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Putting HPH Policy into Action

Working Paper of the WHO Collaborating Centre on Health Promotion in Hospitals and Health Care

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1 Introduction

1.1 On the paper

This paper aims at informing primarily hospital managers and hospital professionals with a strategic perspective, but also government departments and health policy actors who have responsibility for the development of health and social policy.
It should facilitate strategic decision making for Health Promoting Hospitals (HPH) especially for people who are already interested (it does not extensively argue why it makes sense at all for a health care institution to think about health promotion), but on the outset of deciding what to do on what scale.
Thus, it can be also used in training measures for health promoting hospital co-ordinators and change mangers.
As it includes a rather comprehensive systematic theoretical formulation of the possible content of HPH, it should be useful also for partners on that level who are working already with HPH, wishing to evaluate and perhaps focus their strategies.
A short summary for top management will be included in the final version.

1.2 The (strategic) context of HPH

Based on the Ottawa Charter (WHO, 1986), WHO-EURO initiated 3 strands of support for reorienting hospitals towards becoming more health promoting (hospitals):

- Conceptual development (WHO Copenhagen workshop, see Milz / Vang 1988; Budapest Declaration 1991; Vienna Recommendations 1997);
- Implementation experiences (WHO model project "Health and Hospital" in Vienna, 1988-1996; European pilot hospital project 1993-97; hospitals in the framework of national and regional networks since 1992 and more systematically since 1995 – see Ludwig Boltzmann Institute 1996; Pelikan et.al. 1998, Pelikan / Wolff 1999);
- And networking media (business meetings, annual international conferences since 1993, workshops, newsletter, national and regional networks, data base, website etc. – for further information, see web-sites of WHO-European Office for Integrated Health Care Services: www.es.euro.who.int, and WHO Collaborating Centre for Health Promotion in Hospitals and Health care: www.univie.ac.at/hph).

In 2001, after more than 10 years of involvement in HPH, WHO has launched 2 working groups to develop an up-to-date strategic and quality framework for HPH. This paper presents a shortened and focussed version of the main results of the working group "Putting health promoting hospital policy into action"1

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To understand the relationship of hospitals to health promotion and the specific potential of hospitals for health promotion and of health promotion for hospitals, some aspects of the situation of hospitals and the specific characteristics of health promotion need to be clarified.

The situation of **hospitals** is characterised by a permanent and increasing pressure of their relevant, rather dynamic environments. Hospitals have to adapt to changing political and economic, professional and consumer expectations concerning the content of hospital services and the way they do their (core) business.
Two general tendencies can be distinguished within the trend of permanent hospital reform:

1) **Strategic re-positioning of the hospital**: This regards the need for continuously re-defining the specific range and mix of services, i.e. the distinction between core business and other services, within a given health care system (inpatient / outpatient services; acute / chronic / rehabilitative services; inclusion of educative services; hospital as health centre; integration with primary care, social services and other sectors of society; specialisation of types of hospitals and departments).
2) **Assuring and improving quality of services**: Safety, appropriateness, effectiveness and efficiency of services offered have to be improved for cost containment and improved satisfaction of stakeholders. So, many hospitals are increasingly introducing specific quality approaches like systematic process oriented quality management (TQM, EFQM, ISO etc.), evidence based medicine / nursing, patient's rights etc.

To be able to delineate the specific contributions of health promotion to such strategic re-positioning and quality improvement in hospitals, the concept of health promotion has to be explained operationally.

2 Which distinctions are relevant for planning health promotion strategies in hospitals? An introduction to the concept

What do we mean when talking about health promotion in and by hospitals? Over the years, this has proven a difficult and contested issue in the development of the Health Promoting Hospital Network, often resolved in a very pragmatic way that offers some common orientation and sufficient leeway to adapt to national an local circumstances and also individual preferences. But, when faced with the task of developing orientation on how to put health promotion policy into hospital practice, the working group found a consensus that it would be necessary to explicitly and rather comprehensively identify the content of health promotion strategies for hospitals. We have to be explicit whether we are talking about developing a healthy hospital setting and / or the hospital as public health agent in its local community and / or health education services for chronically ill and / or lifestyle education for hospital staff etc.
In the end, the working group has managed to agree in a consensus process on 18 core strategies for Health Promoting Hospitals (Overview in Table 3 at the end of the chapter, specification in Chapter 3), together with propositions on how central or indispensable these strategies should be for a hospital that wants to call itself a “Health Promoting Hospital” or a health policy that wants to systematically develop this potential.
To help the reader to understand the logical structure of these core strategies, the chapter starts out with introducing some conceptual distinctions that are relevant to improve orientation in the wide range of possible developments.
At least out of the perspective of health care professionals and health educators, these distinctions will be considered rather abstract, but they try to orient themselves as what we understand as logic of decision making on a health policy or hospital management level.
The wealth of distinctions that form the very core of providers of individual services (specific risks, diseases, health problems, health potentials, lifestyles, social groups, personal characteristics etc.) will come in only in the following parts. Concerning the 18 core strategies, they will be addressed in Chapter 3-5 in an exemplary way, and they will be explicitly named as areas for specific thematic health promotion policies in Chapter 6.

2.1 Health Promotion in and by Hospitals – for whom? Target Groups

Organising thinking around the “target groups” has a long tradition in the HPH network, and it really makes a lot of difference for decision makers if they are to think about **patients** (clients / customers of the hospital organisation), the **hospital staff** and bystanders in the **community**, who are not (yet) clients of the hospital.
To keep the issue of target group as simple as possible on this level, it is proposed to define all three types of stakeholders in a broader sense:

- “Patients” include also (indirectly) the members of their social network (relatives, friends etc.) whose health can be affected by the well-being of the patient, or by their visits to the hospital.
- For “staff”, we propose the same strategy.
- “Community” includes not only the local bystanders (individuals, social groups, organisations), but can include a wider horizon – as far as global ones, e.g. when Italian hospitals form healthy alliances and work together with developing countries.

For these three target groups holds true that they cannot be considered as homogenous groups, but that their different needs (according to different age, sex, cultural community or religious groups2) will need to be considered in order to allow for the best possible health gain. This is also a principle in HPH policy documents3.

In the tradition of HPH, there still is a fourth stakeholder, the hospital as an **organisation**, represented by its owners and management. Here the movement had used the term of "health of an organisation" in a metaphorical sense, addressing issues like the hospital's ability to survive as an organisation in a turbulent and challenging environment. Although we would like to underline that the strategically well informed and professionally sound implementation of health promotion interventions for patients, staff and community are likely to be of benefit for the hospital organisation – and that these changes can be observed in principle – we decide to leave out this complication. To facilitate a clearer understanding of the very core of HPH, we have decided to discuss the implication for the organisation primarily in chapter 7 "Implementation".

2.2 Health Promotion Services and Health Promoting Settings – Health Outcomes and Health Impact

A second central distinction relates between the well established dimension of health promotion oriented at individuals / social groups vs. settings oriented health promotion. We propose to specify this distinction for the context of health care by distinguishing between hospital **services** vs. hospital **settings** (see table 1 below).
In a third step, this distinction is combined with a distinction concerning the effect on health of services and settings, the health gain (or loss).
We combine **services** with intended and specific health **outcomes** (& partly unintended, more diffuse impacts) and settings with mostly unintended and diffuse health **impacts**.
The underlying assumption is that both outcomes and impacts can be observed, measured and analysed and can also be systematically influenced by health promotion interventions.

2.3 Health Promotion as quality strategy vs. Provision of specific Health Promotion Services

A third dimension tries to disentangle two different meanings or uses of health promotion that are very relevant for health policy and management decisions. Health promotion can be understood as a specific **quality strategy** to improve current practice of hospitals, and health promotion can also be understood as providing "new" (at least for the hospital) specific **services**.
a) Health promotion as a strategy of specific **health promoting quality development** can be applied to improve the health gain of different organisational structures and processes that determine services and thus improve the outcome of the services. This also includes improvement of the hospital setting as material and social framework in which services are provided – and thus improve health impact.

2 see e.g. the Amman Declaration on Health Promotion through Islamic Lifestyles, online availability: http://www.emro.who.int/Publications/HealthEdReligion/AmmanDeclaration/Chapter2.htm

3 see also strategy 10 of the Budapest Declaration on Health Promoting Hospitals (WHO 1991), and Fundamental Principle 1 of the Vienna Recommendations on Health Promoting Hospitals (WHO 1997)

Like all quality development, Health Promoting Quality Development will have to define a specific set of principles, criteria and standards, which basically will contribute to making decision-taking in the hospital a bit more complex and thus more powerful – extending criteria in the way that criteria will be oriented

- at disease & positive health (the latter term is used in the sense of health potentials, e.g. well-functioning, fitness, functional ability, (specific) health literacy, immune status, self-perceived somato-psycho-social well-being, psychological integrity, social status: Positive health can be defined as a person's health minus a person's disease).
- at somatic & psychological & social health
- at protection, prevention, treatment & development of health
- at expert solutions & empowerment (in this paper defined as accepting, encouraging, respectful, supportive information, communication and interaction which takes into account the abilities, disabilities, background and (cultural) preferences of the person or group to be empowered).

This quality strategy is especially relevant for hospitals and other health care institutions, because health outcome and impact have a direct relationship to the primary task of the organisation, but it can be used for other organisations as well.

b) On the other hand, health promotion as the **provision of** specific **health promotion services** or activities that are not directly part of the hospital's core services or related to them, has to follow not only a health promotion or professional logic (what can be done to further improve health?), but also the logic of the specific national and local health and welfare policy and the specific market economy. For a rational hospital organisation, it will be possible to provide these specific services only if there is a demand and an ability and willingness to pay for – publicly or privately, like with any other service. Of course this can be locally developed and where there are good professional arguments that the problem is relevant and the hospital is in a good or best position to offer these services, there might be good chances. In principle, many of these services might also be offered by other organisations than hospitals.

We think this distinction is important for (Health Promoting) Hospitals. It can and should be expected from every hospital which intends to be a Health Promoting Hospital that it uses health promotion as a quality development strategy for everything it does and is. But it depends on its context (national, regional and local health policy, division of labour in local health care services, actual offers of other local providers), how far it can, should, or has to invest in offering health promotion services itself.
Therefore health promotion as a quality development strategy could / should be mandatory for Health Promoting Hospitals, whereas investment in health promotion services would be very welcome, but voluntarily, depending on the specific situation of the hospital in its context.

Table 1 below combines the last two distinctions and provides a first overview.

Table 1: Principal health promoting strategies, based on different, hospital related health determinants, to enhance health gain attributable to hospitals (for patients, staff and community)

Improvement of health gain attributable to different health determinants of hospital….	Health **outcomes** (& impacts) of hospital **services**	Health **impacts** of hospital **setting** & other settings
Specific HP **quality development**	Health promoting quality development of (core) services (of treatment & care)	Health promoting quality development of hospital setting
Provision of specific HP **services** & activities	Provision of health promoting educational, preventive and rehabilitative services	Participation as a partner in HP development of local community (and other settings)

2.4 Empowerment as health promotion core concept – what for?

Combining an analysis of the empowerment concept not primarily as a community oriented or political concept but as being related to the ability to perform specific social roles and an analysis of the distinction between disease and positive health as resource / a potential, we suggest to distinguish between several aspects of empowerment that can be targeted by health promotion interventions

a. Empowerment for health promoting **self-reproduction** / self management)

Looking at self reproduction or self management in the context of the hospital might be rather surprising for many readers, as the basic conceptualisation of the hospital patient still seems to be the passive object of diagnostic and therapeutic interventions that is being cared for comprehensively by the organisations.
But a closer view on patient reality in the hospital draws to our attention, that this view might even be too simplistic or even dangerous for patients (as it can result e.g. in psychosocial hospitalism, especially frequent in the groups of the elderly). Like outside the hospital, the patients are not totally dominated by the reality of disease and illness, but also have a rather healthy part – physically, mentally and socially, and this part can deteriorate during their hospital stay. Health promotion as a post-modern concept draws to our attention the fact, that patients have to reproduce this part of their health to a large extent by themselves – and can be supported or hindered to do so by their environment.

This holds also true for hospital staff who spend a lot of their day in the hospital setting. Independently from conditions which allow for health promoting work performance, staff need also conditions which allow for maintaining their positive somato-psycho-social health (see description of strategy Staff-1 for more details).

Self-reproduction (self-care, self-maintenance) is about taking responsibility, and to care for one's physical health needs (e.g. by getting enough sleep, exercising to keep up physical functioning level as good as possible, healthy nutrition), mental health needs (e.g. by taking enough time for recreation, developing coping mechanisms for stress, keeping up self-respect etc.), and social health needs (e.g. by keeping up social networks, securing support for new needs, adapting one's social positioning to new circumstances, etc.).

Hospital staff can enhance patient, staff and community self care by patient specific communicative and interactive empowering support[4], but also by providing supportive conditions in the hospital setting[5] (see also strategies PAT-3, STA-3, and COM-3).

In addition, the maintenance of positive health will also have to avoid harm to positive health during the hospital stay (e.g. hygiene management to avoid infections;

b. Empowerment for health promoting **co-production[6]** of diagnosis and therapy

This second specification is based on the analysis that (health) services are usually not provided by a professional only, but need the collaboration of the customer, client, patient – by accessing the provider (timely), by openly communicating in diagnostic procedures, by complying to therapy, by collaborating in therapy (breathing correctly, keeping still,..), by communicating dissent if present, by re-organising life so that it is supporting healing and re-cuperation, etc. There is a vast amount of literature that proves that effective co-operation makes a difference that can be measured in outcome: hospital stay, complications, well-being, need for pain medication, etc.
This dimension of collaboration is utilised or hindered by hospital communication routines.

c. Empowering health promotion services for **illness management**

Given the fact that many patients leave the hospital not healthy, but either in different stages of recuperation, or chronically ill, their potential contribution to the process can be either enhanced (by empowerment) or hindered. This usually goes beyond the boundaries of the hospital organisation and is being discussed as challenges for integrated care, interface management etc. as one of the central quality issues for many European healthcare systems.

d. Empowering health promotion services for **lifestyle development**.

Finally, we have to point out the "trivial" case of the classic health education but also community and setting oriented strategies, aiming at empowering people to live their lives as healthy as possible – not regarding specific diseases, but rather risk preventing or possible health enhancing lifestyles.

2.5 Combining distinctions: Six General Health Promoting Core Strategies

Generalising all types of strategies for patients, staff and the community, we get 6 different general health promoting core strategies for every stakeholder (i.e. patients, staff and the community).

4 i.e. accepting, respectful, encouraging and supportive information, communication and interaction
5 e.g. buffets instead of food in bed, or curtains around patients beds to support privacy
6 Following Donabedian (1992), co-production can be defined as a process in which experts and patients act as partners in defining goals, deciding on and applying specifc sercices / treatments, in order to achieve a desired outcome which was commonly agreed upon. (Donabedian 1992)

Table 2: Different general health promoting strategies for stakeholders of the hospital

1.	HP quality development of treatment & care, by empowerment of stakeholders for health promoting *self-reproduction*
2.	HP quality development of treatment & care, by empowerment of stakeholders for health promoting *co-production*
3.	HP quality development for health promoting & empowering hospital setting for stakeholders
4.	Provision of specific HP services - empowering illness management (patient education) for stakeholders
5.	Provision of specific HP services - empowering lifestyle development (health education) for stakeholders
6.	Provision of specific HP activities - participation in health promoting & empowering community development for stakeholders

For all 6 general strategies we formulate stakeholder-specific health promotion core strategies, which makes for the three stakeholders 18 specific strategies in total.

2.6 Health Promotion principles in the Core Strategies

In all these strategies **health promotion** or health promoting is understood in a broad sense, following the definition in the Ottawa Charter: ”Health promotion is the process of enabling people to increase control over, and to improve, their health”.
This includes maintenance and improvement of health, be it by protection or development of positive health or – with reference to specific diseases – prevention or treatment & care, as long as these procedures are applied in an empowering manner by the hospital. Health promotion also means that, when adequate, that next to “empowering” 6 other guiding principles or criteria for health promotion as defined by a WHO European Working Group on Health Promotion Evaluation (cf. Rootman in Rootman et al., 2001, p. 4) need to be applied. These are:

- **Empowering**: Enabling individuals and communities to assume more power over the personal, socioeconomic and environmental factors that affect their health
- **Participatory**: Involving all concerned at all stages of the process
- **Holistic**: Fostering physical, mental, social and spiritual health
- **Intersectoral**: Involving the collaboration of agencies from relevant sectors
- **Equitable**: Guided by a concern for equity and social justice
- **Sustainable**: bringing about changes that individuals and communities can maintain once initial funding has ended)
- **Multistrategy**: Using a variety of approaches – including policy development, organizational change, community development, legislation, advocacy, education and communication – in combination

(Rootman et.al., 2001)

In all these strategies we use **empowerment** or “empowering for health” according to the definition in the WHO Health Promotion Glossary (1998, Section II, p.6):“a process through which people gain greater control over decisions and actions affecting their health.” The term can relate to individual actors, or social groups or communities, and combines measures aiming at strengthening actors’ life skills and capacities (e.g. “to express their needs, present their concerns, devise strategies for involvement in decision-making”) with measures creating supportive physical, cultural and social environmental conditions which impact upon health. The process by which both is done, may be “social, cultural, psychological or political”.

The two terms usually are used in combination deliberately, to signal the comprehensive health gain oriented goal and the specific empowering means by which this goal could or should be reached effectively.

2.7 18 Core Strategies – an overview

The explicit combination of the 6 strategies with the 3 main stakeholders will produce a matrix that follows, on the one side, the traditional distinction between the HPH philosophy and the quality philosophy (e.g. of customers, staff and society in the EFQM model of excellence), and on the other side, of three groups of **stakeholders** or beneficiaries whose health is or can be affected by hospitals: **Patients**, **staff** and **community**. The strategies sketched in the cells of the matrix will be explained in more detail in the next chapter, concerning their objectives, indications, examples, and evidence where available.

Table 3: Core health promotion strategies[7] for Health Promoting Hospitals

HP by … \ HP for …		Patients	Staff	Community
Health promoting quality development of treatment and care by:	**empowerment of stakeholders for health promoting *self-reproduction / self management***	**PAT-1**: Health promoting living in the hospital for patients	**STA-1**: Health promoting living in the hospital for staff	**COM-1**: Health promoting access to the hospital for citizens
	empowerment of stakeholders for health promoting *co-production*	**PAT-2**: Health promoting coproduction of patients in treatment	**STA-2**: Health promoting coproduction of staff in work processes	**COM-2**: Health promoting coproduction with services in the region
	Health promoting & empowering hospital setting for stakeholders	**PAT-3**: Health promoting hospital setting for patients	**STA-3**: Health promoting hospital setting for staff	**COM-3**: Health promoting hospital setting for citizens
Strategic positioning	**empowering illness management (patient education) for stakeholders**	**PAT-4**: Health promoting illness management for patients	**STA-4**: Health promoting illness management for staff	**COM-4**: Health promoting illness management for citizens
	empowering lifestyle development (health education) for stakeholders	**PAT-5**: Health promoting lifestyle development for patients	**STA-5**: Health promoting lifestyle development for staff	**COM-5**: Health promoting lifestyle development for citizens
	participation in health promoting & empowering community development for stakeholders	**PAT-6**: Health promoting community setting for patients	**STA-6**: Health promoting community setting for staff	**COM-6**: Health promoting community setting for citizens

7 The titles of the 18 specific HPH core strategies are formulated as short as possible, so as to be comparable with and distinguishable from each other, and to also signal the specific HP character of each strategy. Detailed descriptions of each strategy, including indications and examples, can be found in the chapters below.

3 Patient oriented core strategies

Patient8 oriented core strategies aim first of all at increasing patients' health gain (measurable as clinical outcome, quality of life, patient satisfaction, health literacy) by making the every day life in the hospital, the clinical processes, and the physical and socio-cultural hospital setting as health promoting as possible for hospital patients. These factors, to which hospital patients are exposed permanently during their hospital stay, have a major influence on the development of their health outcome. The resulting strategies PAT-1, PAT-2 and PAT-3, which aim at further **developing the health promotion quality of hospital core services and setting for patients,** should therefore be performed by all Health Promoting Hospitals:

- **PAT-1 – Making the general life in the hospital as health promoting as possible for patients**: Even in case of severe diseases, patients are always partly healthy when they enter the hospital (e.g. with regard to their physical functioning, emotional balance, social status). To support and empower patients – and their relatives / peers – to maintain or even improve these healthy aspects, e.g. by encouraging them to preserve their self-responsibility (e.g. by activating care), to care for their personal needs, and to keep upright as many of their usual habits as possible during their hospital stay, is an important strategy to prevent symptoms of hospitalism (especially in vulnerable groups of patients like children, elderly).
- **PAT-2 – Making diagnosis and treatment as health promoting as possible for patients**: As research demonstrates and as many health professionals know from experience, the health of patients is not only produced by professionals, but mostly in co-production with patients / relatives. Therefore, it is an important health promotion strategy to empower patients (by information / education / training and adequate communication / interaction strategies) to get involved as partners and (co-)producers of their health into decision-making, diagnostic and therapeutic processes.
- **PAT-3 – Making the hospital stetting as health supporting as possible for patients**: The hospital as a material but also as a socio-cultural setting may have many and very often unintended positive or negative impacts on the health of hospital patients. It is therefore important to reduce the hospital's risk potential (e.g. by accident prevention, hygiene management, avoidance of harmful substances) and to increase the hospital's possible positive health impacts (e.g. by optimising hospital infra structures and availability of personnel) by further developing the hospital setting into a health-supportive environment for patients.

In addition to these 3 quality development strategies, hospitals can also offer 3 **additional health promotion strategies** in the areas of empowering patients for health promoting illness management (**strategy PAT-4**) and for health promoting lifestyle development (**strategy PAT-5**), as well as by contributing to further developing the community setting into a health supporting environment for patients (**strategy PAT-6**).

8 In the context of this paper, the term "patients" refers also (indirectly) to members of patients' social network (e.g. relatives, friends, peers) whose health can be affected by the well-being of the patient, or by their visits to the hospital.

Theses strategies can be offered by hospitals, but also by other providers. Whether or not it makes sense for a hospital to offer one or more of these additional strategies for their patients will depend upon

- the specialisation of the hospital (e.g. illness management will be very important for patients with chronic diseases and patients in rehabilitative treatment);
- the synergies to other strategies performed by the hospital (e.g. it will make sense to offer non-smoking counselling for patients if the hospital has set up a smoke-free hospital policy);
- the availability or non-availability of adequate services in the region (e.g. it might be also of economic interest for the hospital to offer specific lifestyle development services if there are no similar services available in the region);
- the conditions in the community setting (e.g. it will make sense for a rehabilitative hospital to cooperate with the regional community in making community services, shops etc. accessible for the handicapped).

Many of the patient-oriented HPH core strategies which will be described in detail in the chapters below may complement each other and / or will lead to synergies if performed together (e.g. measures around strategies PAT-1 and PAT-2 will hardly be possible without complementary measures from PAT-3). Therefore, it is possible and makes sense to combine patient-oriented strategies into **patient-oriented HPH policies**.

Given the range of the 6 patient-oriented strategies, all professional groups in the hospital – management as well as medical, nursing and therapeutic personnel, pastoral care, but also the hospital's kitchen, the purchasing department, the technical department, the cleaning personnel, etc. – can contribute to promoting the health of hospital patients.

3.1 Core strategy PAT-1: Health promoting living in the hospital for patients

3.1.1 PAT-1: Objectives

Independently from the patient's disease status, strategy PAT-1 aims at maintaining the patient's **"positive" health** during his / her hospital stay, be it as in- or outpatient. (This is in contrast to strategy PAT-2, which aims at **disease-specific** cooperation and coproduction between patients and professionals). The maintenance of patients' positive health his achieved by optimising the hospital's impact on the patients' somato-psycho-social well-functioning, self-perceived well-being and quality of life, both by risk management (e.g. hygiene management, clinical error management), by providing supportive conditions in the hospital setting (see also strategy PAT-3, chapter 3.3), and by supporting the patients' ability for health promoting self management.

Whereas different forms of risk management are already part of many quality strategies in hospitals, self management / self reproduction of patients is an issue specific to health promotion. Therefore, this paper focuses on the latter aspect. This refers to the ability and willingness of patients to take over responsibility, and to care for their own personal health needs while being hospitalised:

- physical needs (e.g. supporting and enabling patients to take enough sleep, eat healthy and culturally convenient food, perform physical activity),

- psychological needs (e.g. supporting and enabling patients to develop coping mechanisms for stress / anxieties; to take care of spiritual needs),
- and social needs (e.g. organising financial support when needed, supporting and enabling patients to stay in contact with their work while hospitalised).

Hospital staff can enhance patient's – and relatives' (proxies') – ability and willingness for health promoting self management by means of patient oriented / patient centred communicative, interactive and empowering support.

3.1.2 PAT-1: Indications

Basic health promotion documents emphasise that the chance to take care of personal health needs, to access supportive environments and to obtain relevant information, are basic preconditions for health[9].

Hospitals usually are unfamiliar surroundings for patients, where they will have to change most of their usual personal habits. In order to avoid unintended side-effects of he disorientation which may result from these circumstances, patients will need adequate information and communication about what to expect in the hospital, and about the possibilities they have of taking care of their own personal health needs. Especially for vulnerable groups of patients (like elderly, migrants, children[10], socially deprived groups), a lack of such orientation may result in symptoms of somatic or psychological hospitalism[11].

Adequate information and orientation of patients about topics related to their health needs, provided by means of empowering communication and interaction, are therefore important determinants of patients' health and quality of life[12].

Measures in line with strategy PAT-1 are indicated for nearly every patient, although to different degrees for patients with different capacities for self management. For groups of patients who are not able to manage their own personal health needs, this strategy also needs to involve relatives / proxies and lay carers (volunteers).

3.1.3 PAT-1: Main topics / routines – selected examples, guidelines and evidence

Hospitals can support the self management of patients' physical health needs by:

1. Assessing patients' possible level of self management[13], e.g. by interprofessional admission encounters, nursing diagnoses (e.g. NANDA)
2. Providing offers and options to encourage patients to perform physical activities (e.g. by serving meals at buffets instead of in bed; offering a gymnasium for patients; organising physical activity groups for patients)[14]

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9 e.g. (WHO 1986b), (WHO - Regional Office for Europe 1998) (WHO 1986a)

10 see e.g. European Association for Children in the Hospital, online information at http://www.each-for-sick-children.org/

11 A vitiated condition of the body, due to long confinement in a hospital, or the morbid condition of the atmosphere of a hospital (source: Websters Dictionary, http://www.books.md/H/dic/hospitalism.php); also mental deterioration; see (Vetter 1995)

12 see e.g. (Di Blasi, Harkness et al. 2001)

13 see also Standard 1 on health promotion in hospitals, WHO 2004

3. Providing adequate (e.g. with regard to culture, dietary needs), adequately distributed and healthy food
4. Providing adequate palliative care[15] [16] and pain management[17]

Hospitals can support the self management of patients' psychological / emotional health needs by:

5. Providing adequate information and guidance about general living in the hospital at admission (example of good practice: Griffin Hospital, USA[18]) and, when possible, also prior to admission (e.g. information about what patients need to bring to the hospital)
6. Communicating in a supportive and respectful manner with patients in every encounter
7. Securing personal privacy (e.g. data protection; curtains around beds)
8. Providing animal therapy (example: Griffin Hospital, USA[19])
9. Providing offers and options to encourage psycho-social activities of patients (e.g. cultural activities, patient libraries, discussions, patient internet cafe, ...)
10. Bringing humour into the hospital, e.g. by clown doctors[20]
11. Using arts / art as therapy[21]
12. Providing adequate visiting hours for family members, friends / peers, lay carers
13. Providing the possibility for caring relatives / friends to stay in the hospital (especially for very vulnerable groups of patients, like children[22], terminally ill patients)
14. Organising visiting and lay support services for unattended patients[23]
15. Providing psychological and social assistance to cope with stress or anxieties related to the hospital stay or to the patient's specific disease (e.g. cancer, terminal illness) or to the patient's general life situation (e.g. loss of work due to disease), by specialised personnel (e.g. clinical psychologists, social workers, pastoral carers)

Hospitals can support the self management of patients' social health needs by:

16. Supporting patients / proxies / peers in organising financial support, if needed (e.g. for long-term patients)
17. Empowering relatives / proxies to get actively involved in the self care processes of patients

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14 Example from HPH network: Project "Patient comfort during hospital stay, Koranyi Institute, Budapest, Hungary: Moving patients can walk in the forest garden, use a room cycling ergometer. Disabled, not moving elderly people are seated in wheeled chair and moved to the balcony or to TV room to chat with others or with visitors. Massage, bed-gymnastics are taught.

15 See e.g.(Fins, Miller et al. 1999) who detect huge potentials for improving end-of-life decision making in hospitals, and (Seymour 2000).

16 Example from HPH network: Ehrlich M., Ziegenfuß Th., Moers (2001): "Palliative care: a cost effective and highly sufficient integrative medical concept" in: HPH-Newsletter 18, Dec. 2001, online available at http://www.univie.ac.at/hph/NL18.PDF

17 Experience from HPH Network: Visentin M. (2003): "Towards a pain-free hospitals. In: Virtual Proceedings of 11th International Conference on Health Promoting Hospitals, online availability: file:///C:/Dokumente%20und%20Einstellungen/default/Lokale%20Einstellungen/Temporary%20Internet%20Files/Content.IE5/6D6L0NSD/256,1,TOWARDS A PAIN-FREE HOSPITAL

18 see http://www.griffinhealth.org/

19 see http://www.griffinhealth.org/

20 One of the best known medical doctors who is applying humour as a form of therapy is Patch Adams. Further information available at http://www.patchadams.org/home.htm

21 example from the HPH Network: Arts in the Service of Health as a model of good practice for HPH work; further information: helle.maeltsemees@itk.ee or tiiu.harm@itk.ee

22 (Aujoulat, Simonelli 2003)

23 Example: Rudolfstiftung Hospital, Vienna (Nowak, Lobnig et al. 1998)

18. Especially for long-term patients: Offering possibilities to keep up with their professional relationships or other social duties (e.g. school education for children, internet access to maintain contact with work for adult patients)

3.1.4 PAT-1: Possible combinations and synergies with other strategies

Strategy PAT-1 will be more likely to be effective when combined with

- **Strategy PAT-3** (*"health promoting hospital setting for patients*" – see chapter 3.3), since patients' ability to manage their personal health needs will depend upon prerequisites within the hospital setting;
- **Strategy PAT-4** (*"Health promoting illness management for patients"* – see chapter 3.4), since the continuity and sustainability of health promoting self management and self care also after discharge will depend upon patient information, education and counselling about health promoting disease management;**Strategy PAT-5** (*"Health promoting lifestyle development for patients"* – see chapter 3.5), since the continuity and sustainability of health promoting self management also after discharge may depend upon general lifestyle-related patient information, education and counselling.

3.2 Core strategy PAT-2: Health promoting co-production of patients in treatment

3.2.1 PAT-2: Objectives

Strategy PAT-2 aims at optimising the outcome of hospital interventions by empowering patients for improving their health promoting co-production / cooperation in treatment and care.

Such co-production can be achieved by means of empowering, enabling, and supportive communication and interaction between staff and patients with regard to

- treatment related information for and communication with patients;
- treatment processes (provide transparency);
- involvement of patients in treatment related decisions;
- enablement of patients to develop and perform treatment related health literacy[24], attitudes / preferences, skills and actions where indicated and adequate;
- Activation / motivation / mobilisation of patients.

As a precondition, hospital staff need communication, interaction and training skills as well as procedures and structures which enable them to apply these skills in daily treatment and care routines.

3.2.2 PAT-2: Indications

Communication with patients in the above described way has positive clinical effects[25] on clinical and other patient outcomes of hospital services for all hospital patients, e.g.

- Reduced complication rates[26]
- Reduced duration of recuperation processes and length of hospital stay[27]
- increased patient (and relatives') satisfaction [28] [29].

There is evidence that measure in line with strategy PAT-2 can effectively be performed by hospitals[30]. This strategy is also in line with the basic health promotion principle of enablement[31], and in line with policy documents of the International Council of Nursing (ICN)[32].

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24 For a definition of health literacy, see (Nielsen-Bohlman, Panzer et al. 2004)

25 (Johnston, Vögele 1992), (Di Blasi, Harkness et al. 1999) (Trummer, Müller et al. 2004)

26 (Trummer, Müller et al. 2004)

27 (Trummer, Müller et al. 2004)

28 (Coulter 1998)

29 (Trummer, Müller et al. 2004)

30 (Wimmer, Denck 1989), (Trummer, Müller et al. 2004)

31 WHO-Ottawa Charter: increased control over, and thus improvement of health; (WHO 1986b) see also strategies 3 and 4 of the Budapest Declaration on HPH, implementation strategies 1.1. and 1.2 of the Vienna Recommendations on HPH

32 the ICN has adopted policies on "Informed Patients" (2003), and on "Health information: Protecting Patient Rights" (2000). Online availability: http://www.icn.ch/policy.htm

Measures in line with strategy PAT-2 are indicated for nearly every patient, except for those who cannot be involved in communication processes (babies, unconscious patients). For those groups of patients, communication processes need to involve relatives / proxies.
But there are specific techniques which can even be applied to unconscious patients (e.g. "basic stimulation"33).

3.2.3 PAT-2: Main topics / routines – selected examples, guidelines and evidence

Hospitals can improve the amount of coproduction / cooperation in treatment and care by empowering (skills enabling), and supportive communication with and involvement of patients in decision-making (joint agreements) with regard to

1. pre-admission (e.g. information events, brochures, videos, web-site34)
2. admission interviews (e.g. orientation about and agreement on individual treatment schedule)
3. rounds
4. diagnostic processes
5. diagnostic results (e.g. talks, brochures, patient information systems)
6. treatment (e.g. alternatives; side effects; information on how patients can contribute to their treatment)
7. discharge (e.g. information about after care)

Hospitals can improve the amount of coproduction / cooperation in treatment and care by enabling their staff through

8. training their staff with regard to communication skills
9. developing inter-professional cooperation structures and processes in order to facilitate comprehensive patient participation (e.g. consider necessary time in day schedules; organise interdisciplinary case discussions)

3.2.4 PAT-2: Possible combinations and synergies with other strategies

Strategy PAT-2 is more likely to be effective when combined with

- **Strategy PAT-1** ("*health promoting living in the hospital for patients" – see chapter 3.1*), since patients who are encouraged to manage their personal health needs will more likely be able to act as partners in the coproduction of their health;
- **Strategy PAT-3** ("*health promoting hospital setting for patients" – see chapter 3.3*), since empowering communication requires preconditions in the hospital setting, e.g. supportive rooms or work time regulations which consider the time necessary for empowering communication with patients.
- **Strategy STA-1** ("*health promoting living in the hospital for staff" – see chapter 4.1*), since staff who are empowered to manage their own personal health needs are more likely to be able to communicate in an empowering and involving way with patients;
- **Strategy STA-2** ("*health promoting coproduction of staff in work processes" – see chapter 4.2*), since empowerment of patients for coproduction can best be achieved when hospital staff are used to an empowering work style;

33 (Nydahl 2004)

34 Example from HPH network: patient information web-site of Tartu University Clinics, Estonia: www.kliinikum.ee

3.3 Core strategy PAT-3: Health promoting hospital setting for patients

3.3.1 PAT-3: Objectives

Strategy PAT-3 aims at optimising the hospital's health impact on patients and their visitors, by developing the hospital setting into a more health promoting, empowering and supportive environment for patients and visitors.

This refers to

- Infra structures and material hospital setting (hotel infrastructures as well as treatment and care related infrastructures) and
- socio-cultural aspects of the hospital setting (e.g. rules and regulations which affect patients' hospital stay, like day schedules, smoking regulations).

In the context of this paper, we understand "setting" as the situative material, social and cultural aspects of the hospital settings which form the precondition for many of the activities relating to other strategies. Therefore, strategy PAT-3 will mostly be combined with other patient-related strategies.

3.3.2 PAT-3: Indications

Settings in general affect their users[35]. Specifically for hospitals, studies show that conditions of the hospital setting may represent important health risks or resources for patients[36], independently of the quality of the disease treatment they receive provided (e.g. risk of nosocomial infections; risk of accidents; risk of malnutrition, risk of being neglected).

Strategy PAT-3 is also in line with the settings approach in health promotion[37] and with principal HPH policies[38].

Measures around strategy PAT-3 are indicated for all patients, though specific adaptations may vary for different types of hospital wards and for different groups of patients (e.g. intensive care, paediactric wards, maternity wards, long-term care).

3.3.3 PAT-3: Main topics / routines – selected examples, guidelines and evidence

The material hospital setting / the hospital infrastructure can be (further) developed into a supportive setting for patients by reducing risks through:

1. Providing adequate hygiene management in the hospital in order to prevent nosocomial infections[39])

35 Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. (WHO 1986)

36 (Di Blasi, Harkness et al. 2001; Vetter 1995)

37 (Green, Poland et al. 2000)

38 see e.g. Budapest Declaration on HPH – Strategy 3: Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process. (Health Promoting Hospitals Network 1991)

2. Implementing devices for accident prevention (e.g. falls in elderly)[40]
3. Avoiding materials which might endanger (specific groups of) patients, e.g. latex, PVC, mercury41.
4. "Building green" (without toxic and dangerous materials for patients)42
5. Providing safes for patients (in order to avoid theft)
6. Providing adequate and adequately distributed food (e.g. buffets where possible, in order to encourage patient activity and social interaction) in order to prevent malnutrition in the hospital43
7. Protect non-smokers against smoke (see e.g. guidelines of European Network of Smoke-Free Hospitals44)

The material hospital setting / the hospital infrastructure can be (further) developed into a supportive setting for patients by offering resources through:

8. Providing functional and safe design
9. Providing an agreeable view out of the window45
10. Offering arts in the hospital46
11. Providing infra structures for patients' leisure time activities (e.g. gymnasium, patient library, television room, internet café, patient garden)
12. Providing adequate infra structures for patient oriented diagnostic and treatment processes (e.g. respecting privacy; friendly design)
13. Providing for the material and social needs of specific groups of patients (e.g. culturally adequate food; baby friendly surroundings, etc.)
14. Providing clean air
15. Providing "healthy" lighting systems

The socio-cultural hospital setting can be (further) developed into a supportive setting for patients by

16. Implementing patient-friendly day schedules (waking times, service of meals etc., visiting hours, etc.)
17. Implementing policies for supporting healthy lifestyles of patients (e.g. specific rules and regulations on smoking)

3.3.4 PAT-3: Possible combinations and synergies with other strategies

Strategy PAT-3 is an important determinant for the successful implementation of

- **Strategy PAT-1** (*"health promoting living of patients in the hospital" – see chapter 3.1)* and

39 Example from the HPH network: Model document "How hospitals can improve their hygiene organisation" (Lobnig, Nowak et al. 1996c), derived from the Austrian Model Hospital "Rudolfstiftung (available only in German language)

40 see e.g. (Joanna Briggs Institute for Evidence Based Nursing and Midwifery 1998)

41 Health Care Without Harm, web-site: http://www.noharm.org/ (Health Care without Harm 2002)

42 Health Care Without Harm, web-site: http://www.noharm.org/ (Health Care without Harm 2002)

43 Beck A.M., Ballknäs U.M., Fürst P., Hasunen K., Jones L., Keller U. Melchior J.-C., Mikkelsen B.E., Schauder B. Sivonen L., Zinck O., Olien H., Ovesen L. (2001): Food and nutritional care in hospitals: How to prevent undernutrition. Report and guidelines from the Council of Europe. In: Clinical Nutrition 20, 455-460

44 Smoke Free Hospital European Implementation Guide: Online access via http://www.gspwien-info.net/downloads/en-ENSHimplementation-guide.pdf

45 Results on the influence of views out of the window for hospital patients can be found in (Beauchemin, Hays 1998)

46 example from the HPH Network: Arts in the Service of Health as a model of good practice for HPH work; further information: helle.maeltsemees@itk.ee or tiiu.harm@itk.ee

- **Strategy PAT-2** *("health promoting coproduction of patients in treatment" – see chapter 3.2*), since both self management of patients' health needs and patients' coproduction of their health in treatment and care depend also upon specific prerequisites in the hospital setting (e.g. privacy in patient rooms for strategy PAT-1, availability of counselling rooms for strategy PAT-2).

It is also advisable to combine Strategy PAT-3 with

- **Strategy STA-3** (*"health promoting hospital setting for staff" – see chapter 3.3*) and
- **Strategy COM-3** (*"health promoting hospital setting for citizens" – see chapter 5.3*), since many issues of developing the hospital setting will only slightly differ for the different target groups (e.g. non-smoking areas), and the combined implementation will therefore allow to use synergies.

3.4 Core strategy PAT-4: Health promoting illness management for patients

3.4.1 PAT-4: Objectives

Strategy PAT-4 aims at improving the health gain for hospital patients also after discharge by offering specific services (patient information, education, counselling and training) which empower patients to develop the specific health literacy they need for managing specific (temporary) impairments and recuperation processes (e.g. after surgical interventions), as well as chronic diseases, in a health promoting way.

3.4.2 Pat-4: Indications

- Disease related quality of life, recuperation processes after hospital interventions and, in the case of chronically ill patients also the stabilisation or at least the retardation of the disease progress, can be positively influenced by improving patients' self care for their condition[47] [48]
- Patients' knowledge and skills with regard to their impairments or diseases are of course important preconditions for successful self care. There are many examples for patient information, education, counselling and training being adequate means to empower patients for disease-specific self care by providing them with the necessary knowledge, preferences and skills[49].
- Such measures, especially with regard to chronic diseases (e.g. diabetes), are therefore already part of the standard procedure in many hospitals, and their feasibility has also been successfully demonstrated through projects in many hospitals of the International Network of HPH[50].

Measures in line with strategy PAT-4 are indicated for most hospital patients, especially for

- patients with chronic diseases problems
- patients whose recuperation after discharge needs specific measures of self care after discharge (e.g. physical exercise; wound care; compliance with drug prescriptions; injections)

Strategy PAT-4 is not indicated for patients who are not (fully) able to care for themselves (e.g. babies, demented patients). For those groups of patients, empowerment processes need to involve relatives / proxies / lay carers, but also health care providers in the community in some cases (see also strategy COM-2).

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47 see e.g. (Devine, Pearcy 1996; Hirano, Laurent et al. 1994; Lacasse, et al. 1996; Mazzuca 1982; Smith, et al. 1992)

48 see e.g. for Diabetes: Mühlhauser I., Berger M. (2000): Evidence based patient information in diabetes. In: Diabetes Medicine, 823-829. Online available at http://www.chemie.uni-hamburg.de/igtw/Gesundheit/images/pdf/DiabMed2000EBMdiabetes.pdf

49 see e.g. Centre for Health Information Quality (2002): Hi Quality. Guidelines on health information quality. Hampshire: The Help for Health Trust. Online availability: www.highquality.org.uk/guidelines.htm

50 Examples from the HPH network: see e.g. chapter "Tackling diabetes and other chronic diseases in the Virtual Proceedings of the 9th International Conference on HPH, online available at http://www.univie.ac.at/hph/9ic/proc9ic.html; see also Koranyi Hospital, Budapest, Hungary; numerous projects within the Lithuanian Network of HPH

3.4.3 PAT-4: Main topics / routines – selected examples, guidelines and evidence

Experience exists especially around illnesses with specific relevance for public health like

1. Asthma51
2. Diabetes 52
3. Cancer53
4. COPD54
5. Coronary heart problems
6. Specific recuperation and rehabilitation processes

3.4.4 PAT-4: Possible combinations and synergies with other strategies

The implementation of strategy PAT-4 will be improved if it can rely on or follow up on

- **Strategy PAT-1** (*"health promoting living in the hospital for patients" – see chapter 3.1)* since patients who are encouraged to take care of the their own personal health needs in the hospital will be better able to take over the responsibility to manage their disease / impairment;
- **Strategy PAT-2** *("health promoting coproduction of patients in treatment" – see chapter 3.2*), since the involvement of patients as co producers of their health may also empower and motivate them for self-managing of their disease after discharge.
- **Strategy PAT-3** ("*health promoting hospital setting for patients" – see chapter 3.3*), since the provision of information, education, counselling and training services for self management of diseases will also depend upon prerequisites (e.g. rooms) in the hospital setting.

For some indications, it will be possible to organise information, education, counselling and training services jointly for patients, staff (see also **strategy STA-4,** *"health promoting illness management for staff" – see chapter 4.4*), and persons from the hospital community (see also **strategy COM-4**, *"health promoting illnesses management for citizens – see chapter 5.4*).

51 see e.g. (Williams, Schmidt et al. 2003)

52 see Mühlhauser I., Berger M. (2000), cited above

53 (Zuk, Quinn 2002)

54 see e.g. Kane G.C., Graham M.G. (2004): An evidence based approach to COPD. In: Jaapa Archives. Online available at http://www.memag.com/be_core/content/journals/j/data/2004/0401/w0404copd.html, in which they state that an optimal treatment plan for COPD will begin with patient education.

3.5 Core strategy PAT-5: Health promoting lifestyle development for patients

3.5.1 PAT-5: Objectives

Strategy PAT-5 aims at improving the outcome of hospital interventions by empowering patients to build up specific health literacy (knowledge, skills and preferences) for developing and maintaining health promoting life styles.

3.5.2 PAT-5: Indications

- Lifestyles (nutrition, exercise, substance (ab)use, stress management) have proven effects on clinical health indicators, quality of life and longevity[55].
- The development of health promoting lifestyles can be successfully influenced by health promoting interventions like information, education, training, and counselling.
- Hospitals have the potential (credibility, knowledge and skills) to offer effective lifestyle education and counselling services for their patients. Lifestyle interventions in hospitals may also be specifically efficient, as patients who need a hospital intervention may be more willing to accept the necessity of a lifestyle change ("teachable moment") than healthy people. The many projects which have been performed in the International network of Health Promoting Hospitals demonstrate that hospitals can successfully apply lifestyle interventions.

Measures in line with strategy PAT-5 are indicated especially for
- Patients with unhealthy lifestyles (e.g. smokers, drinkers)
- Patients with chronic diseases (since healthy lifestyles may positively influence the retardation of the disease progress)
- Children and youth, since lifestyle interventions may have a long lasting impact upon their health.

3.5.3 PAT-5: Main topics / routines – selected examples, guidelines and evidence

Lifestyles with specific impact on health and which should therefore be especially considered in lifestyle interventions are:
1. Breast feeding[56]
2. Alcohol prevention
3. Smoking prevention / cessation[57] [58]
4. Coping with stress
5. Sexual health[59]
6. Physical exercise
7. Healthy nutrition

55 see e.g. (World Health Organization 2002; Tubiana 2000; Willett 1995)
56 see e.g. (Wang 1994)
57 see e.g. (Taylor, Dingle 2004), (European Network for Smoke-free Hospitals 2001)
58 example from the HPH Network: Smoking cessation clinics for patients, Estonia (contact: ylle.ani@kliinikum.ee
59 see e.g. (Feldman, Martell et al. 2004)

3.5.4 PAT-5: Possible combinations and synergies with other strategies

Strategy PAT-5 is best combined with

- **Strategy PAT-1** (*"health promoting living in the hospital for patients" – see chapter 3.1),* since patients who are encouraged to take care of their own personal health needs during their hospital stay will be better able to take over the responsibility to develop and maintain healthy lifestyles;
- **Strategy PAT-2** *("health promoting coproduction of patients in treatment" – see chapter 3.2*), since patients who are encouraged to coproduce their health during hospital stay will be better able to take over the self-responsibility to develop and maintain healthy lifestyles also after discharge;
- **Strategy PAT-3** ("*health promoting hospital setting for patients" – see chapter 3.3*), since the provision of information, education, counselling and training services for health promoting life styles will also depend upon prerequisites (e.g. rooms) in the hospital setting;
- **Strategy PAT-4** (*"health promoting illness management for patients" – see chapter 3.4*), since the self management of diseases / impairments is often with specific lifestyles.

There are also synergies with **strategy STA-5** (*"health promoting lifestyle development for staff" – see chapter 4.5*) and **strategy COM-5** (*"health promoting lifestyle development for citizens" – see chapter 5.5*), since general lifestyle interventions can be offered jointly for staff, patients and community members. (For specific lifestyle problems of the different target groups, e.g. disease-specific lifestyle requirements for patients, or work-specific lifestyle problems of staff, target group-specific services will be needed).

If hospitals are not offering lifestyle education and counselling services themselves, the hospital may also cooperate with lifestyle education and counselling services in the hospital community and develop quality assessment for these, as well as referral procedures for hospital patients when indicated.

3.6 Core Strategy PAT-6: Health promoting community setting for patients

3.6.1 Objectives of strategy PAT-6:

Strategy PAT-6 aims at improving health gain for patients by initiating of or contributing to specific local health promoting and empowering community development projects, which are oriented at improving health related regional living conditions that meet the specific health needs of (former) hospital patients.

3.6.2 Indication for strategy PAT-6

- There is consensus that the general living circumstances (e.g. noise, pollution, accessibility of public transport, availability of healthy food choices in local stores, road safety, …) have an impact on health and quality of life, therefore community development is a central health promotion strategy[60].
- This holds of course also true for (specific groups of) patients. Examples from the HPH network demonstrate the feasibility of specific measures around strategy PAT-6 in the context of Health Promoting Hospitals[61].

Measures in line with strategy PAT-6 are of course indicated for all groups of patients, although for most hospitals, the investment in measures around this strategy will only make (economic) sense with regard to larger groups of patients with similar health needs.

3.6.3 PAT-6: Main topics / routines: Selected examples, guidelines and evidence

Experiences with measures in line with strategy PAT-6 exist e.g. with regard to:

1. Supporting self help groups
2. Assisting patients in adapting their home for meeting specific needs (e.g. handholds in the bathroom; example: “transition care”, General Hospital, Linz, Austria[62])
3. Cooperating with local stores in order to make healthy food choices available (example: project “Shops for a better life”, Linköping[63])
4. Cooperating with other health care providers (e.g. pharmacies) in order to make sure that patients have access to necessary medication and medical supply after discharge
5. Cooperating with community services who are supporting patients at home (see also strategy COM-2 – chapter 5.2)
6. Cooperating with responsible community authorities in order to make preventive devices for specific health problems available in public places[64]
7. Cooperating with responsible community authorities in order to make public buildings and public transport accessible for handicapped community members.

60 see e.g. WHO 1986

61 Example from the HPH network: “Transition Care”, General Hospital Linz, Austria: A nursing model which ensures that the home environment of a hospital patient will allow him / her to successfully (Schwarz, Stefan 4 A.D.)

62 see above

63 (Kristenson, Vang 1998)

64 Example: Availability of defibrillators in public buildings, Vienna, Austria

3.6.4 PAT-6: Possible combinations and synergies with other strategies

This strategy will be more effective when combined with

- **strategy COM-2** (*"health promoting coproduction with services in the region" – see chapter 5.2*), since many aspects of community development for meeting patients' health needs have to do with providing adequate access to specific health care services.
- **strategy STA-6** (*"health promoting community setting for staff – see chapter 4.6*) and **strategy COM-6** (*"health promoting community setting for citizens" – see chapter 5.6*), since the combined application of community development strategies for all target groups of a Health Promoting Hospital may produce synergies for the benefit of all.

3.7 Examples: What can the different professional groups in the hospital contribute to promoting the health of hospital patients?

Hospital management / hospital financier:
- Put health promotion for hospital patients high on the hospital's agenda
- Make sure that health promotion for hospital patients is considered in the strategic hospital planning (e.g. set specific goals, set up specific projects, have a specific health promotion budget, include health promotion outcomes into monitoring and evaluation)
- Include patients into the strategic planning of the hospital
- Consider health promotion aspects when (re-)building hospitals (e.g. build green; build the hospital as patient-oriented as possible)

Medical personnel:
- Develop further training / information / education, communication and interaction strategies with patients in order to optimise the involvement of patients / relatives in medical diagnosis and treatment processes
- Include patient empowerment into specific clinical pathways
- Cooperate with community health services in order to contribute to continuous and integrated care
- Cooperate with self help groups
- Offer specific health promoting lifestyle or illness-related counselling information / education / training services

Nursing personnel:
- Develop further training / information / education, communication and interaction strategies with patients in order to optimise the involvement of patients / relatives in medical diagnosis and treatment processes
- Include patient empowerment into specific clinical pathways
- Cooperate with community health services in order to contribute to continuous and integrated care
- Cooperate with self help groups
- Offer specific health promoting lifestyle or illness-related counselling information / education / training services

Therapeutic personnel:
- Develop further training / information / education, communication and interaction strategies with patients in order to optimise the involvement of patients / relatives in therapeutic processes
- Include patient empowerment into specific clinical pathways
- Cooperate with self help groups
- Offer specific health promoting lifestyle or illness-related counselling information / education / training services

4 Staff oriented core strategies

Staff-oriented core strategies aim first of all at making everyday work life and processes, as well as the hospital as a work environment (the material and socio-cultural hospital setting) as health promoting as possible for hospital staff, since these factors, to which hospital staff are exposed almost every day, have a major impact on their health. The resulting strategies STA-1, STA-2 and STA-3, which aim at further **developing the health promotion quality of the hospital as a work place,** should therefore be performed by all Health Promoting Hospitals:

- **STA-1 – Making work life in the hospital as health promoting as possible for hospital staff**: This strategy is about respecting staff not only as a work force but as human beings with human, somato-psycho-social needs, and, consequently, to support and empower them to take care of these needs as much as is possible during work life in the hospital. This will greatly contribute to maintaining staff's positive health.
- **STA-2 – Making work processes as health promoting as possible for staff**: In addition to "classical" aspects of health and safety at work (as regulated in specific health safety acts in most countries), health promotion adds here the specific criterion of empowerment of hospital staff for coproduction at and of work, i.e. health promotion aims at involving staff as experts for their work situation in further developing work processes and to participate in work related decisions.
- **STA-3 – Making the hospital stetting as health supporting as possible for staff**: The hospital as a material but also as a socio-cultural setting may have many and very often unintended positive or negative impacts on the health of hospital staff. It is therefore important to reduce the hospital's risk potential (e.g. by accident prevention, hygiene management, avoidance of harmful substances) and to increase the hospital's possible positive health impacts (e.g. by optimising hospital infra structures and availability of personnel) by further developing the hospital setting into a health-supportive environment for staff.

In addition to these 3 quality development strategies, hospitals can also offer 3 **additional health promotion strategies** for their staff, aiming at empowering staff for health promoting management of (work related) illnesses (**strategy STA-4**) and for health promoting lifestyle development (**strategy STA-5**), as well as by contributing to further developing the community setting into a health supporting environment for staff (**strategy STA-6**).

These strategies can be offered by hospitals, but also by other providers. Whether or not it makes sense for a hospital to offer one or more of these additional strategies for their staff will depend upon

- the prevalence of specific (work related) health problems of hospital staff (e.g. it may make sense to offer specific back care training for nursing personnel if there are many sick-leaves related to back problems, if there are no such services available in the region);
- the synergies to other strategies performed by the hospital (e.g. it may make sense to offer non-smoking counselling for staff if the hospital has set up a general smoke-free hospital policy, and if there are no such services available in the hospital region);
- specific strategic considerations of the hospital (e.g. further developing the community setting for hospital staff by offering adequate kindergarten services, by offering flats for a moderate rent, by offering reduced entrance fees to regional leisure facilities etc. may contribute to making the hospital a more attractive workplace and therefore to reducing staff turnover).

Many of the staff-oriented HPH core strategies which will be described in detail in the chapters below may complement each other and / or will lead to synergies if performed together (e.g. measures around strategies STA-1 and STA-2 will very often rely on complementary measures around strategy PAT-3). Therefore, it is possible and makes sense to combine staff-oriented strategies into **staff-oriented HPH policies**[65].

Given the range of the 6 staff-oriented strategies, all professional groups in the hospital are affected and can be involved.

65 But synergies can also be developed between patient and staff oriented strategies, e.g. strategies PAT-5 and STA-5 can be combined into a lifestyle development policy for patients and staff.

4.1 Core strategy STA-1: Health promoting work life in the hospital for staff

4.1.1 STA-1: Objectives

Strategy STA-1 aims at optimising the hospital's impact on staff's health during work life. This strategy is about respecting staff not only as members of the hospital's work force, but as human beings with human, somato-psycho-social (health) needs, which have to be addressed also during work life if staff are to maintain or even improve their positive health status. This refers to staff's

- physical health needs (e.g. supporting and empowering staff to eat healthy and culturally convenient food; to exercise; to make sufficient breaks; managing accident and infection risks);
- psychological health needs (e.g. supporting and empowering staff to develop coping strategies for stress at work; managing stressors within the hospital);
- social health needs (e.g. supporting and empowering staff to have social relationships also at work; to develop career perspectives; to keep work-life balance).

The success of strategy STA-1 will very much rely on the attitude of hospital management towards their staff: If staff feel supported and empowered to take care of themselves, they will be more likely to do so.

4.1.2 STA-1: Indications

- As stated in the WHO Ottawa Charter, health promotion is about improving health by enabling people to increase control over it.66 Being able to control one's health in a specific situation / setting becomes the more important, the more time people spend there.
- Therefore, it is necessary that staff can control their health at their work place, where they usually spend a considerable amount of time. The general self-management of personal somato-psycho-social health needs can be considered an important aspect of improving control over one's health.
- To be able to do so, hospital staff need information and orientation about the possibilities they have to self-manage their health needs at work (e.g. availability of infra structures / rules /regulations concerning recreation). Therefore, adequate accepting, supportive, empowering communication and interaction of management with their staff will contribute to maintaining staff's (occupational) health and is thus also an important precondition of staff's quality of work life67.
- This holds especially true for specific (vulnerable) groups of staff like migrant staff members or elderly staff members.
- In addition, in risky settings like the hospital (hospital staff are especially at risk of acquiring psychosocial health problems, back problems and infectious diseases68), the maintenance of personal health by self management includes also the management of risk factors within

66 (WHO 1986a)

67 see e.g. (Michie, Williams 2003) who state that lacking leadership competency, lacking social support and lacking possibilities for co-decision making at work are amongst the major courses for psychosocial ill health and related sick leaves

68 (European agency for safety and health at work 2000)

the setting. Staff therefore also need specific information and support to cope with work-specific risks.

Strategy STA-1 is indicated for all staff members from all professions and levels of hierarchy.

4.1.3 STA-1: Main topics / routines – selected examples, guidelines and evidence

Hospitals can support their staff's self management of physical health needs by:

1. Empowering staff to apply muscle- and joint-friendly working styles (e.g. Kinesaesthetics, lifting aids)
2. Developing work schedules that allow for necessary recreation breaks, for adequate food consumption during work
3. Providing adequate rooms for staff recreation (see also strategy STA-3);
4. Providing safe[69], ergonomic, and otherwise adequate working environments (see also strategy STA-3)
5. Offering exercise clubs etc. to encourage self management of physical health
6. Managing work related risks (e.g. accidents, contaminations)
7. Offering occupational health services (e.g. vaccination, infection prevention, ergonomic counselling)
8. Enable staff to eat healthy food (enough time, offer healthy food choices)

Hospitals can support their staff's self management of psychological / emotional health needs by:

9. Offering training for stress management[70] [71]
10. Offering training in time management
11. Offering counselling / coaching services
12. Supporting staff in keeping work-life balance (e.g. by staff-friendly work schedules)

Hospitals can support their staff's self management of social health needs by:

13. Providing mentoring / training / education for hospital staff in order to support professional development / career development[72]
14. Providing / developing social events at work (e.g. works outings, a regulars' table for staff, …)

4.1.4 STA-1: Possible combinations and synergies with other strategies

Strategy STA-1 will support the effective implementation of

69 see e.g. fact sheet "Safety and Health Good Practice on-line for the Healthcare Sector" by the European Agency for Safety and Health at Work (2002). Online availability: http://agency.osha.eu.int/publications/factsheets/29/en/index.htm

70 see e.g. document "Prevention of psychosocial risks and stress at work in practice" by the European Agency for Safety and Health at Work (2002). Online availability: http://agency.osha.eu.int/publications/reports/104/en/stress.PDF

71 Example from HPH network: "How to relax", Parádfürdő Hospital, Parád, Hungary: In order to restore their physical and mental power, staff get training for proper, adequate relaxation.

72 See e.g. project "career-focused mentoring: a school to career transition project", information online available at http://www.hospitalconnect.com/healthforum/hfeducation/chcfknight-kerr.html

- **strategy PAT-1** (*"health promoting living in the hospital for staff" – see chapter 3.1*), since staff who are empowered to take care of their own health needs are in a better position to empower their patients to do the same.
- of **strategy STA-2** (*"health promoting coproduction of staff in work processes" – see chapter 4.2*), since staff who act responsibly towards their own health are more likely to act responsibly in their professional relationships.

The effective implementation of strategy STA-1 will be enhanced by **strategy STA-3** (*health promoting hospital setting for staff – see chapter 4.3*), since specific aspects of health promoting self management for staff require preconditions in the hospital setting (e.g. recreation rooms).

4.2 Core strategy STA-2: Health promoting coproduction of staff in work processes

4.2.1 STA-2: Objectives

Taking further classical aspects of health and safety at work, the health promotion-specific aspect of strategy STA-2 is about optimising the health impact of work processes on hospital staff by empowering staff for health promoting co-production of these processes. This strategy refers especially to the development of health promoting work roles, work relationships and communication styles (e.g. leadership and management styles; information flow; transparency of decisions and work processes; participatory involvement of staff into decisions and work development processes). Executive personnel are therefore crucial for applying strategy STA-2 in hospital practice.

Hospital management can enhance the development of health promoting working roles and relations by empowering, enabling and supporting staff to engage in participation and co-production across hierarchical, professional and departmental boundaries[73].

4.2.2 STA-2: Indications

- Management styles (e.g. participatory / authoritative; gratification styles; information provision; orientation of staff with regard to their roles and tasks) are one of the most important factors for work satisfaction, work-related quality of life and work-induced health problems. These in turn have an influence on staff sick leaves[74], turnover rates, staff performance and visible outcomes of work (e.g. errors – as empowered staff are more likely to use health protection measures) [75].
- The development of management styles and organisational culture can therefore contribute to improving these factors.[76]
- There is also a number of examples from the International Network of Health Promoting Hospitals that prove the feasibility of measures around strategy STA-2 in the hospital.[77]

This strategy is also in line with the general health promotion principle of enablement (WHO, 1986), with the health promotion criteria “empowering” and “participatory”[78], and with findings of workplace health promotion[79].

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73 see e.g. (Michie, Williams 2003) who state that lacking leadership competency, lacking social support and lacking possibilities for co-decision making at work are amongst the major courses for psychosocial ill health and related sick leaves

74 See above

75 (Spence-Laschinger, Almost et al. 2003)

76 see above

77 Examples from HPH network: e.g. “Staff Empowerment Training at South Ostrobothnia Central Hospital, Finland”. In: Virtual Proceedings of 11th International Conference on HPH, online availability http://www.univie.ac.at/hph/florence2003/htm/virtual-proceedings/Vihriaelae-staff-empowerment.doc; see also model document in German language: “How a leadership training course for nursing personnel can be organised in the hospital” (Lobnig, Nowak et al. 1996a)

78 Rootman et.al. 2001

79 e.g. Luxemburg Declaration of Workplace Health Promotion

Strategy STA-2 is indicated for staff members from all professions and levels of hierarchy.

4.2.3 STA-2: Main topics / routines – selected examples, guidelines and evidence

Executive personnel can empower their staff for health promoting co-production of work / working roles / relations at work through

1. Improving / developing specific leadership competencies (e.g. conflict management; gratification styles; communication styles) e.g. by participating in leadership training[80]
2. Implementing introductory training and orientation phases for new staff members
3. Creating mechanisms for involving staff in participatory decision-making processes in areas where staff are affected (e.g. health circles for managing health risks / for developing health potentials)[81]
4. Implementing feedback mechanisms (e.g. staff interviews)
5. Implementing rules and regulations for coping with specific problems with regard to working roles and relationship, e.g. mobbing regulations, regulations for dealing with violence at work[82]
6. Considering individual strengths and weaknesses of staff when allocating tasks and responsibilities

Staff members can contribute to health promoting co-production of work by developing health promoting working roles and relations through

7. Making use of existing options for co-decision making and co-production – bringing in their expertise for their work role (e.g. by means of health circles)
8. Participating in trainings for improving communication skills
9. Using offers for counselling and coaching
10. Suggesting changes in work routines (e.g. “idea boxes”)

4.2.4 STA-2: Possible combinations and synergies with other strategies

Strategy STA-2 will also improve the realisation of strategy PAT-2 (*“health promoting coproduction of patients in treatment” – see chapter 3.2*), since staff who are empowered to co-produce their work, will be in a better position to involve patients in co-producing their health.

80 Example from HPH network: Model document on leadership training in nursing staff, (Lobnig, Nowak et al. 1996a)

81 see e.g. (Occupational Safety & Health Service 2002)

82 see e.g. (Occupational Safety & Health Service 1995)

4.3 Core strategy STA-3: Health promoting hospital setting for staff

4.3.1 STA-3: Objectives

Strategy STA-3 aims at optimising the hospital's health impact on its staff by developing the hospital setting into a more health promoting, empowering and supportive environment.

This refers to

- Infra structures / the material hospital setting (working environments) and
- socio-cultural aspects of the hospital setting (e.g. rules and regulations).

In the context of this paper, we understand "setting" as the situative material, social and cultural aspects of the hospital settings which form the precondition for many of the activities relating to other strategies. Therefore, strategy STA-3 will mostly be combined with other staff-related strategies.

4.3.2 STA-3: Indications

- Following health promotion concepts, the development of settings is an important health promotion strategy (see e.g. WHO 1986), since the material as well as the socio-cultural conditions within a setting can influence health directly (e.g. via the quality of air, via radiation), but they have also an important impact on health behaviours.
- Worksites are especially important settings, as adults usually spend a lot of time at work where they are exposed to numerous influences which is of importance for their life as a whole.
- Hospital staff form 3% of the total European work force. According to some studies, hospital settings are specifically risky work places (e.g. risk of exposure to toxic agents, radiation and germs; musculo-skeletal strains; necessity of shift work; high level of stress due to high responsibility, the contact with severely ill and dying patients, and the increasing acceleration of work as a consequence of the decreasing lengths of stays).
- Interventions to improve the setting as a working environment therefore seem to be of specific importance in hospitals. That's why already HPH policy documents like the Budapest Declaration on Health Promoting Hospitals and the Vienna Recommendations on Health Promoting Hospitals name numerous options around this topic.[83] There are also many examples from the HPH network which demonstrate the feasibility of developing the hospital into a more health promoting setting for hospital staff[84].

83 **Budapest Declaration**: Strategy 1: Provide opportunities throughout the hospital to develop health-orientated perspectives, objectives and structures., Strategy 3: Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and Improve the healing process. Strategy 6: Create healthy working conditions for all hospital staff. Strategy 7: Strive to make the HPH a model for healthy services and workplaces. Strategy 14: Improve the health promoting quality and the variety of food services in hospitals for patients and personnel. **Vienna Recommenmdations:** Implementation strategy 1.3: creating healthy working conditions for all hospital staff, including the reduction of hospital hazards, as well as psychosocial risk factors (Health Promoting Hospitals Network 1991)

84 see e.g. model document "How a hospital ward can be renovated together with affected staff" (Lobnig, Nowak et al. 1996b), online available in German at http://www.univie.ac.at/lbimgs/berichte/md3.PDF

4.3.3 STA-3: Main topics / routines – selected examples, guidelines and evidence

The material hospital setting / the hospital infrastructure can be (further) developed into a supportive setting for staff by reducing risks through:

1. Avoiding contact with dangerous materials and substances, e.g. latex, PVC, mercury, radiation, germs[85].
2. "Building green" (without toxic and dangerous materials) [86]
3. Implementing non-smoking areas in order to protect non-smokers
4. Providing clean air (e.g. by restricting smoking to specific areas in the hospital, or by reducing narcotic gases in operating theatres
5. Fulfilling all legal aspects of safety at work (depending from country to country)

The material hospital setting / the hospital infrastructure can be (further) developed into a supportive setting for staff by offering resources through:

6. Providing ergonomic devices (e.g. ergonomic chairs, lifting aids): There is evidence that these can minimise the incidence of work related injuries and malaises.[87]
7. Providing adequate recreation areas for staff
8. Providing healthy food for staff
9. Renovating hospital wards according to functional needs

The social and cultural hospital setting can be (further) developed into a supportive setting for staff by

10. Offering age-specific lengths of shift work
11. Organising tasks in a way that allow to have sufficient breaks

4.3.4 4STA-3: Possible combinations and synergies with other strategies

Strategy STA-3 should be planned together with

- **strategy STA-1** (*"health promoting work life in the hospital for staff" – see chapter 4.1*) and
- **strategy STA-2** (*"health promoting coproduction of staff in work processes" – see chapter 4.2*), as these strategies also need to be supported by conditions in the hospital setting.

It is advisable to plan and implement strategy STA-3 in relation to strategies PAT-3 ("*health promoting hospital setting for patients" – see chapter 3.3*) and COM-3 ("*health promoting hospital setting for citizens" – see chapter 5.3*), since the development of the hospital setting will influence all three target groups, which can lead to synergies but also contradictions between strategies PAT-3, STA-3 and COM-3. These synergies and contradictions can best be optimised when considering all relevant stakeholders at once.

85 Reference: Health Care Without Harm web-site: http://www.noharm.org/

86 see above

87 see e.g. (Stone, McCloy 2004)s

4.4 Core strategy STA-4: Health promoting illness management for staff

4.4.1 STA-4: Objectives

Strategy STA-4 is about improving the health outcomes of the hospital's illness management for staff who are affected by occupational or other illnesses. The specific HP contribution is realised by offering specific empowering services, e.g. education and counselling, to allow for a more health promoting management of physical, mental and social consequences of relevant occupational diseases and impairments, but also of other illnesses that affect staff. This strategy will enhance the disease specific quality of life of staff.

4.4.2 STA-4: Indications

- Hospitals present a number of specific health risks to their staff, those most often quoted include infections, injuries, musculo-skeletal impairments, and different stress symptoms[88]. Therefore, the prevention, retardation and health promoting managements of such impairments should be a priority in the hospital setting. Measures taken will of course have to be specific for specific health problems.
- Hospitals as risky and stressy workplaces are also difficult workplaces for staff with non-worksite-caused health impairments. In order to enable staff with health problems to remain in the work process and thus to prevent further deterioration, these staff members need specific support.

Strategy STA-4 is indicated for all members of staff with a limited health status, independently of the cause of the health problems (occupational or other).

As this strategy can (but does not have to be) offered by hospitals, hospitals may decide to perform measures around this strategy if a sufficient number of staff suffer from specific health problems (e.g. high frequency of sick leaves due to back problems).

4.4.3 STA-4: Main topics / routines – selected examples, guidelines and evidence

Empowering staff for health promoting management of physical health impairments:

1. Back care training[89]
2. Training for health promoting lifting techniques (e.g. kinaesthetics) and for the adequate use of lifting aids
3. Training for compensatory exercise, e.g. for members of administrative staff and staff working in hospital laboratories

88 see e.g. Canada's National Occupational Health and Safety Resource (http://www.ccohs.ca/oshanswers/occup_workplace/nurse.html); McAbee, R.R. (1988); see e.g. European Agency for Safety and Health (2000)

89 see e.g. (Occupational Safety & Health Service, Department of Labour 1993a; Occupational Safety & Health Service, Department of Labour 1993b)

Empowering staff for health promoting management of psychological health impairments:

4. Counselling for the health promoting self management of psychological health problems, e.g. stress, mobbing, burnout
5. Counselling for coping with alcohol or drug addiction

Empowering staff for health promoting management of social health problems:

6. Empowering and support staff with health impairments to remain in the work process

Reorganising of work processes in order to allow staff with health impairments to remain in the work process:

7. Making hospital facilities available for staff in need of these services (e.g. physiology)
8. Considering health impairments of staff when allocating tasks and responsibilities to staff members
9. Combine person-oriented empowerment strategies with developing supportive conditions in the hospital setting (e.g. implementation of lifting aids – see also strategy STA-3)

4.4.4 STA-4: Possible combinations and synergies with other strategies

It is advisable to combine **strategy STA-4** with **strategy STA-3** ("*health promoting hospital setting for staff*" – *see chapter 4.3*), since the empowerment of staff for the health promoting management of specific illnesses relies to a great extent on supportive conditions in the hospital setting.

It makes also sense to combine measures addressed at the management of specific illnesses with similar measures for patients (*see strategy PAT-4 "health promoting illness management for patients" – chapter 3.4*) and for the hospitals community (*see strategy COM-4 "health promoting illnesses management for citizens" – chapter 5.4*).

4.5 Core strategy STA-5: Health promoting lifestyle development for staff

4.5.1 STA-5: Objectives

Strategy STA-5 aims at improving the health outcomes of hospitals for their staff by empowering staff for health promoting life style development. This strategy is put into practice by offering specific empowering services, e.g. health education, training and counselling. This strategy will enhance the quality of life and longevity of staff.

4.5.2 STA-5: Indications

- Lifestyles (nutrition, exercise, substance (ab)use, stress management) have proven effects on clinical health indicators, quality of life and longevity[90].
- Hospital staff exhibit a relevant amount of lifestyle risks and problems (e.g. smoking, overweight due to nutrition problems and lack of exercise).
- The development of health promoting lifestyles can be successfully influenced by health promoting interventions like information, education, training, and counselling.[91]
- Hospitals have the potential (credibility, knowledge and skills) to offer lifestyle education and counselling services for their staff, and the practicability of such interventions is also demonstrated by projects of the International HPH network[92].

Measures in line with strategy STA-5 are indicated especially for
- Staff who exhibit unhealthy lifestyles (e.g. smokers, drinkers, “workaholics”)
- Staff suffering from chronic diseases (since healthy lifestyles may positively influence the retardation of the disease progress)

4.5.3 STA-5: Main topics / routines – selected examples, guidelines and evidence:

Lifestyles with specific impact on health and which should therefore be especially considered in lifestyle interventions are:

1. **Smoking**[93]: Measures may include the provision of smoking counselling for individuals or groups, nicotine replacement therapy for staff members, implementation of non-smoking areas in the hospital, non-smoking policies etc.
2. **Nutrition**: Measures may include specific individual or group counselling services, the provision of healthy food in the hospital canteen, the implementation of a nutrition policy, cooking workshops etc.
3. **Alcohol and substances**: Measures may include specific individual or group counselling services, the implementation of an alcohol policy (e.g. no alcohol at parties), etc.

90 see e.g. (World Health Organization 2002; Tubiana 2000; Willett 1995)

91 see Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO 1997)

92 example from HPH network: physical activity and exercise as a life-style model for medical personnel, Estonia; further information: helle.maeltsemees@itk.ee or Tiiu.harm@itk.ee

93 see e.g. (Taylor, Dingle 2004), (European Network for Smoke-free Hospitals 2001)

4. **Physical exercise**: Measures may include specific individual or group counselling, exercise training for individuals or groups, the implementation of staff sports clubs, access to local fitness studies at reduced fees, etc.94
5. **Stress**: Measures may include individual or group counselling, time and self management training, etc.

4.5.4 STA-5: Possible combinations and synergies with other strategies

Strategy STA-5 is best combined with

- **Strategy STA-1** (*"health promoting work life in the hospital for staff" – see chapter 4.1),* since staff who are encouraged to take care of their own personal health needs when working in the hospital will be better able to take over the responsibility to develop and maintain healthy lifestyles;
- **Strategy STA-2** *("health promoting coproduction of staff in work processes" – see chapter 4.2*), since staff who are encouraged to co-produce their health at work will be better able to take over the self-responsibility to develop and maintain healthy lifestyles;
- **Strategy STA-3** ("*health promoting hospital setting for staff" – see chapter 4.3*), since the provision of information, education, counselling and training services for health promoting life styles will also depend upon prerequisites in the hospital setting (e.g. rooms, specific policies like smoking or nutrition policies);
- **Strategy STA-4** (*"health promoting illness management for staff" – see chapter 4.4*), since the self management of diseases / impairments is often with specific lifestyles.

There are also synergies with **strategy PAT-5** (*"health promoting lifestyle development for patients" – see chapter 3.5*) and **strategy COM-5** (*"health promoting lifestyle development for citizens" – see chapter 5.5*), since general lifestyle interventions can be offered jointly for staff, patients and community members.

If hospitals are not offering lifestyle education and counselling services themselves, the hospital may also cooperate with lifestyle education and counselling services in the hospital community and develop quality assessment strategies, as well as referral procedures for these.

94 example from HPH network: physical activity and exercise as a life-style model for medical personnel, Estonia; further information: helle.maeltsemees@itk.ee or Tiiu.harm@itk.ee

4.6 Core strategy STA-6: Health promoting community setting for staff

4.6.1 STA-6: Objectives

Strategy STA-6 aims at improving the health impact of hospitals on their staff, by initiating or participating in specific local health promoting community development projects which aim at developing the living conditions / infrastructures in the local community to better meet the specific health needs of hospital staff.

4.6.2 STA-6: Indications

- The general living circumstances (e.g. noise, pollution, accessibility of public transport, availability of healthy food choices in local stores, road safety, …) have an impact on the health and quality of life of the population. Therefore community development is perceived a central health promotion strategy (see e.g. WHO 1986).
- Apart from these general living circumstances, health related demands on the environment may vary between different groups of the population because of their different (cultural) habits and values or because of their specific (work related) living circumstances.
- E.g. for hospital staff who have to work in shifts, their community setting should provide adequate opening hours of kindergartens and shops, have public transport available around the clock, have good streetlights in areas where female staff members have to walk home at night, etc.
- Examples from the International Network of HPH demonstrate the feasibility of specific measures around strategy STA-6 in the context of Health Promoting Hospitals95.

Measures in line with strategy STA-6 are indicated especially for all staff, but especially for those whose work and life situation can specifically benefit from the development of conditions in the community, e.g. staff on shift work or single parents.

4.6.3 STA-6: Main topics / routines – selected examples, guidelines and evidence

Contributions to facilitating health promoting work performance of staff:

1. Cooperating with authorities who are responsible for adequate streetlight in order to make commuting from home to work safer especially for female staff members;
2. Cooperating with authorities who are responsible for public transport around the clock in order to enhance safe commuting to and from work

Contributions to facilitating everyday life of staff:

3. Offering staff homes
4. Offering staff kindergarten or cooperating with authorities who are responsible for availability and opening times of kindergartens
5. Cooperating with authorities who are responsible for the opening times of shops, banks etc.

95 Examples from HPH network: e.g. onsite-creche for staff, Northern Ireland HPH network, further information mlafferty@alt.n.i.nhs.uk

Contributions to further health promotion for hospital staff:
6. Offering staff access to local sports and fitness facilities at reduced fees

4.6.4 STA-6: Possible combinations and synergies with other strategies

Strategy STA-6 can also be combined with **strategy PAT-6** (*"health promoting community setting for patients – see chapter 3.6*) and **strategy COM-6** (*"health promoting community setting for citizens" – see chapter 5.6*), since the combined application of community development strategies for all target groups of a Health Promoting Hospital may produce synergies for the benefit of all.

5 Community oriented core strategies

5.1.1 Core strategy COM-1: Health promoting access to the hospital for citizens

COM-1: Objectives

Strategy COM-1 aims at optimising the health outcome of the hospital for members of its community by improving an adequate health promoting access to hospital services (i.e. to reduce over- as well as under-use) for citizens. The goal of this strategy is to improve the effectiveness of hospital services by improving both the timeliness and the scope of access of patients, as well as the quality of admission.

5.1.2 COM-1: Indications

- Adequate access to hospital services is a precondition for effective treatment in the hospital.
- But according to some estimations the percentage of wrongly allocated patients is rather high.
- Health care services in general are less often frequented by members of disadvantaged groups, although hospitals are very often the first entry point into the health care systems for members of these groups.
- Thus, there is a high potential for improving the effectiveness of hospital services, and by that the health of (specific) groups of potential patients, by improving adequate access to the hospital in cooperation with relevant partners (e.g. extramural health care providers / referring practitioners; cultural communities).
- Therefore, improved access to the hospital is also a desideratum in policy papers on hospital reform like e.g. the Ljubljana Charta on Health Care Reforms[96].
- Examples demonstrate that hospitals can successfully improve their admission policies[97].

Measures in line with strategy COM-1 are indicated for all potential users of hospital services in the local community, but especially for members of disadvantaged groups of the local population, e.g. ethnic minorities or socially deprived groups.

5.1.3 COM-1: Main topics / routines – selected examples, guidelines and evidence

Measures within the hospital

1. Provide clear information about hospital admission via the hospital web-site / via hospital media
2. Have interpreters available at hospital admission[98]

96 *as is also demanded by the Ljubljana Charter on Health Care Reforms (WHO - Europe 1996)*

97 see e.g. fact sheet "Improving interpreting services for clinical communication" from the European project "Migrant Friendly Hospitals; online availability: http://www.mfh-eu.net/public/resources/mfh_subproject_a_fact_sheet_public.pdf

98 see above

Measures in cooperation with regional health care providers

3. Provide adequate information about hospital admission for general practitioners and other health service providers in the hospital community (e.g. develop admission protocols for specific diagnoses);
4. Empower health care providers in the community to avoid unnecessary hospital stays by providing hospital at home services

Measures in cooperation with (representatives of) the local population

5. Use information channels within the community (e.g. regional web platforms, journals) to distribute relevant information about adequate hospital admission
6. Use information channels of regional subcultures / cultural communities (e.g. web-sites, journals, meetings) for disseminating information about adequate hospital admission

5.1.4 COM-1: Possible combinations and synergies with other strategies

It is advisable to develop measures around **strategy COM-1** together with measures in line with **strategy COM-2** (“*health promoting coproduction with services in the region” – see chapter 5.2*), since they partly involve the same partners.

Core strategy COM-2: Health promoting coproduction with services in the region

5.2.1 COM-2: Objectives

Strategy COM-2 aims at optimising the health outcomes of hospital treatment and care for patients by securing an optimal health promoting continuity of care. This goal is achieved by empowering, enabling and supporting the carers who come before and next in the network of care.

5.2.2 COM-2: Indications

- A lack in the continuity of care can reduce the effectiveness of hospital care and the chance of health outcomes, quality of life and satisfaction of patients, because a discontinuity of care may result in
    - a prolonged length of hospital stay (e.g. because a lack in cooperation between referrers and hospital at admission makes it necessary to invest time into [repeated] diagnoses);
    - an increased risk of losing health gain which was achieved during hospital stay again after discharge (e.g. when patients face treatment gaps after discharge).
    - an increased risk of early re-admissions to the hospital
- This is even more so for patients with longer patient careers (e.g. chronic patients / patients who are treated sequentially by different health care providers / patients in need of rehabilitation after hospital stay).
- Thus, contributions of the hospital to improve continuity of care by better cooperation with other health care providers may greatly contribute to improving the sustainability of health gain, quality of life and satisfaction of patients and are therefore also listed as central

strategies in HPH policy documents (e.g. Budapest Declaration and Vienna Recommendations on Health Promoting Hospitals[99]).
- Examples from the International Network of HPH demonstrate the feasibility of improving cooperation with other health care providers[100].

Measures in line with strategy COM-1 are indicated for all hospital patients, but especially for those with chronic conditions or patients in need of rehabilitation after discharge.

99 **Budapest Declaration**: Strategy 9: Improve communication and collaboration with existing social and health services in the community. Strategy 17: Develop an epidemiological data base in the hospital specially related to the prevention of illness and injury and communicate this information to public policy makers and to other institutions in the community. **Vienna Recommendations**: Implementation strategy 2.4: improving the hospital's communication and cooperation with social and health services in the community, community-based health promotion initiatives and volunteer groups and organisations, and thus helping to optimise the links between different providers and actors in the health care sector (Health Promoting Hospitals Network 1991)

100 see e.g. chapter "Promoting integrated care" in Virtual Proceedings of 11th International Conference on HPH; online availability: http://www.univie.ac.at/hph/florence2003/htm/details/virt-proc-gesamt.htm

5.2.3 COM-2: Main topics / routines – selected examples, guidelines and evidence

Cooperation with other levels of care in order to secure continuous treatment of patients

1. Develop / improve guidelines / standards for admission and discharge, e.g. cooperate with referring doctor or other health care professional at admission; involve family doctor / nurse / social worker / lay carers in the discharge process;
2. Improve flow of information between hospital and other levels of care, e.g. implement electronic information systems which facilitate the transfer of patient data between different levels of care[101];
3. Develop a network of carers, including the hospital and all other relevant levels of care, with a common framework of regulations for cooperation.

Cooperation with other levels of care in order to improve professional quality

4. Organise joint professional training for health care professionals from the hospital and the extramural health care sector

5.2.4 COM-2: Possible combinations and synergies with other strategies

Measures in line with **strategy COM-2** should be combined with **strategy COM-1** (*Health promoting access to the hospital for citizens – see chapter 5.2*), since both strategies involve partly the same partners .

101 Example from HPH network: HPH and GP project, Hungarian Network of HPH: The main aim is to organise discharge in cooperation with the GP service who will follow up treatment. GPs are requested to consult with hospital doctors, and lectures are held for GP's postgraduate training.

5.3 Core strategy COM-3: Health promoting hospital setting for citizens

5.3.1 COM-3: Objectives

Strategy COM-3 aims at optimising the long term health impact of the hospital as a material and socio-cultural environment for the (neighbouring) community population, whose health may be affected by hospital decisions and actions. The aim is to develop the hospital into a more health promoting and empowering supportive setting for these stakeholders.

5.3.2 COM-3: Indications

- Settings in general have an impact on the people affected by them.
- So as other big enterprises, the inputs and outputs of hospital settings produce specific environmental risks (e.g. waste, transportation), but provide also specific resources (e.g. they are important regional purchasers) for their surrounding neighbourhood[102].
- Hospitals can successfully reduce these risks for the community and increase their respective resources[103] by environmental (quality) management strategies (e.g. EMAS, ISO).This is also demanded by HPH policy documents like the Budapest Declaration and the Vienna Recommendations on Health Promoting Hospitals[104], and in the policy of the International Council of Nursing (ICN)[105]. The feasibility of measures in line with this strategy, and in some cases even their cost-reducing effect, has been demonstrated by projects in the International Network of HPH.

5.3.3 COM-3: Main topics / routines – selected examples, guidelines and evidence

Hospitals can contribute to a more health promoting hospital setting for citizens by improving their inputs:

1. Consider ecological aspects in purchasing goods (e.g. ecological food; bio-degradable cleaning agents; prefer goods from the neighbourhood in order to avoid long transportation);
2. Reduce energy consumption of the hospital (e.g. by better isolation of buildings, energy-saving equipment, separate).
3. Reduce traffic to (and from) the hospital (e.g. by improving accessibility of the hospital by public transport; offering tickets)
4. Make traffic around the hospital safe[106]

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102 See e.g. “Health Care without Harm”, online information at http://www.noharm.org/

103 E.g. the Vienna Hospital Association has launched a policy that hospitals should purchase goods in the near community if possible, and that biological food products are to be preferred.

104 Budapest Declaration: Strategy 3: Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process. Vienna Recommendations: Hospitals are producers of large amount of waste. They can contribute to the reduction of environmental pollution and, as consumers of large amounts of products, they can favour healthy products and environmental safety. (Health Promoting Hospitals Network 1991)

105 The council adopted its policy on “Medical Waste: Role of nurses and nursing” in 1998. Online availability: http://www.icn.ch/policy.htm

106 Example from HPH network: “Care of public roads”, Hungary: The project takes care of clean road surfaces, frost free roads in winter, anti slippery pavements, and the using of sand instead of sodium or magnesium chemicals for frost prevention.

Hospitals can contribute to a more health promoting hospital setting for citizens by improving their outputs:

5. Consider ecological aspects in waste, waste water and emission management; (e.g. collect goods for recycling; have a separate canalisation system for drugs / medication contaminated sewage; reduce and ecologically dispose of chemical and biological pollutants in used air and water, e.g. antibiotic relay, CO2, Cytostatica, dioxin, mercury and fluorocarbon from cooling systems, nuclear, biological and chemical residues)

5.3.4 COM-3: Possible combinations and synergies with other strategies

It is advisable to plan and implement measures in line with **strategy COM-3** together with measures around

- **strategy STA-3** (*"health promoting hospital setting for staff" – see chapter 4.3*) and
- **strategy PAT-3** (*"health promoting hospital setting for patients" – see chapter 3.3*), since there will be some overlaps but also contradictions in further developing the hospital into a health promoting setting for patients, staff and citizens. These can best be optimised when considering all relevant stakeholders at once.

5.4 Core strategy COM-4: Health promoting illness management for citizens

5.4.1 COM-4: Objectives

Strategy COM-4 is about improving the hospital's health outcomes for the general population in the local community, by offering specific empowering services, e.g. patient education, to allow for a more health promoting management of physical, mental and social consequences of chronic illness. This will also enhance the (disease specific) quality of life of citizens.

5.4.2 COM-4: Indications

- Citizens' knowledge and skills with regard to possible impairments and (chronic) diseases (specific health / illness literacy) are important preconditions for their successful self care, and by that, they are important determinants of recuperation processes, the retardation of the progress of diseases, and the (disease specific) quality of life.
- There are many examples for information, education, counselling and training being adequate means to empower people for disease-specific self care by providing them with the necessary knowledge, preferences and skills. 107
- Related measures are also in line with the Ottawa-Charter on Health Promotion108.
- Adequate information and training measures, especially with regard to chronic diseases (e.g. diabetes), are already part of the standard procedure **for in-patients** in many hospitals, and their feasibility has been successfully demonstrated by numerous projects in the International Network of HPH. But there are also examples that hospitals can offer such services successfully also for the local population. 109

Measures in line with strategy COM-4 are indicated especially when there are no other providers for information, education and training services on specific illnesses for which there is a certain demand in the local community.

For some groups of citizens (e.g. babies, elderly, handicapped), measures around strategy COM-4 need to involve relatives / proxies / lay carers, but also health care providers in the community in some cases (see also strategy COM-2, *"health promoting coproduction with services in the region"*).

5.4.3 COM-4: Main topics / routines – selected examples, guidelines and evidence

Experience exists especially around illnesses with specific relevance for public health like
1. Asthma110
2. Diabetes 111

107 see e.g. (Devine, Pearcy 1996; Hirano, Laurent et al. 1994; Lacasse, et al. 1996; Mazzuca 1982; Smith, et al. 1992)

108 WHO: „Enabling people to learn throughout life, to prepare themselves for all of its stages and to **cope with chronic illness and injuries is essential**." (WHO 1986b)

109 e.g. smoking cessation clinics in Estonian HPHs

110 see e.g. (Williams, Schmidt et al. 2003)

3. Cancer112
4. COPD113
5. Coronary heart problems
6. Specific recuperation and rehabilitation processes

5.4.4 COM-4: Possible combinations and synergies with other strategies

The implementation of strategy COM-4 will be improved if it can rely on or follow up on

- **Strategy COM-2** *("health promoting coproduction with services in the region" – see chapter 5.2*), since citizens with (chronic) health problems do not only need to self-manage their condition, but they will also need to co-produce their health together with regional services.

For some indications, it will be possible to organise information, education, counselling and training services for citizens jointly with hospital patients (see also **strategy PAT-4,** *"health promoting illness management for patients" – see chapter 4.4*), and hospital staff (see also **strategy STA-4**, *"health promoting illnesses management for staff – see chapter 4.4*).

111 see Mühlhauser I., Berger M. (2000), cited above

112 (Zuk, Quinn 2002)

113 see e.g. Kane G.C., Graham M.G. (2004): An evidence based approach to COPD. In: Jaapa Archives. Online available at http://www.memag.com/be_core/content/journals/j/data/2004/0401/w0404copd.html, in which they state that an optimal treatment plan for COPD will begin with patient education.

5.5 Core strategy COM-5: Health promoting lifestyle development for citizens

5.5.1 COM-5: Objectives

Strategy COM-5 aims at improving the outcome of hospital services for the general population in the local community, by offering specific empowering services for building up the specific health literacy for the development and maintenance of health promoting life styles.

5.5.2 COM-5: Indications

- Lifestyles (nutrition, exercise, consumption of substances like alcohol, nicotine) have proven effects on clinical health indicators, quality of life and longevity[114].
- Health promoting lifestyles can be successfully influenced by information, education, training and counselling services.
- Hospitals have the potential (credibility, knowledge and skills) to offer effective lifestyle education and counselling services not only for their inpatients, but also for the general community population.
- Numerous examples from the International Network of HPH demonstrate the feasibility of such strategies in hospitals.[115]

Measures in line with strategy COM-5 are especially indicated for those lifestyles which promise the biggest effects on health:
- Smoking
- Nutrition
- Exercise

5.5.3 COM-5: Main topics / routines – selected examples, guidelines and evidence

Lifestyles with specific impact on health and which should therefore be especially considered in lifestyle interventions are:
1. Breast feeding[116]
2. Alcohol prevention
3. Smoking prevention / cessation[117] [118]
4. Coping with stress[119]
5. Sexual health[120]
6. Physical exercise
7. Healthy nutrition

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114 see e.g. (World Health Organization 2002; Tubiana 2000; Willett 1995)

115 see e.g. chapter on "tackling smoking" in the Virtual proceedings of the 9th International Conference on HPH, online availability http://www.univie.ac.at/hph/9ic/proc9ic.html

116 see e.g. (Wang 1994)

117 see e.g. (Taylor, Dingle 2004), (European Network for Smoke-free Hospitals 2001)

118 example from the HPH Network: Smoking cessation clinics for patients, Estonia (contact: ylle.ani@kliinikum.ee

119 By some, stress is already called the "public health enemy no. 1". For further online information, see http://www.betterlife.com/education/topic_307.html

120 see e.g. (Feldman, Martell et al. 2004)

5.5.4 COM-5: Possible combinations and synergies with other strategies

It is possible to offer lifestyle interventions for citizens jointly also for patients (*see strategy PAT-5 "health promoting lifestyle developoment for patients", chapter 3.5*), and for staff (*see strategy STA-5, "health promoting lifestyle development for staff, chapter 4.5*).

5.6 Core strategy COM-6: Health promoting community setting for citizens

5.6.1 COM-6: Objectives

Strategy COM-6 aims at improving the hospital's health impact on citizens by initiating or participating in specific health promoting community development projects or programs, which aim at improving the health related general living and working conditions (housing, traffic, nutrition etc.).

5.6.2 COM-6: Indications

- As already stated by the WHO Ottawa Charter (WHO 1986), the general living circumstances (e.g. noise, pollution, accessibility of public transport, availability of healthy food choices in local stores, road safety, …) have an impact on the health and quality of life of the population. Therefore community development is perceived as a central health promotion strategy.
- Hospitals (often as biggest regional health care provider) can use their patient data to generate an overview on the most important health problems in their region. They can use these data to inform local authorities and to initiate preventive and health promoting measures.121
- Furthermore, hospitals have a lot of knowledge and expertise which they can bring into regional health promotion programs / projects (alliances for health / ZITAT).
- Examples from the International Network of HPH demonstrate that hospitals can successfully initiate / contribute to specific health related community development programs / projects. 122

Measures in line with strategy COM-6 are indicated especially when a hospital detects that specific health problems are above-average in the region.

121 Example from the HPH network: "Healthy playground project", University hospital Graz, Austria: Data from the department for paediatric surgery were used to identify causes of playground accidents. In order to prevent these accidents, the hospital initiated the development and implementation of a "safe playground" accreditation scheme for playgrounds.

122 Examples from the HPH network:

- Graz University Hospital (Austria) initiated a traffic safety campaign after having identified some „hotspots" for traffic accidents with children in the city of Graz.
- Linköping University Hospital (Sweden) co-operated with supermarkets in order to increase provision of healthy goods)
- Northern Ireland HPH Network: School Aged Mothers Project

5.6.3 COM-6: Main topics / routines – selected examples, guidelines and evidence

Measures around strategy COM-6 may include:

1. Analysis of hospital data to identify major health problems in the community
2. Use of hospital data for regional health reporting
3. Initiation of / participation in healthy alliances (e.g. in the framework of Healthy Cities, Healthy Enterprises, Healthy Schools initiatives) to improve the local health situation[123]

5.6.4 COM-6: Possible combinations and synergies with other strategies

In order to make use of synergies, measures around **strategy COM-6** should ideally be set up in concordance with measures around **strategy PAT-6** *("health promoting community setting for patients" – see chapter 3.6)* and **strategy STA-6** ("*health promoting community setting for staff – see chapter 4.6"*).

123 See above.

6 HPH thematic policies:

In order to use synergies within and across the core strategies (and building up on Rootman's health promotion principle of "multistrategy"), it can be proposed that hospitals follow specifically focused, comprehensive, thematic health promoting policies around specific health factors or determinants, rather than to focus on single strategies.

In the description of the 18 HPH core strategies, possible synergies with other strategies were already pointed out. In general, HPH policies can focus on

- specific target groups (e.g. patient orientation policy; staff orientation policy, community orientation policy);
- specific lifestyles, self care / self management processes (e.g. smoke-free hospital policy; hospital nutrition policy);
- specific illnesses (e.g. hypertension prevention policy);
- the hospital setting (e.g. air an light policy);
- the community setting (e.g. accident prevention policy).

So as between the strategies, there can also be synergies and contradictions between HPH thematic policies, so they need to be matched and tuned with each other in order to become useful instruments of HPH action. Policies should be developed according to the specific strengths, development areas and areas of expertise of a specific hospital. The following list provides examples for possible HPH policies.

Examples for target group specific policies – patients:
1. Migrant friendly hospital policy124
2. Patient orientation policy
3. Patient communication policy
4. Patient-friendly day schedules policy
5. Patient privacy policy
6. Patient safety policy
7. UNICEF Baby friendly hospitals initiative125

Examples for target group specific policies – staff:
1. Workplace health promotion policy
2. Family friendly workplace policy
3. Participatory management policy
4. Staff safety policy
5. Age-specific working hours policy

Examples for target group specific policies – community:
1. Socially disadvantaged groups support-policy

Examples for lifestyle specific policies:
1. Alcohol policy
2. Exercise policy
3. Nutrition policy

124 see e.g. European project "Migrant friendly hospitals", www.mfh-eu.net
125 For further information, see http://www.unicef.org/programme/breastfeeding/baby.htm

4. Physical activity policy
5. Smoking policy
6. Stress management policy

Examples for illness specific policies:
1. Alcohol addiction prevention policy
2. Diabetes policy

Examples for hospital setting policies:
1. Architecture, design and landscaping policy
2. Clean air policy
3. Ecological material policy
4. Ecological purchasing policy
5. Energy consumption policy
6. Cleaning management
7. Ergonomics policy
8. Hygiene policy
9. Latex-free-policy
10. Light policy
11. Noise reduction policy
12. Safety policy
13. Traffic policy
14. Waste, waste water and emission management policy (environmental management policy)

Examples for community setting related policies
1. Health information policy
2. Health reporting policy
3. Health care network policy (network with other care providers)
4. Healthy alliances policy (including schools, enterprises, …)

7 Challenges and basis for implementing Health Promoting Hospital strategies

7.1 Challenges for implementation of health promotion strategies in hospitals

The introduction of a holistic and more complex understanding of health (expected health outcomes) and the production of health in the hospital, as explained in the 18 HPH core strategies, has to be followed by more comprehensive and complex processes and structures in the hospital organisation.
These processes and structures have to be integrated into all existing procedures and be accepted and followed by everybody working in the hospital. This cannot be implemented by just making some structural changes in hospitals, but the introduction of these paradigm extensions requires basic changes in the culture of the hospital and the culture of the professionals working there.
These changes best have to start in the basic professional education and be supported by specific further education and training for health promotion in hospitals.
Without initiative and strong leadership support, this kind of culture change will not happen, and not develop in a sustainable way in hospitals.

The three health promotion potentials (of achieving improved short-term, mid-term and long-term health outcomes) provide quite different challenges for implementation in hospitals.
Some specialised health promotion strategies need to be implemented by adding on new – or by differentiating already existing – departments or positions / roles in hospitals. This could be either

- units for rehabilitation, prevention, health education / promotion, safety & occupational health or even community development,
- or new types of professionals like rehabilitation specialists, psychologists, education specialists, social workers, specialists for hygiene, occupational health, health promotion, or even sociologists etc.

7.2 Practical experience

Since the existence of the international HPH network, and of course also before and outside of it, hospitals all over the world have developed and implemented health promotion solutions, although these have been rarely properly documented and evaluated. But there are examples of good and best practice, which demonstrate that effective solutions can be successfully implemented by hospitals.

Descriptions of these solutions have been presented at HPH and other conferences, have been published in the HPH newsletter, in conference proceedings and other journals, and they can be found in the HPH project data base and at other websites.

7.3 Political declarations and professional recommendations

Based on research experience, evidence, and consensus processes, many agencies investing in health policy, lead by WHO, the World Bank, EU have laid down principles and declarations supporting the implementation of health promotion principles and practices (in hospitals).
The same holds true for professional bodies and NGOs like IUHPE, European Network of Workplace Health Promotion, and others who have developed health promotion relevant materials, guidelines and recommendations.

7.4 The implementation of health promotion into hospitals as a specific quality improvement strategy – principal approaches

The introduction of health promotion strategies does not just happen or cannot just be left to chance in hospitals. Health promotion strategies have to become an integral part of the official hospital (quality) policy, and be institutionalised and supported in a systematic fashion, analogous to quality management.

We propose therefore to understand HPH as a specific strategy to improve hospital quality by developing

- health promotion processes,
- health promotion structures and
- a specific health promotion quality system

As we can see from quality management, there are two principal approaches to implement good quality (in hospitals):

1. Single quality development projects
2. Comprehensive “total” quality management

7.5 Single health promotion project approach

Health promotion can be implemented into hospitals by selected health promotion projects, to realise specific health related aims or solve specifically assessed health problems of a hospital, a strategy which has been followed by many hospitals within the last decennium.

Health promotion implementation projects have to follow the usual project implementation cycle: setting goals → assessing problems (and causes) → planning and implementing measures (using best available evidence for section of measures) → evaluation → and so on.

Evaluation should follow 7 principal criteria in 3 phases:

1. **comprising a feasibility study (criteria 1-3)**
   - Plausibility of intervention
   - Acceptability for stakeholders
   - Socio-technical feasibility of measure in a specific context
2. **quality monitoring or process evaluation (criteria 4)**
   - Quality of implementation of measure

3. **outcome evaluation (criteria 5-7).**
   - Effectiveness (outcome & impact)
   - Sustainability
   - Cost-effectiveness/ efficiency

But in order to follow health promotion principles not only in content, but also in process, the development of a health promotion project (planning, implementation and evaluation) has to be done in a participatory manner including all relevant stakeholders involved in and affected by the issue in question. So, following health promotion principles, standards have to be formulated concerning the adequate health promoting development of projects.

7.6 The continuous, complete, comprehensive, holistic, overall or total HPH approach

But to become a Health Promoting Hospitals is more than the occasional tackling of health promotion projects in a hospital. There is a (more or less) total approach of HPH evolving, which could be understood as a systematic, comprehensive and continuous organisational development strategy or process, comparable to other comprehensive strategies which are already (partly) followed or could be used by hospitals, like (total) quality management (e.g. EFQM or CQI, Kaizen), learning or intelligent organisation.

To be effectively implemented and realised, such comprehensive developmental approaches have to rely on a specific organisational subsystem institutionalised within the hospital, specialised for and focused on initiating and supporting the development process throughout all the sub-units of the hospital.

Therefore, what a “quality management system” (e.g. SO 9000 certification) is for hospital total quality policy, a “health promotion management system” will be for total HPH policy.

A number of necessary or favourable characteristics of a health promotion management system, in the sense of a specific supporting system for continuous and comprehensive implementation of health promotion, can be identified. For these characteristics criteria can be formulated, which have to be developed into health promotion standards and integrated into protocols and guidelines:

7.7 List of criteria for a health promotion management system in a HPH – Outcome

There have to be explicit

- goals,
- criteria,
- standards and
- indicators for health promotion outcomes,
- (as well as for health promotion processes, for health promotion structures and for health promotion quality monitoring)
- so that fulfilment of being a HPH can be regularly observed, monitored, documented, evaluated, reported and improved.

7.8 List of criteria for a health promotion management system in a HPH – Structure

- Health promotion as explicit aim and value in **mission statement** of hospital (should include reference to patients rights, health of patients, staff and community etc.)
- Formulated health promotion **strategic policy document**, specifying aims, goals, targets and health promotion principal and core strategies and policies to reach them
- Specific annual health promotion **action plan**
- Specific **budget** ear-marked for health promotion
- Specific health promotion **management structure**
  - health promotion **steering committee** (including a member of the directorate of the hospital),
  - **health promotion manager / tea**m (reporting directly to directorate of hospital),
  - network of health promotion **focal points** in all sub-units of hospital
- Specific health promotion **organisational manual**

7.9 List of criteria for a health promotion management system in a HPH – Processes

- Regularly **monitoring, evaluation, reporting** and improvement initiatives of health promotion outcomes and impact (by surveys, balanced score card, reporting)
- Regularly health promotion information and **health promotion involvement** of staff and leadership
  - health circles,
  - employee suggestion system
  - implementation projects
  - news-letters,
  - annual presentations,
  - forum on website
- Health promotion **education and training** for staff and leadership
- Regularly conducting **health promotion projects** for planning and implementation of specific health promotion policies
- Regular involvement of hospital in **healthy alliances and partnerships** with other partners in local community

8 Glossary

The intention of this glossary is to propose the usage of specific terms of relevance which are used in this paper.

Coproduction

Disease (vs. positive health): an impairment of the normal state of an organism that interrupts or modifies its vital functions." (Encyclopädia Britannica; http://www.britannica.com/), but we propose to use the term disease for mental and social impairments as well

Empowerment: accepting, encouraging, respectful, supportive information, communication and interaction which takes into account the abilities, disabilities, background and (cultural) preferences of the person or group to be empowered. The aim is to improve the control of an individual or a population over its / their health determinants / health factors.

Health: : a quality of human beings (living systems) related to their capacity of self-reproduction / self-maintenance in time, which can be observed in a multi-dimensional (>) way. health is a multi-dimensional quality, i.e. it can be observed concerning at least 4 different dimensions: ill/ well-functioning/ feeling, absence of disease (>)/ presence of positive health (>), somatic/ mental/ social, individual/ population

Health gain (vs. loss): the sum of health outcomes and health impacts, attributable to a specific intervention, action, behaviour or to an actor, an object or a situation.

Health impact (vs. outcome): rather diffuse and unintended health related consequences of an object, a situation, or an action

Health literacy: positive health /disease related knowledge, skills and attitudes of an individual or population

Health promoting hospital: a hospital that is engaged to improve its health gain by systematically, continually and comprehensively applying HP core strategies and policies

Health promoting (vs. healthy): health improving, i.e. disease reducing or positive health developing, qualities or health outcomes, attributable to an object (e.g. medication), a situation or an action (e.g. treatment, rehabilitation, training)

Health promotion: Following the WHO Ottawa Charter (WHO 1986), health promotion is the process of enabling people to increase control over, and to improve their health.

Health promotion management system in a HPH: organisational structures and processes institutionalised in a HPH to initiate and support a total HPH approach to optimise the health gain of the hospital (see chapter 7 of the paper)

Healthy (vs. health promoting): health maintaining, i.e. positive health protecting and disease preventing, qualities or positive health impact, attributable to an object, situation or action

Illness: not only the clinical condition, but also the subjective well-being / quality of life which result from a specific disease

Positive health: physical/somatic, mental and social health resources of individual human beings or populations: well functioning (fitness) (with vital functions at its core), self-perceived somato-psycho-social well being (wellness), (specific) health literacy, immune status, psychological integrity, social status. Positive health can be defined as a person's health minus a person's disease).

Reproduction: systems theory term referring to the fact that each system can only exist when it is able to continuously re-produce itself.

Reproduction of health: the way a human being (living system) reproduces his / her / its physical, psychological and social status by adequate behaviour and action

Setting (vs. lifestyle) approach in HP: a comprehensive strategy to improve the health of a human population, by improving the health gain attributable to an organisation (business enterprise, hospital, prison, school, university) or community (city, island, village) by health related organisational or community development

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