaches based in hospitals that combine clinical care with social support and health promotion. The health impacts of lifestyle-related disorders go way beyond the disease entities. They include multimorbidity, functional impairment, psychosocial distress, and increasing health system expenditure. Evidence-based models in hospitals indicate the urgency of cooperative change in the implementation of shift majorly involving curative approaches into integrated prevention, lifestyle medicine, and determinant-based interventions as a measure to reduce the increasing clinical and social morbidity of lifestyle-related conditions.

Hospital Practice and Public Health Policy Implications

The evidence of the lifestyle related disorders provided in the hospital settings implies that a serious re-evaluation of the models of healthcare delivery is necessary to shift away from the paradigm of episodic and curative health work, toward the paradigms of integrated, preventive and lifestyle-oriented healthcare provision. The growing cases of metabolic ailments, cancerous illnesses of lifestyle, chronic respiratory and subordinate morbidity cases recorded in hospitals and hospitals reveal that the hospitals have ceased being treatment units and are becoming focal intervention locations of lifestyle change and risk elimination.

Changing current Hospital Practice to Lifestyle Medicine

This evidence indicates that tertiary and secondary care hospitals should strategically install lifestyle medicine in clinical practice. The implementation of strategies like structured lifestyle assessment, risk stratification, and point-of-care counseling effects have been confirmed to positively change long-term outcomes and lower readmissions (Petersen et al., 2021). Clinics and hospitals that treat diabetes, metabolic syndrome, renal disease, and chronic respiratory illness are strategic points to start causing dietary modification, promoting physical activity, quitting tobacco, and intercessory substance abuse. A special focus needs to be on

multidisciplinary care models, i.e. the combination of physicians, dietitians, physiotherapists, mental health professionals and social workers, which is especially crucial when it is necessary to manage the patterns of multimorbidity among hospital patients (Lopez et al., 2026; Bharathi et al., 2022). These measures can not only be used to address biological risks factors, but they reduce psychosocial obstacles that can negatively affect treatment adherence and recovery (Morton et al., 2010).

Enhancing Early Diagnosis and Persistence of Care

The data presented in hospitals always show late-stage manifestation of lifestyle-related diseases, especially cancers and long-term metabolic diseases (Alzahrani, 2023; Puspitaningtyas et al., 2025). This brings out the need to intensify screening measures in hospital outpatient departments particularly among high-risk groups. Downstream morbidity can be greatly minimized by opportunistic screening of metabolic syndrome, tobacco-related disorders, visual impairment, and early renal dysfunction. It is also important to provide continuity of care after discharging hospitals. Sustainable lifestyle change and long-term disease management can be facilitated by referral connections with the primary healthcare, community health workers, and digital health services. New evidence indicates that digital engagement tools and patient-centered education promote the adherence and self-management of chronic lifestyle-related conditions (Catherine et al., 2025; Swadhi et al., 2025).

Enhancing Social Determinants and Health Inequities

Results of hospitals indicate that there was a strong social stratification of the load of lifestyle-related disorders. Low-income groups, women engaged in hazardous professions, and people with low education levels are more prone to diseases and worse outcomes (Ashifa, 2019; Ashifa, 2021a; Ashifa and Ramya, 2019). The hospitals have therefore to embrace equity-based practices such as culturally sensitive counseling, social support referral system and targeted outreach programs. Upstream determinants like food insecurity, exposure to occupational risks, and psychosocial stress can be tackled by incorporating social work services into hospital care pathways as they are the key drivers of lifestyle-related morbidity (Ashifa, 2022). This type of integration enhances the position of the hospital as a center of clinical and social intervention.

POLICY-LEVEL IMPLICATIONS

Policy-level evidence has been provided by hospitals to the priority of lifestyle-related disorders in the national and regional health policies. Preventive infrastructure, training of the workforce in lifestyle medicine, and surveillance systems based on data is necessary to put a check on the growing healthcare expenses and burden of disease. Hospital based interventions are supported by policies that promote healthy food environments, regulation of tobacco and alcohol, and urban designs that encourage physical activity and make the impact more effective (Kant et al., 2008; Tuck et al., 2023). Also, hospital-generated data may be incorporated into the planning of the public health so that the trends in lifestyle-related diseases could be monitored in real-time and used to inform the specific intervention. This applies especially to the low and middle-income nations with high rates of epidemiological transition.

CONCLUSION

Evidence based on hospital-based research is strong to the assertion as lifestyle-associated disorders are a prevailing mode of disease burden in modern times. They have more than individual morbidity clinical effects and pose a significant burden to healthcare systems because of multimorbidity, psychosocial distress, health inequities, and strain. To overcome this burden, a paradigm change is necessary, which means that hospitals should become active agents of lifestyle change, prevention, and care based on equity. Through the introduction of lifestyle medicine, enhancement of early diagnosis, social determinants, and the alignment of clinical practice with population health policy, healthcare systems will be able to transition to sustainable management of lifestyle-associated diseases and better population health outcomes.

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