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Health promotion in hospitals:

Evidence and quality management



Health Promotion in Hospitals: Evidence and Quality Management

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ABSTRACT

More than a decade ago the WHO Health Promoting Hospitals project was initiated in order to support hospitals towards placing greater emphasis on health promotion and disease prevention, rather than on diagnostic and curative services alone. Twenty hospitals in eleven European countries participated in the European pilot project from 1993 to 1997. Since then, the International Network of Health Promoting Hospitals has steadily expanded and now covers 25 Member States, 36 national or regional networks and more than 700 partner hospitals.

But, what has been achieved with regard to the implementation of health promotion services at both hospital and network level? Is there an evidence base for health promotion and has this facilitated the expansion of health promotion services in hospitals? And how can we evaluate the quality of health promotion activities in hospitals?

This volume addresses some of these key issues in health promotion evaluation and quality management and is intended to help health professionals and managers to assess and implement health promotion activities in hospitals.

Keywords

HOSPITALS - standards
HEALTH PROMOTION -standards
QUALITY OF HEALTH CARE
PROGRAM EVALUATION
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Introduction (Mila Garcia-Barbero)

More than a decade ago, the WHO Health Promoting Hospitals (HPH) project was initiated in order to support hospitals towards placing greater emphasis on health promotion and disease prevention, rather than on diagnostic and curative services alone. The Health Promoting Hospitals strategy focuses on meeting the physical, mental and social needs of a growing number of chronically ill patients and the elderly; on meeting the needs of hospital staff, who are exposed to physical and psychological stress; and on meeting the needs of the public and the environment.

Twenty hospitals in eleven European countries participated in the European pilot project from 1993 to 1997. Since then, the International Network of Health Promoting Hospitals has steadily expanded and now covers 25 Member States, 36 national or regional networks and more than 700 partner hospitals.

But, what has been achieved with regard to the implementation of health promotion services at both hospital and network level? What is the scope of health promotion activities in hospitals and how can the principles laid out in the Ottawa Charter for Health Promotion be put into practice? Is there an evidence base for health promotion and has this facilitated the expansion of health promotion services in hospitals? Is health promotion a service anyway? How does health promotion relate to quality management? And how can we evaluate the quality of health promotion activities in hospitals?

This volume provides a review of the background of the Health Promoting Hospitals project and addresses some of the key issues in health promotion evaluation and quality management:

Chapter 1 gives an overview on the principles and concepts of health promotion in hospital, summarizes the rationale and development of the Health Promoting Hospitals movement and raises a range of issues on the evaluation and implementation of health promotion activities in hospitals.

Chapter 2 presents a summary of the evidence base for disease-specific and for general health promotion activities in hospitals indicating the level of evidence for major health promotion interventions.

Chapter 3 offers many conceptual innovations in thinking about the strategic importance of health promotion in hospitals and describes 18 core strategies for health promotion in hospitals.

Chapter 4 describes the importance of using quality standards to assess health promotion in hospitals and describes the properties of the five standards developed to support implementation of health promotion activities.

Chapter 5 finally offers valuable insights in the implementation of health promotion activities in hospitals through a combined application of the European Foundation for Quality Management (EFQM) excellence model with the Balanced Scorecard approach.

This book is intended to help health professionals and health managers to assess and implement health promotion activities in hospitals. We hope that the principles, evidence, strategies, tools and quality standards presented in this volume support practical application and thus help hospitals ensuring safe, high quality and effective health care.

Health promotion in hospitals - From principles to implementation (Oliver Groene)

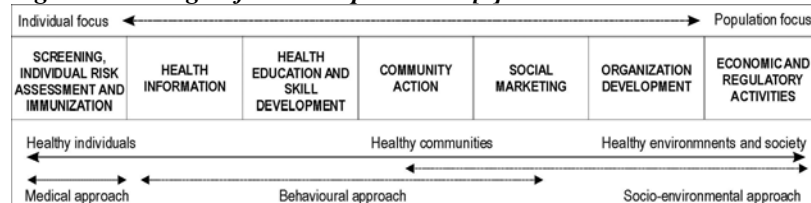
Health promotion: definition and concept

Health promotion measures focus on both individuals and on contextual factors that shape the actions of individuals with the aim to prevent and reduce ill health and improve wellbeing. Health in this context not only refers to the traditional, objective and biomedical view of the absence of infirmity or disease but to a holistic view that adds mental resources and social well-being to physical health [1, 2]. Health promotion goes beyond health education and disease prevention, in as far as it is based on the concept of salutogenesis and stresses the analysis and development of the health potential of individuals [3].

The scope of *disease prevention* has been defined in the Health Promotion Glossary as “measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established” [4]. The same source defines the scope of *health education* as comprising “consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and community health”. Health promotion is defined as a broader concept in the WHO Ottawa Charter as “the process of enabling people to increase control over, and improve, their health” [5].

In practice, these terms are frequently used complementarily and measures for the implementation may overlap; however, there are major conceptual differences with regard to the focus and impact of health promotion actions (Figure 1).

Figure 1: Strategies for health promotion [6]



Whereas the medical approach is directed at physiological risk factors (e.g. high blood pressure, immunization status), the behavioural approach is directed at lifestyle factors (e.g. smoking, physical inactivity) and the socio-environmental approach is directed at general conditions (such as unemployment, low education or poverty). Health promotion consequently includes, but goes far beyond medical approaches directed at curing individuals.

Based on the notion of health as a positive concept, the Ottawa Charter put forward the idea that “health is created and lived by people within the settings of their everyday life; where they learn, work, play and love”. This settings approach to health promotion, founded on the experience of community and organizational development, led to a number of initiatives such as Health Promoting Cities, Health Promoting Schools, and Health Promoting Hospitals, etc. in order to improve people’s health where they spend most of their time: in organizations [7,8].

The settings approach acknowledges that behavioural changes are only possible and stable if they are integrated into everyday life and correspond with concurrent habits and existing cultures [9]. Health Promotion interventions in organizations therefore not only have to address changing individuals but also underlying norms, rules and cultures.

The Ottawa Charter identifies five priority action areas for health promotion:

- Build healthy public policy: health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organization change. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and the development of ways to remove them.

- Create supportive environments for health: the protection of the natural and build environments and the conservation of natural resources must be addressed in any health promotion strategy.
- Strengthen community action for health: Community development draws on existing human and material resources to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters. This requires full and continuous access to information and learning opportunities for health, as well as funding support.
- Develop personal skills: Enabling people to learn (throughout life) to prepare themselves for all stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings.
- Re-orient health services: the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Reorientation of health services also requires stronger attention to health research, as well as changes in professional education and training.

The following section will explain the need for a reorientation of health services and expand on some of the ideas set forward in the Ottawa Charter.

Why hospitals for health promotion?

The impact of health services on health

Many health professionals presume that health promotion has always been the core business of medicine in general and hospitals in particular. This view may be challenged for a variety of reasons.

Although the history goes back further, the first identifiable hospitals were built during the 12th century and were religious-oriented, cloister-affiliated institutions providing support to the poor, elderly, psychologically deviant and others in need. In the foreground were the accommodation, nourishment and the isolation of infectious diseases, not the treatment of disease.

Table 1: Historical evolution of hospitals [10]:

Time	Role of hospital	Characteristics
7 th century	Health care	Byzantine empire, Greek and Arab theories of diseases
10 th to 17 th century	Nursing, spiritual care	Hospitals attached to religious foundations
11 th century	Isolation of infectious diseases	Nursing of infectious diseases such as leprosy
17 th century	Health care for poor people	Philanthropic and state institutions
Late 19 th century	Medical care	Medical care and surgery, high mortality
Early 20 th century	Surgical centres	Technological transformation of hospitals, entry of middle-class patients; expansion of outpatient departments
1950s	Hospital-centred health systems	Large hospitals, temples of technology
1970s	District general hospitals	Rise of district general hospital, local, secondary and tertiary hospitals
1990s	Acute care hospital	Active short-stay care
1990s	Ambulatory surgical centres	Expansion of day admissions; expansion of minimally invasive surgery

Until the late 19th century hospitals were not a place where health was created, but rather a place to die [11]. This changed with the development of the science of medicine, supported by utilitarian state philosophy and humanism. Since then, the potential of hospital care to improve health has made rapid improvements with the development of aseptic and antiseptic techniques, more effective anaesthesia, greater surgical knowledge and skills, trauma techniques, blood transfusion, coronary artery bypass surgery, effective pharmaceuticals, transplantation techniques and minimal invasive surgery [12].

However, parallel to the advances in hospital procedures, questions have been raised with regard to the contribution of health care to the health of the population and the effectiveness of health care services. Various accounts have been made discarding the claims of health care for the reduction of infectious diseases, the significant decline in infant mortality, reductions in the major causes of death and resulting increase in life expectancy [13].

Although controversy is still continuing on details of his work, McKeown demonstrated compellingly how reductions in mortality in the United Kingdom, which were thought to be related to accomplishments of medical care, were in fact related to improvements in hygiene and nutrition [14,15,16,17]. Another perspective was brought in by Ivan Illich and Rick Carlson who argued that medical care is more a cause of death, than of health. According to Illich, medicine has the potential to cause as much harm as good, as reflected in his concept of *iatrogenesis* [18]. He strongly criticized the medical professions of their “sick-making powers” and contended that health care institutions performed the opposite of their original purpose. Carlson argued along the same lines and forecasted that the limited effectiveness of medicine will further decline in the future [19]. Recently, these perspectives gained a lot of prominence with the report of the Institute of Medicine, “To err is human”, which estimates that in the USA about 100,000 deaths in hospitals annually are due to medical errors [20].

A more operational perspective was brought in by the Avedis Donabedian and others who, being well aware of the limited population impact of health care, focused on strategies to improve the quality of health care services [21,22,23]. Although major advances have been made with the outcomes movement and health technology assessment, the definition of quality as doing the right thing and doing it well, still raises fundamental questions and points to potential improvements in the provision of health care services [24].

The Health Promoting Hospitals network links the various perspectives above. It is driven by the strong perception that hospital services need to be more targeted towards the need of people, and not only to their organs or physiological parameters, in order to have a more substantial and lasting impact on health. At the same time the HPH philosophy is now based on strong evidence and methods to incorporate health promotion as a core principle in the organization. Quality strategies already applied in clinical settings and for the management of health care organizations are applicable to health promotion as well. Before addressing this issue further below, the following paragraphs provide the rationale for and concrete examples of health promotion services in hospitals.

Health promotion activities in hospitals

Given the scope of possible health promotion interventions in hospitals, the WHO HPH movement focuses on four areas: promoting the health of patients, promoting the health of staff, changing the organization to a health promoting setting, and promoting the health of the community in the catchment area of the hospital. These four areas are reflected in the definition of a health promoting hospital:

“A *health promoting hospital* does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment, and actively cooperates with its community” [25].

There is a large scope and public health impact for offering health promotion strategies in health care settings [26]. Hospitals consume between 40% and 70% of the national health care expenditure and typically employ about 1% to 3% of the working population. These working places, most of which are occupied by women, are characterized by certain physical, chemical, biological and psychosocial risk factors. Paradoxically, in hospitals – organizations that aim to restore health – the acknowledgement of factors that endanger the health of their staff is poorly developed. Health promotion programmes can improve the health of staff, reduce absenteeism rates, and improve productivity and quality [27,28].

Health professionals in hospitals can also have a lasting impact on influencing the behaviour of patients and relatives, who are more responsive to health advice in situations of experienced ill-health [29]. This is of particular importance for two reasons: firstly, the prevalence of chronic diseases (e.g. diabetes, cardiovascular diseases, cancer) is increasing in Europe and throughout the world [30]; secondly, many hospital treatments today not only prevent premature death but improve the quality of life of patients. In order to maintain this quality, the patient’s own behavior after discharge and effective support from relatives are important variables [31]. Health Promotion Programmes can encourage healthy behavior, prevent readmission and maintain quality of life of patients.

Hospitals also typically produce high amounts of waste and hazardous substances. Introducing Health Promotion strategies in hospitals can help reduce the pollution of the environment and the

cooperation with other institutions and professionals can help achieve the highest possible coordination of care. Furthermore, as research and teaching institutions hospital produce, accumulate and disseminate a lot of knowledge and they can have an impact on the local health structures and influence professional practice elsewhere.

Table 2: Example of health promotion projects/activities in hospitals

<p><i>Patients</i></p> <ul style="list-style-type: none"> • Brief interventions for smoking cessation • Introduction of a patient charter • Patient satisfaction measurement 	<p><i>Staff</i></p> <ul style="list-style-type: none"> • Healthy nutrition • Introduction of interdisciplinary team-work • Education on lifting techniques to prevent back pain
<p><i>Organization</i></p> <ul style="list-style-type: none"> • Conflict and change management • Health promotion mission statement • Introduction of Total Quality Management 	<p><i>Community</i></p> <ul style="list-style-type: none"> • Reduction of waste and ecological risks • Use of hospital data to assess population health promotion need • Safe driving ways for ambulance cars

Evolution of the International Network of Health Promoting Hospitals

In order to support the introduction of health promotion programmes in hospitals, the WHO Regional Office for Europe started the first international consultations in 1988. In the subsequent year, the WHO model project “Health and Hospital” was initiated with the hospital Rudolfstiftung in Vienna, Austria, as a partner institution.

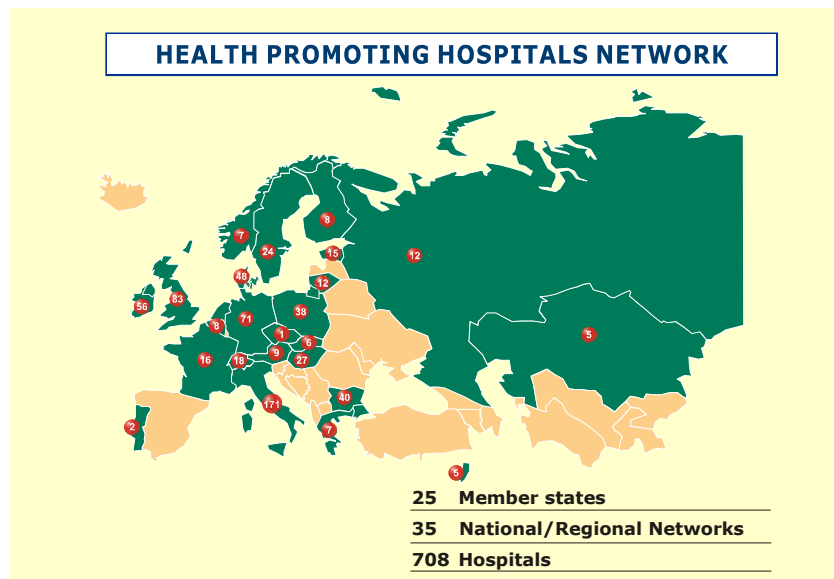
After this phase of consultation and experimenting the HPH movement went into its developmental phase, being marked by the initiation of the European Pilot Hospital Project by the WHO Regional Office for Europe in 1993. This phase, which lasted from 1993 to 1997, involved intensive monitoring of the development of projects in 20 partner hospitals from 11 European Countries.

Subsequent to the closing of this pilot phase, national and regional networks were developed and the network reached its consolidation phase. Since then, national and regional networks take an important role in encouraging the cooperation and exchange of experience between hospitals of a region or a country, including the identification of areas of common interest, the sharing of resources and the development of common evaluation systems. In addition, a

thematic network exists, bringing together psychiatric hospitals and allowing the exchange of ideas and strategies in this particular field.

The International Network of Health Promoting Hospitals acts as a network of networks linking all national/regional networks. It supports the exchange of ideas and strategies implemented in different cultures and health care systems, developing knowledge on strategic issues and enlarging the vision. As of May 2005, the International HPH Network comprises 25 Member States, 35 national and regional networks and more than 700 hospitals.

Figure 2: overview of the distribution of HPH in the WHO European Region. [32, 33, 34].



In the past, the projects carried out within the HPH network were characterized by a more traditional focus on health education interventions for patients and to a lesser extent for staff. The focus of the HPH projects is now enlarging, addressing also organizational and community issues such as a change of organizational culture and environmental issues [35].

A future challenge of HPH is still to link organizational health promoting activities with continuous quality improvement programmes, making use of the apparent similarities such as the focus on continuous process and development, involvement and ownership,

monitoring and measurement, and to incorporate the principle of health promotion into the organizational structure and culture.

Johnsen & Baum pointed out that there is still a long way to go until health promotion is anchored to the organizational culture and structure [36]. Based on a review of the literature and an assessment of health promoting hospitals projects in Australia, HPH activities are grouped in a typology with four dimensions (Table 3).

Table 3: Typology of HPH activities

Type	Implication
Doing a health promotion project	No re-orientation of the whole organization or staff roles. This may be a starting point for health promotion activities when no support from senior management is available.
Delegating health promotion to a specific division, department or staff	A specific department deals with health promotion, but activities are not integrated in the overall organization. Hospitals falling within this type may be in a developmental phase.
Being a health promotion setting	Health promotion is considered a cross-sectional issue in hospital decision-making. The hospital has become a health promoting setting, although no resources are applied to impact in the community.
Being a health promotion setting and improving the health of the community	The hospital is a health promoting setting, takes responsibility for, and improves community health.

Although the authors are aware of the difficulties of becoming a health promoting setting with visible community impact, they claim that the "...settings approach to health promotion is about much more than introducing a variety of opportunities for individuals using the hospital to change their behaviour". Their argumentation is in line with our observations of activities in the International Network of Health Promoting Hospitals. We found that many hospitals have introduced selected health promotion activities; however, the process of extending and incorporating these activities at a broader level has been slow.

The preceding paragraphs illustrated that, although many may perceive the hospital as a health promoting setting, there are varying degrees to which hospitals actually have an impact on population health, potentially harm individuals seeking cure and care and make use of the knowledge available to improve health. While the main determinants of health lie outside the health care sector, hospitals can

improve the health of their patients and can have a longer lasting impact, in particular for patients with chronic conditions.

In addition, the health promotion strategy includes the issue of staff health, which is not only important for the direct health effect of health professionals, but also for the link between staff health and satisfaction and patient outcome and satisfaction.

Various strategies of health promotion exist and hospitals engage in one form or another in some of them, e.g. patient information and individual risk assessment. However, the main shortcoming is still the systematic implementation and quality assurance of health promotion activities in hospitals. The question of how health promotion activities can be implemented and their quality assessed will be addressed in the subsequent section.

Evidence base and quality management

One of the factors for the further advancement of HPH will be a strong evidence base, since the lack of evidence, coupled with prevailing cost pressures in almost any health care system, tends to make health promotion programmes an easy choice for budget cuts [37]. Tools for implementation represent another factor; as the experience show that despite of good evidence, there are often great variations in clinical practice.

Evidence-based health promotion?

Focusing on evidence in Health Promotion has become a major issue [38, 39]. One key publication in the field has been the Report of the International Union for Health Promotion and Education for the European Commission [40]. Parts of this work deal specifically with Health Promotion in the Health Care Sector [41]. ‘Evidence’ was also a major issue at the recent 5th Global Conference on Health Promotion 2000 in Mexico [42] and at the 9th International Conference on Health Promoting Hospitals in Copenhagen in 2001¹ [43].

¹ Abstracts of the conference are available at the web of the International Journal of Integrated Care, <http://www.ijic.org> (2001, 1, 3, supplement); virtual proceedings of this and former conferences are available on the web of the Ludwig Boltzmann Institute of the Sociology of Health and Medicine

With a certain delay, the call for evidence in health promotion follows the development of the evidence-based medicine movement, and many indeed demand the application of the same set of methods and criteria to the evaluation of health promotion (HP) interventions that have proven to provide evidence in clinical medicine.

As defined in the WHO Health Promotion Glossary [44], “*Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a ‘valued’ outcome*”. Assessment methods and outcomes differ in health promotion as compared to clinical medicine (Table 4).

Table 4: Clinical trials vs. HP interventions.

	Clinical Trial	Health Promotion Intervention
Context and design of intervention	physiological intervention randomization, blinding and placebo control possible unit is individual under controlled conditions (<i>efficacy evaluation</i>)	behavioural intervention randomization, blinding and placebo control often impossible unit is individual, organization or the community in everyday life situation (<i>effectiveness evaluation</i>)
Provider	health professionals implement intervention in clinical trial	often various providers and institutions involved
Addressee	participants with health problems hoping for relief	participants not necessarily aware of health problem
Time frame for outcome	aims to cure disease, end point is end of treatment or when intervention is technically stable	aims to prevent future ill-health, outcome possibly in years, decades or even the offspring

Although experimental designs and quantitative methodologies can also be applied to health promotion interventions, in particular those related to staff and patients, the importance of qualitative methods also has to be considered for the evaluation of HP interventions on broader organizational, policy or community issues [45].

in Vienna, WHO Collaborating Centre for Hospitals and Health Promotion (<http://www.hph-hc.cc/>).

With the current focus of health system and hospital managers on outcomes, qualitative methods are frequently considered as offering only weak evidence. In fact, the long-term benefit of many health promotion interventions makes it necessary to distinguish between different levels of health promotion outcomes, beyond changes in clinical parameters and in health status. In the context of health promotion participation, partnership, empowerment and actions directed to the creation of supportive environments are also important aspects that need to be evaluated, and many proponents of health promotion indeed recommend different levels of analysis [46-50].

Don Nutbeam suggests distinguishing outcomes according to health promotion outcomes, intermediate outcomes and health and social outcomes [51]:

- *Health promotion outcomes* refer to modifications of personal, social and environmental factors to improve people's control over the determinants of health (e.g. health literacy, social influence and action, healthy public policy and organizational culture);
- *Intermediate outcomes* refer to changes in the determinants of health (e.g. lifestyles, access to health services, reduction of environmental risks);
- *Health and social outcomes* refer to subjective (self reported assessments such as Nottingham Health Profile, SF-36 or EUROQOL) and objective measures (weight, cholesterol level, blood pressure measurement, biochemical test, mortality) of changes in health and in social status (e.g. equity).

The HPH movement has provided many good examples of health promotion interventions that hospitals can carry out. Some of these interventions have been evaluated in the literature as being highly effective and cost-effective as described in the chapter on Evidence for Health Promotion in this volume. Some may discard the narrow view of health promotion activities that were evaluated using controlled designs, and argue that our understanding goes beyond these activities.

Assessment of activities in Health Promoting Hospitals?

Currently, the quality of health promoting activities in the hospitals of the International HPH network is not systematically assessed. Hospitals becoming members of the International Network:

- endorse the fundamental principles and strategies for implementation of the Vienna Recommendations;

- belong to the National/Regional HPH Network in the countries where such networks exist (hospitals in countries without such networks apply directly to the international coordinating institution); and
- comply with the rules and regulations established at the international and national/regional levels.

Hospitals in the International Network further have to commit themselves to become a smoke-free hospital and to run three specific projects/activities addressing health issues of staff, patients, community, or improving organizational routines with a possible impact on health. A web-based database has been established to register projects and activities, providing information on key indicators of the hospital and on health promotion activities [52].

At the international level, attempts have been made to review and develop evaluation systems for health promotion. The Fourth and Fifth Annual Workshop of National and Regional Network Coordinators in 1998 and 1999 addressed the issue and concluded that so far, evaluations, if any, were mostly carried out at project level, only a few strategies of quality assurance were applied at network level and most coordinators experienced great problems in developing and applying evaluation schemes. There are different evaluation approaches at national and regional network levels, although none of them are well developed yet [53].

A previous review in 1998 identified existing approaches and problems in the evaluation of HPH [54]. Among the most developed tools applied was the Hospital Accreditation Scheme that evolved from the Healthy Hospital Award in the United Kingdom. Hospitals were formally accredited as Health Promoting Hospital after application, standardized self-audit survey and external assessment to validate the survey and interview staff and patients.

A similar system was installed in the German system consisting of two peer-reviews from hospitals and one site-visit from a representative of the network to the applicant hospital. External assessors decided on the acceptance in the network. However, the German experience shows that, due to the financial implications, these visits are difficult to carry out. The German Network has also worked on adapting the excellence model of the European Foundation of Quality Management and the Balanced Scorecard for the systematic implementation of health promotion in the hospitals' organizational

structure and culture. A report on the process of this work is also available in the present volume.

In 1994, the Polish Network started a self-assessment system to monitor the improvement of individual hospital performance; however, its application was not continued due to validity and reliability issues of the tool. The Danish Network decided in December 2000 to initiate the establishment of a set of standards; part of this work is also presented in this volume.

Other countries in the WHO European Region initiated in the past similar schemes consisting of site-visits, peer review, self-assessment, and surveys. Outside Europe, the Ministry of Health in Thailand conducted a survey comparing 17 Health Promoting Hospitals with 23 non-HPH [55]. A questionnaire was designed and items were constructed for a self-assessment of HPH strategy implementation according to the following dimensions: a) Leadership and administration, b) Resource allocation and Human Resource development, c) Supportive environment, d) Health promotion for staff, e) Health promotion of patients and families, and f) Community health promotion. Many methodological issues need to be resolved before a valid comparison can be made; however, the survey contains many innovative ideas that may be elaborated in the future.

At the time of the review, approaches of other national/regional networks in the WHO European Region were still in their initial stage [56, 57]. Although it is not the intention of WHO to evaluate the performance and rank hospitals with regard to health promotion, the absence of systematic assessments of health promotion activities hinders the direct improvement of activities.

The way forward

Although a lot of progress has been made in the last decade, the idea of health promotion has only slowly been introduced to hospitals. Perhaps one of the main factors explaining this was the lack of clear strategies and tools for implementation. The knowledge and tools presented in this volume will, without any doubt, accelerate the pace of implementation and make sure that health promotion gains more importance within the hospital setting. There is now much better and stronger evidence for many health promotion interventions directed at patients, staff and the community. Likewise, tools have been developed to help health professionals to prioritize and implement

health promotion. The evidence of health promotion activities, strategies and quality tools, that will allow better implementation of health promotion in hospitals in the future, will be presented in the following chapters.

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Evidence for health promotion in hospitals (Hanne Tønnesen, Anne Mette Fugleholm & Svend Juul Jørgensen)

Health Promoting Hospitals have committed themselves to integrate health promotion in daily activities and to follow the Vienna Recommendations, which advocate encouraging patient participation, involving all professionals, fostering patients' rights and promoting a healthy environment within hospitals. Thus, health promotion in hospitals includes interventions and actions. In order to ensure effective and efficient implementation of health promotion valid standards and guidelines are needed just as for other clinical activities. The evidence base for a wide range of interventions will be reviewed in the following sections.

Evidence-based health promotion in hospitals

While "curative" medicine is delivered to symptomatic patients who seek health care, health promotion and preventive interventions will often attempt to modify individuals' lives, and this must be based on the highest level of randomized evidence "that our preventive manoeuvre will do more good than harm" [1].

Practice guidelines are considered valid if "when followed, they lead to the health gains and the costs predicted for them" [2], and they must be based on evidence from trials using valid methods. Evidence is usually categorized as:

- 1a: Evidence from meta-analysis of randomized controlled trials;
- 1b: Evidence from at least one randomized controlled trial;
- 2a: Evidence from at least one controlled study without randomization;
- 2b: Evidence from at least one other type of quasi-experimental study;
- 3: Evidence from descriptive studies, such as comparative studies, correlation studies and case-control studies;
- 4: Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both.

Health promotion should be based on a high level of evidence, i.e. level 1a, 1b or 2a, whenever possible. Weaker evidence may be

used for describing good clinical practice in health promotion in hospitals, but whenever category 1a to 2a is absent, it should be considered relevant to establish new evidence.

Clinical trials in the spectre of health promotion must meet the same criteria for quality as other randomized trials. They are: Appropriateness of inclusion and exclusion criteria, concealment of allocation, blinding of patients and health professionals if possible, objective or blind method of data collection, valid or blind method of data analysis, completeness and length of follow up, appropriateness of outcome measures and statistical power of results.

The large group of qualitative studies are outside the evidence definition. They describe the opinions and feelings of selected persons, and they are based upon the specific interviewer's interpretation and competences, and the concrete context. They are important for an implementation process and may give rise to new hypothesis, but the results can seldom be generalized. Using both quantitative research and qualitative studies is a unique combination in exploring new areas for investigation and implementation.

Concepts used

In public health, disease prevention is usually defined as a) primary disease prevention which prevents diseases from occurring, b) secondary prevention which detects disease at an early stage and prevents disease from developing, and c) tertiary prevention or rehabilitation which prevents aggravation or recurrence of disease and secures maintenance of functional level.

Traditionally, hospitals primarily take care of tasks that relate to secondary or tertiary prevention whereas the primary sector and other social institutions take care of primary prevention. It is, however, increasingly recognized that also hospitals can play a significant role in primary prevention.

When integrating health promotion in clinical activity it makes more sense to use a classification that distinguishes between patient pathways in ordinary clinical practice, staff and the community:

- Patients: General health promotion which should be offered to all patients and which addresses all patient pathways. Specific health promotion vis-à-vis defined patient groups,

characterized through their belonging to certain diagnosis groups or otherwise.

- Staff: General health promotion aiming at a healthy and safe work environment. Training in the field of clinically related health promotion.
- Community: Cooperation with relevant structures and organizations. Information on health promotion and concrete services for citizens.

General health promotion addresses general determinants of health and disease (including tobacco, alcohol, nutrition, physical activity and psychosocial issues). One example of this is lifestyle intervention, which involves activities aiming to influence individual behaviour (alcohol consumption, smoking etc.). Lifestyle intervention includes counselling, recommendations and empowering the patients to enhance their competence and their capability.

Specific health promotion addresses conditions that are significant for specific patient groups. Examples of this are the prevention of complications in diabetes patients, education of asthma patients, cardiac rehabilitation etc. An important element in disease-related health promotion is strengthening the patient's ability to manage his/her condition.

Policy of health promotion in hospitals

Hospitals are a special type of workplace with many employees that are exposed both physically and mentally in connection with their clinical tasks. In spite of work environment regulations, many exposures and risk situations cannot be avoided. Therefore it is necessary for hospitals to have a health promotion policy.

On the basis of existing knowledge of the importance of lifestyle factors for treatment and prognosis, all hospitals should establish policy, counselling services, education and support for health promotion as an integrated part of the individual patient pathway as well as for the staff.

Effect of a health promotion policy in hospitals is based upon descriptive studies, exclusively, giving a low level of evidence.

Health promotion for hospital staff

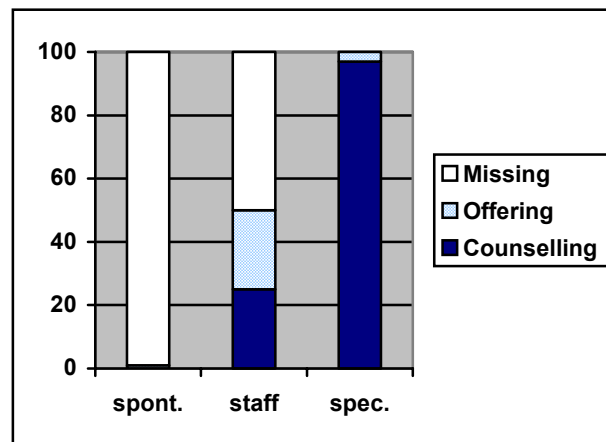
Those working in the health care sector can play an important role in promoting health, either through providing examples of what can be done to achieve a healthy environment or through using their authority to act as advocates for public health policies or in giving advice to individual patients or citizens [3].

Learning and teaching in methods used in health promotion and patient education should build on evidence [4]. The individual lifestyle habits of health care staff, their attitudes and competencies influence the way they handle prevention issues.

Staff who are smokers generally underestimate the role of smoking as a risk factor, whereas non-smokers in some cases overestimate this risk factor. Thus smokers are less prone to advise patients on lifestyle issues in general and the same is true of staff that feel that they have too little training in this field [5]. Staff who are smokers do not convey through their behaviour the health knowledge they are supposed to communicate to the patients; there is a cognitive disparity between their behaviour and their knowledge, i.e. staff either choose to stop smoking or ignore their knowledge to the detriment of advice for patients.

Interestingly, staff that stops smoking initiate more interventions among patients with improved effect. Special competences are another important way of improving the integration in the clinical daily life. The figure below shows the results of an implementation study of smoking cessation among medical patients admitted for acute illness. The implementation rates are given for “spontaneous” motivational counselling in the emergency department, for the usual staff, and for specialist nurses in three successive periods, each including 100 patients [6]. Specialized staff offer more systematic advice on smoking cessation than other staff.

Figure 1: Smoking cessation among patients



Effect of role models and education of staff is based upon moderate to high level of evidence.

Evidence for general health promotion

There is documentation for the effect of health promotion in relation to lifestyle factors.

Tobacco

Tobacco causes a wide range of diseases. Smoking causes 30% of all occurrences of ischaemic heart disease, explains 90% of lung cancer, 75% of chronic obstructive lung disease (smoker's lungs) and 6 % of hip fracture. Not only do diseases occur more frequently in smokers, they also occur at a younger age compared to non-smokers. Danish figures show, for instance, that among patients with cerebral infarction, smokers are admitted 10 years earlier than non-smokers [7]. And population studies show that there are twice as many admissions among smokers as among non-smokers [8].

A great number of hospital admissions are related to patients' lifestyles. Tobacco related diseases cause 30% of all admissions in an ordinary medical ward [9]. And in addition, tobacco plays an indirect role for many other admissions. Smoking also influences the outcome

of treatment. It is well documented that medical treatment for hypertension, radiation treatment of cancers of the head and the neck, treatment of arteriosclerosis and wounds are much less effective in smokers than in non-smokers. Smoking influences the immune system and plays a role in the prolongation of hospital stay for patients with infections.

Patients' long term condition and prognosis are also influenced. There is documentation that patients who stop smoking following myocardial infarction diminish the risk of recurrence within the following two years by 50%. Unplanned readmissions cause considerable expenditure for the health care sector. Smokers have almost twice as many readmissions as non-smokers [10]. Studies show that the average rate of readmission amounts to between 16% and 27%; patients with ischaemic heart disease, smokers' lungs (COPD) and lung cancer have a particular high rate of readmissions [11].

Smoking cessation has a well-documented effect on symptoms and health [12]. Many studies show a dose-response relation between exposure to tobacco (duration of smoking habit and amount smoked) and the occurrence of disease. Similarly, there is direct proportional relationship between how long a person has been smoke free and a reduced risk of disease. Recent studies document that even smoking cessation at the age of 65 has a positive effect on health and reduces morbidity [13], however, a reduction of the amount consumed plays no decisive role [14].

In short, documentation shows that smoking cessation:

- reduces or removes lung diseases such as coughing and expectorate in healthy smokers;
- normalizes future loss of lung function in patients with established chronic lung disease;
- reduces by half the risk of cancers after 5 years (former large scale smokers do, however, have an increased risk of lung cancer for the rest of their lives);
- leads to an immediate drop in the risk of cardiac and cerebral infarction;
- reduces by half the risk of another infarction and of death within the years following acute myocardial infarction;
- reduces the risk of arteriosclerosis and related diseases;
- reduces the risk of osteoporosis and resulting hip fracture;

- reduces the risk of giving birth to a premature infant if undertaken during the first 3 to 4 months of pregnancy;
- reduces the risk of late complications in patients with diabetes;
- improves the delayed healing process of wound and tissue healing.

The evidence is based upon descriptive studies of smoking and randomized clinical studies of stop smoking, giving a high level of evidence.

Alcohol

Large scale alcohol consumption adds to the risk of diseases such as pneumonia, infections, diarrhoea and malabsorption, dissemination of cancer, non-alcoholic liver disease, hypertension, poorly regulated diabetes, fluid and electrolyte imbalances. Patients with a high alcohol intake are more often admitted to hospital; about 20% of men and 10% of the women admitted to hospital consume alcohol in excess of internationally recommended limits.

Patients' alcohol consumption also influences the outcome of treatment and care. The mechanisms include reduced immune function, sub clinical or clinical cardiac dysfunction, haemostatic imbalance, delayed healing of wound and slow tissue and bone turnover, myopathy, and increased stress-response; all contribute to prolongation of hospital stay for the patients [15].

There is evidence that cessation and to some degree reduction of alcohol consumption leads to:

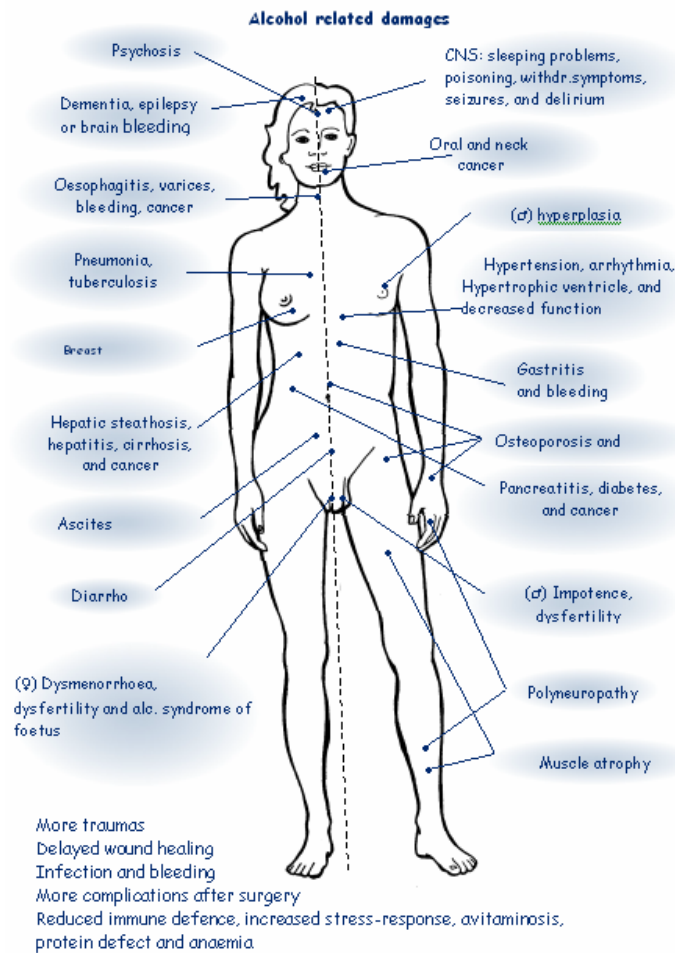
- fewer admissions with alcohol related disorders such as cirrhosis of the liver and Pancreatitis;
- fewer admissions due to poisoning, alcoholism and alcohol psychosis;
- fewer infections (especially pneumonia and tuberculosis);
- improved wound and bone healing;
- improved heart function and blood pressure;
- improved outcome for several non-alcoholic diseases (among other effects).

The evidence is based upon descriptive studies of alcohol intake and randomized clinical studies of stop drinking as well as randomized

studies of voluntary excessive alcohol intake, giving a high level of evidence.

High alcohol consumption causes a wide range of diseases; involving nearly all organs, see the figure below.

Figure 2: Alcohol related damages



Physical activity

Lack of physical activity is associated with increased occurrence of type 2 diabetes, overweight, high blood fat levels, hypertension and development of metabolic syndrome.

There is evidence that regular physical activity [16]:

- reduces the risk of developing cardiovascular disease in general and ischaemic heart disease in particular;
- reduces the risk of developing type 2 diabetes;
- reduces mortality in middle-aged and elderly persons of both sexes;
- strengthens the development of bone density, restrains age related drop in bone mineral content and prevents the development of osteoporosis;
- prevents hypertension and reduces hypertension;
- prevents overweight;
- prevents depression, reduces tension and increases self-respect;
- prevents loss of muscle mass in elderly patients and reduces the risk of falls.

Physical training is an important element in several rehabilitation programmes, e.g. cardiac rehabilitation, rehabilitation of chronic obstructive lung disease, surgical rehabilitation, psychiatric rehabilitation etc.

Physical training for patients with myocardial infarction reduces the risk of another infarction by 25% in the first three years. Training is also an important element in mobilization of patients with rheumatoid arthritis and patients with arthritis, and studies have shown that exercise in the form of walks may put off the time of surgical intervention for patients who are waiting for knee or hip replacement.

The evidence is based upon descriptive studies of physical activity and randomized clinical studies, giving a high level of evidence.

Nutrition

In the European population, overweight is the most common health problem. The increasing prevalence of overweight leads to a growing number of persons with diabetes, cardiovascular disease, strain injury and hormone related cancers. However, a problem

encountered by hospitals is under-nourishment. Studies show that almost 30 % of hospital patients are undernourished on admission. At the same time, studies show that patients' food intake during hospital stay often amounts to only 60% of their actual needs [17].

There is documentation that undernourished patients have increased morbidity and mortality than well-nourished patients. At the same time, there is documentation that systematic screening of nutrition status and proper nutritional therapy during admission reduce the risk of wound infection and lead to shorter hospital stay and contribute to more rapid convalescence [18]. There is evidence that nutritional interventions in relation to undernourished patients [19]:

- improve lung functions and walking distance in patients with chronic lung disease;
- increase weight and muscle mass in patients with cancer;
- increase physical activity and reduces mortality in geriatric patients;
- reduce mortality in patients with acute renal failure.

The evidence is based upon several randomized clinical studies, giving a high level of evidence.

Recommendations with regard to hospital tasks

There is international consensus that patients should be given recommendations, guidance and support with regard to health promotion in hospitals. Health promotion secures that risk conditions are identified and that the patient has knowledge of the significance of these conditions, recommendations for changes and active support for carrying out these changes. Evidence exists for the following interventions, which should be implemented in general hospital practice:

Tobacco:

- identification of smokers and establishing a thorough tobacco history;
- oral and written information to patients on damaging effects and health benefits, and the possibility of smoking cessation;
- advice and recommendations with regard to cessation;

- establishing smoking cessation services or integration of smoking cessation counselling as part of treatment.

Alcohol:

- identification of patients with harmful and dependent alcohol consumption according to ICD-10 criteria;
- oral and written information to patients on damaging effects and health benefits and the possibilities of assistance to stop or reducing consumption;
- recommendations for large scale consumers to stop or reduce consumption;
- offering brief interventions (for harmful intake) or referral to alcohol unit (for dependent intake).

Physical activity:

- identification of patients with a need for counselling on physical activity;
- counselling on exercise in accordance with international guidelines, and follow-up and counselling in connection with subsequent contacts with the department;
- establishing systematic training programmes for relevant patients (heart and lung patients, diabetes, surgery, psychiatry, overweight and underweight).

Nutrition:

- identification of undernourished patients and patients at risk of under-nourishment;
- initiation of relevant nutrition treatment and continued observation of body weight and food intake throughout the patient's stay in hospital;
- communication of information on discharge (to own doctor, home care, general practitioner);
- identification of overweight patients and screening for diabetes and other complications;
- counselling on diet and physical training;
- establishing of systematic training programmes for relevant patients;
- secure follow up in the primary health care sector.

Systematic intervention and patient education

The aim of health counselling is to support the individual's process of change with regard to lifestyle. Health counselling is based on theories of behavioural change [20]. The theories describe the phases and processes that people go through when they change behaviour. The model describes behavioural change as a circular process. Most people go through the process several times before they finally change behaviour.

Health counselling consists of a dialogue with the patient and is based on:

- the patient's knowledge of the influence of tobacco and alcohol on health and the significance of cessation/reduction for disease, treatment and health;
- the patient's ideas, emotions and attitudes with regard to the consumption under consideration;
- the patient's previous experiences when trying to change habits;
- recognition of the patient's emotions with regard to consumption;
- acceptance of the patient's choice with regard to consumption and;
- setting realistic goals for the outcome of the interview that correspond to the phase of change that the patient is going through.

There is evidence that health counselling may be used to motivate lifestyle changes [21]. Since 1996, the Bispebjerg Hospital (Copenhagen, Denmark) has been trying to develop systematic intervention with regard to alcohol and tobacco, which includes health counselling for all patients including outpatients, elective patients, day patients and acutely admitted patients.

The intervention is based on clinical guidelines developed by interdisciplinary groups of health care staff from relevant clinical departments in the hospital. These clinical guidelines are fully in line with international guidelines concerning the treatment of tobacco and alcohol-related disease in hospitals. The tobacco indicators integrated in the routine audits performed in all clinical departments twice a year are given below:

Table 1: Tobacco-related indicators for routine audit

N°	Indicators for systematic intervention with regard to tobacco	Yes	No
1	Have the smoking habits been documented in the medical record?		
2	Does the patient smoke daily?		
3	Has information been given about the influence on tobacco related to the patient's symptoms, treatment and prognosis?		
4	Has intervention been initiated according to the clinical guidelines?		
5	Has motivational counselling been performed?		
6	Has the patient been admitted to the clinic of smoking cessation?		

It is recommended that following screening for risk factors (tobacco, alcohol, nutrition and physical activity), health counselling is offered systematically to all patients and that relevant intervention is offered by way of follow up.

Evidence for specific prevention

Specific prevention concerns prevention activities addressing specific groups of patients. Patient education and rehabilitation programmes are examples of this. Rehabilitation programmes that aim to support the individual's own ability to manage disease are thus part of the clinical guidelines for several patient groups, not as a supplementary aspect, but as part of treatment [22]. The various education and rehabilitation programmes include common elements, e.g. counselling on smoking cessation, stopping or reducing alcohol intake, physical activity, nutrition, psychosocial support, patient education and optimizing the medical (or surgical or psychiatric) treatment.

Heart patients

Ischaemic heart disease is one of the biggest disease groups in the hospital sector and is the source of large, and ever increasing, pressure of demand on the health care sector altogether. Formerly rehabilitation

of heart patients primarily concerned physical training, but against the background of the scientific results achieved over the past 10 to 15 years, the concept of heart rehabilitation has been extended to cover the following elements:

- physical training;
- lifestyle intervention and risk factor control: support to change of eating habits, smoking cessation, alcohol reduction, moderate physical training and preventive medical treatment;
- patient education;
- psychosocial care;
- medical treatment of symptoms;
- systematic control and follow up.

Results from international, controlled studies show evidence that heart rehabilitation may provide significant health outcomes [23, 24, 25] in the form of:

- reduction of the number of admissions, both readmissions and overall cardiac admissions;
- maintenance of the patient's functional level;
- improvement of the patient's health related quality of life;
- improvement of overall risk factor control through lifestyle change and enhanced medical compliance.

There is a high level of evidence for the value of cardiac rehabilitation.

Chronic lung patients

Chronic obstructive lung disease (COPD) is a frequently occurring disease and is the cause of 20 to 25 % of admissions to medical departments in Europe. COPD is one of the five most resource demanding diseases in Denmark. Over the past 20 years many different lung rehabilitation programmes have been developed and tested, and there is now documentation that these programmes lead to [26, 27]:

- alleviation of breathing difficulty;
- increase in the distance that the patient is able to walk;
- improved physical capacity;
- improved functional level in everyday life;
- improved quality of life;

- improved ability to cope with disease and aggravation of disease;
- fewer admissions.

It is still not clear what the optimum structure, content and duration of COPD rehabilitation programmes is, however, there is agreement that as a minimum the following elements should be included:

- smoking cessation assistance;
- physical training/training in the home;
- physiotherapy;
- nutritional counselling;
- psychosocial support;
- patient education.

There is a moderate to high level of evidence for the value of rehabilitation after lung disease.

Asthma patients

Asthma is a widespread disease, which occurs in about 5% of the adult population and in 5 to 10% of school children in most European countries. Over the past 30 to 40 years, a large number of randomized studies have been carried out in order to throw light on the effect of various education programmes. The programmes have been tested both in the hospital sector and in general practice. The resulting evidence has been summarized in several reviews [28] and a Cochrane [29] study, which conclude that there is documentation that patients who take part in asthma education programmes focusing on the training of skills achieve considerable effects, such as:

- fewer admissions;
- fewer emergency ward visits;
- less absence from work;
- fewer asthma attacks at night;
- improvement of the patient's general capacity;
- improved medical compliance;
- improved quality of life.

It is still not clear what the optimum structure, content and duration of education programmes for asthma patients is. Usually programmes cover 4 to 5 lessons in the course of a couple of weeks.

There is a high level of evidence for the value of rehabilitation among asthma patients.

Diabetes patients

Type 1-diabetes occurs in all age groups. Less is known about the occurrence of type 2-diabetes than about type 1-diabetes. The occurrence of type 2-diabetes is increasing rapidly and because of the increase in overweight/obesity it is seen in younger and younger persons. With regard to both types of diabetes the most significant health risk is development of late complications (risk of cardiovascular disease increased 3 to 5 times) and occurrence of diabetic eye disease, renal disorder and nervous disorder (retinopathy, nephropathy and neuropathy).

A number of randomized and controlled studies have been carried out with regard to both type 1 and type 2 diabetes. These studies all show that interventions with regard to one or several risk factors that can lead to late complications are effective [30, 31]. Interventions should address [32]:

- near normalization of blood sugar;
- near normalization of blood pressure and blood fat levels;
- smoking cessation;
- psychosocial support;
- counselling on nutrition, including alcohol, and physical activity.

There is a high level of evidence for the value of diabetic rehabilitation.

Osteoporosis patients

There is an increase in the prevalence of osteoporosis in the western world, among other things because of an increase in the number of elderly persons. The risk of osteoporosis-related fractures increases considerably with age and is especially frequent in women. The three most frequent osteoporosis-related fractures occur in different age groups. Fracture in or near the wrist increases markedly from the age of 55, back problems from the age of 65, and fracture in or around the hip from the age of 75.

There is evidence that increased calcium intake in childhood may increase bone mineral content. There is no agreement as to whether women may benefit from calcium intake after the menopause. But there are studies that indicate that calcium intake along with vitamin D, reduce the number of fractures in elderly men and women [33].

Physical activity and an active lifestyle increase bone mineral content along with enhanced muscle strength and muscle coordination, which contributes to reduction of the risk of fractures [34]. Smoking increases the risk of osteoporosis in women because female smokers have an earlier menopause than non-smokers and enhanced oestradiol metabolism. In the same way alcohol abuse in men constitutes a significant risk factor for the development of osteoporosis because of poor nutrition and reduced testosterone production.

Thus primary prevention should address:

- smoking cessation;
- reduction or cessation of alcohol consumption;
- motivation for physical activity.

Furthermore there is evidence that hip protectors reduce the number of fractures by 67% among elderly persons in rest homes. Thus hip protectors are an important element of the prevention programmes for frail elderly persons who are prone to falls and osteoporosis [35].

There is a low to moderate high level of evidence for rehabilitation among these patients.

Patients with cancer

A reduction of the occurrence of cancer is a primary goal in health care plans in most countries whereas rehabilitation of cancer patients has not been considered equally. It is estimated that two thirds of newly diagnosed cancer patients need rehabilitation services [36].

It is necessary to initiate further knowledge in this area, however interventions should address:

- psychosocial support and counselling;
- physical training/relaxation;
- nutrition guidance;
- smoking cessation;
- sexual problems;

- communication of knowledge to patients and relatives.

There is a low level of evidence for cancer rehabilitation.

Stroke

Stroke is a serious condition in so far as 40% of the patients die during the first year after onset of the disease, and many patients are not able to return to their own homes.

Many factors increase the risk of stroke: smoking, alcohol abuse, lack of physical activity, increased blood fat levels, hypertension, diabetes, irregular heartbeat. The risk increases with age [37]. There is evidence that patients participating in rehabilitation in the form of comprehensive interdisciplinary treatment through all the phases of the disease may achieve [41]:

- a reduction of mortality of 25%-50%;
- a reduced need for residential homes of 40%;
- improved functional level.

Furthermore prevention includes counselling on smoking cessation, stop drinking or reduction of alcohol consumption, regulation of blood fat levels, optimization of blood pressure and heart function as well as anticoagulant therapy.

Thus, it is recommended that patients with stroke are admitted to special stroke units where rehabilitation may be initiated already in the acute phase [38].

There is a high level of evidence for rehabilitation after apoplexy.

Patients with psychiatric disorders

A large proportion of psychiatric patients is smokers or have other substance abuse problems.

Treatment with psychoactive medicine leads to considerable weight gain in many patients and therefore there is a need for intervention with regard to nutrition and physical activity. Physical activity in psychiatric patients has a documented positive effect on the course of treatment. Thus, prevention should be integrated in psychiatric patient pathways in the same way as in somatic pathways.

Work has been carried out concerning documentation and evaluation of various ways of organizing treatment, e.g. in the form of Assertive Community Treatment teams. There is evidence that Assertive Community Treatment Teams that address patients with a large use of inpatient days may reduce the cost of hospital treatment, increase the number who are in contact with the treatment system, and improve user satisfaction among patients and relatives. There is also a positive effect with regard to a number of social parameters, e.g. homelessness or not having an independent home [39, 40]. It is recommended that outreach psychosis teams be introduced generally for the treatment of patients with long-term psychotic disorders.

There is a high to moderate level of evidence for psychiatric rehabilitation.

Surgical patients

A varying number of patients that undergo surgical intervention suffer from long-term and complicated conditions. The development of complications can be related to the diagnosis and the spread of the disease, type of intervention and the organization, i.e. staff competence, use of clinical guidelines etc. In recent years, we have acquired new knowledge on the significance of the patient's general lifestyle habits with regard to tobacco, alcohol, nutrition and exercise in connection with intervention. There is now evidence that targeted prevention initiatives can reduce the number of complications. The significance of increased risk of complications due to the above mentioned factors should form part of overall indications for surgery. As in the case of intervention with regard to medical patients with chronic disorders, qualitative intervention should comprise seven elements, i.e. tobacco, alcohol, physical activity, nutrition, psychosocial support, medical (including surgical and anaesthetic) optimization and patient education [41].

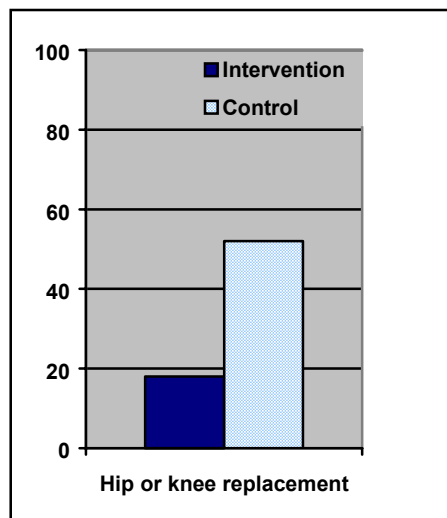
Against the backdrop of available evidence, the National Board of Health has established general recommendations for intervention with regard to tobacco and alcohol in connection with surgical intervention [16]. Early mobilization and nutrition have been described as significant elements of the postoperative phase [42].

Smoking

Altogether smokers have three times as many complications in the form of poor healing of wounds and other tissue and heart and lung complications in connection with surgical intervention compared to non-smokers.

The first international intervention study from 2002 documents that complications in surgical patients, who stop smoking 6 to 8 weeks before the intervention, are reduced from 52% to 18% and that average length of stay is reduced from 13 days to 11 days [43].

Figure 3: Complications in surgery after health promotion intervention



New Danish figures furthermore show that cessation just two weeks prior to surgical intervention reduces complications to some degree [44].

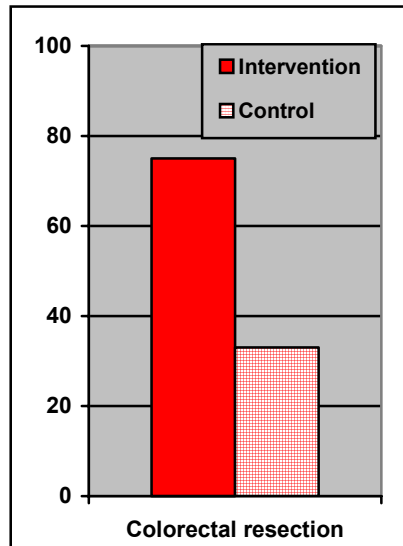
Alcohol

Excessive alcohol consumption is linked to increased surgical risk, which increases with consumption so that there are three times as many complications in patients who consume five or more units per

day. Complications are due to alcohol-induced organ damage that is reversible to a wide extent if no alcohol is consumed.

Thus there is evidence that preoperative alcohol abstinence for four weeks reduces complications following colorectal surgery by half, as illustrated in the figure below [45].

Figure 4: Complications after colorectal resection



Nutrition

There is evidence that nutritional intervention for undernourished patients [18] reduces complications in connection with surgical intervention by 10% and reduces the frequency of infection and increases muscle strength in surgical patients.

There is also evidence that resumption of food intake immediately after intervention considerably reduces complications [46, 47].

Physical activity

Early mobilization and increased physical activity following surgery has turned out to be significant and is part of a new overall concept for rehabilitation in connection with surgery [43]. The

intervention reduces weight loss and the fatigue often seen after surgery [48].

Preventive intervention that should be offered systematically:

- identification of risk factors;
- dialogue with the patient to clarify the role of these factors and the patients' own responsibility and options for influencing their own situation;
- evidence-based offer of intervention and follow up.

Intervention with regard to surgical patients is supported by the high motivation for changes in lifestyle prior to surgery, as measured by surprisingly high compliance [44,46,47]. Patient information should include the high postoperative morbidity related to lifestyle factors, and the evidence based programme should be offered in due time before surgery.

The level of evidence is high to moderate with regard to prevention and rehabilitation in relation to surgery.

Conclusion

Evidence supports the recommendation of clinical guidelines for the hospital's preventive intervention in relation to a number of specific conditions, for which clinical health promotion has a decisive influence on further development. Clinical guidelines should be established that describe evidence in accordance with standards for health promotion developed by the Health Promoting Hospitals Network.

Hospitals have tradition and expertise in health promotion within research and practice and should prioritize further research on developing health promotion programmes. The health care sector alone cannot bring about major changes in health behaviour, but the sector can play an important role in identifying important health problems and drawing the attention of society and the political level to those problems.

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Eighteen core strategies for Health Promoting Hospitals (Jürgen M. Pelikan, Christina Dietscher, Karl Krajic, Peter Nowak)²

Introduction

Based on the Ottawa Charter [1], the WHO-Regional Office for Europe initiated three strands of support for reorienting hospitals towards health promotion:

- conceptual development [2]; Budapest declaration [3]; Vienna recommendations [4];
- implementation experiences through the WHO model project Health and Hospital in Vienna [5] and the European pilot hospital project [6, 7]; and
- networking and media (business meetings, annual international conferences since 1993, workshops, newsletter, national and regional networks, data base, website, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care, WHO Collaborating Centre for Evidence-based Health Promotion in Hospitals [8,9].

In 2001, WHO launched a working group to develop an up-to-date strategic framework for health promoting hospitals (HPH). This paper presents a shortened and focused version of the main results of the working group “Putting health promoting hospital policy into action”. In order to understand the relationship of hospitals and health promotion and the specific potential of hospitals to engage in health promotion, some aspects of the situation of hospitals and the specific characteristics of health promotion need to be clarified.

The situation of hospitals is characterized by a permanent and increasing pressure of their dynamic environments to adapt to changing political and economic, professional and consumer

² This paper is based on the discussions within the WHO Working Group „Putting HPH Policy into Action“. We want to thank the other working group members for their valuable comments: Elimar Brandt, Carlo Favaretti, Pascal Garel, Bernhard J. Güntert, Oliver Gröne (WHO Barcelona), Ann Kerr, Elisabeth Marty-Tschumi, Raymond McCartney, Yannis Tountas

expectations concerning the process and content of hospital services. Two general tendencies can be distinguished within the trend of hospital reforms:

- Strategic re-positioning of the hospital: The need to redefine the range and mix of services (i.e. the distinction between core business and other services; balancing inpatient/outpatient services or acute/chronic/rehabilitative services; inclusion of educative elements; specialization of types of hospitals and departments; and integration with primary care and social services and intersectoral collaboration).
- Assuring and improving quality of services: To improve the safety, appropriateness, effectiveness and efficiency of services and improve satisfaction of stakeholders. Many hospitals are increasingly introducing quality approaches such as TQM, EFQM, ISO, accreditation and put a stronger emphasis on evidence based medicine and patient's rights.

To be able to identify the specific contributions of health promotion to such strategic re-positioning and quality improvement in hospitals, we need to follow the definition in the Ottawa Charter: "Health promotion is the process of enabling people to increase control over, and to improve, their health". Health is thus understood as the absence of disease and positive health, and both are understood in relation to body, mind and social status. Health promotion interventions include the maintenance and improvement of health, be it by protection or development of positive health or prevention or treatment and care.

The term "enabling" from the Ottawa Charter refers to the fact that health has to be reproduced by the people themselves and therefore depends upon their abilities and orientations on the one hand, and on opportunities and incentives in the situations in which they are living and acting on the other. Only in extreme cases, will the control of health be completely handed over to experts (from health care and other systems). From this perspective follows that it makes sense to invest not only in clinical interventions, but also in other interventions to improve health: Educating persons for self-management (lifestyle approach) and developing situations to make the "healthy choice the easy choice" [10].

Following the Ottawa Charter, the term of "enabling" has been developed into the more specific concept of empowerment, "a process

through which people gain greater control over decisions and actions affecting their health” [11]. Empowerment relates to individual actors, 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. Processes to achieve both may be social, cultural, psychological or political.

The two terms are usually used in combination in order to signal the comprehensive goal and the empowering means by which this goal could or should be reached. In the list of 7 guiding principles or criteria for health promotion, as defined by a WHO European Working Group on Health Promotion Evaluation (Rootman et.al. 2001, p. 4) [12], empowering is the first, followed by:

- participatory (involving all concerned in all stages of the project);
- 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).

If health promotion is applied to improve quality in hospitals, it widens the concept of outcomes and has implications for structures and processes of hospitals. Following the more explicit quality philosophy of hospitals, the outcome concept of hospitals already has widened to include, in addition to clinical outcomes, also health-related quality of life and patient satisfaction.

Health promotion underlines the psychological and social dimensions of health outcome and adds health literacy as a specific measurable outcome dimension of (educative) empowerment processes – as far as services are concerned. By the settings approach, health promotion introduces health impacts of the setting as relevant effects of hospitals to be observed, controlled and improved. The total health gain of the hospital thus can be understood as the sum of

outcomes of services and impacts of the – material and social – clinical and hotel hospital setting. This widening of the expected outcome also leads to a widening of the focus for quality improvement of the processes and underlying structures. The conceptual distinction that is most relevant for distinguishing between different health promotion strategies to be implemented in or by hospitals to improve health, can be summarized as *service oriented* strategies (strategies 1, 2 and 4, 5 in Table 1 below) vs. *setting oriented* strategies (strategies 3, 6).

Table 1: Six general health promotion strategies for each group of stakeholders of the hospital (patients, staff, community)

1.	HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>self care / self-reproduction</i>
2.	HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>co-production</i>
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

Service oriented strategies include *quality improvement of already existing* clinical and hotel services (strategies 1, 2) or strategies introducing *new, primarily educative services with mid-term or long-term health effects* (strategies 4, 5). Strategies can be distinguished according to their orientation of treating or managing specific *diseases* (strategies 2, 4) and strategies oriented at services for maintaining or improving *positive health* (strategies 1, 5). Concerning settings, strategies developing the hospital setting itself (strategy 3) can be distinguished from strategies of participation of the hospital in developing the community setting (strategy 6) or other settings within the community (e.g. workplaces or schools). By being oriented at improving health gain and not just clinical outcome, these six strategies do not only apply to patients (and their relatives), but in a somewhat modified way also to staff and members of the community the hospital serves and is situated in, *resulting in 18 strategies for health promotion in hospitals.*

The amount and quality of evidence that supports the feasibility, effectiveness and the amount of health gain that can possibly be reached is different for each of these strategies, but there are models of good practice and evidence for each of them. For reasons of a clear description, the strategies are described for specific aims although they may overlap in reality.

Patient-oriented strategies

HP quality improvement strategies for acute hospital services

Empowerment of patients for health promoting self care/ self maintenance/ self reproduction in the hospital

Even if patients are not only understood as the object of treatment but also as co-producers of their health outcomes, we have to take into account that they can only fulfil their patient role in relation to the trinity of body, psyche, social status).

Depending on their condition, the patient's contribution to co-production ranges self-care of the patient, over professionally supported care to intensive care (heart/lung machine). Following the four criteria of the complex concept of health gain, reproduction concerns all three dimensions of health – the physical (e.g. adequate nutrition), the mental (e.g. enough privacy in the hospital), and the social (e.g. possibilities for contacts with relatives, patient support).

In order to avoid hospitalization as far as possible, it should be made a principle to allow for as much self-care as possible, and to provide as much professional care as necessary. To make self-care possible under the difficult conditions of partly severely ill individuals outside their usual household environment, and subjected to the bureaucratic imperatives of the hospital organization, professional care has to be as empowering as possible, and needs to take into account cultural differences of patients. Empowerment again includes physical, mental and social dimensions, knowledge, skills and motivations. This again can be seen as the specific contribution of health promotion.

The effects of this strategy have not been systematically researched, but examples of interventions that have been successfully implemented in specific hospitals are:

- visiting and lay support services to support the psychosocial needs of patients [5];
- patient information about general hospital features (e.g. where to find what; visiting hours) at hospital admission [14];
- offers and options to encourage patient activities and patient self-responsibility (e.g. exercise, culture activities, patient libraries, discussions, patient internet cafe);
- provide psychological assistance to cope with stress or anxieties related to the hospital stay or to the patient's disease (e.g. cancer).

Empowerment of patients for health promoting participation / co-production in treatment and care

The core task of the modern acute care hospital is to offer diagnostic and therapeutic services for incidents of acute illness (of a rather severe type or with the need / opportunity for technical diagnostics and treatment) as well as acute episodes of chronic disease – for inpatients and outpatients.

The second health promotion strategy relates to the long and changing tradition of quality assurance and quality improvement of core tasks – starting with the education of professionals, and in the last 20 years switching towards developing processes and structures of organizations and larger systems. How can health promotion contribute to the quality improvement of core processes in hospitals?

The concept of empowerment stresses the necessity that individuals take control over their health – which means in the context of the hospital that patients are not only seen as objects of interventions but also as co-producers of these interventions – an idea that fits well with other traditions of analysing services as co-produced. As the co-producer has to actively contribute to the process, he / she has to be actively empowered for making this contribution. This sort of empowerment cannot be achieved by the clinical/technical interventions themselves, but by communicative/educative interventions. Medicine has to open itself towards education. Education refers to the transfer of knowledge (data, information), training of skills and enhancement of motivation.

The concept of health gain defines the relevant output of the hospital interventions in a more complex way: clinical outcome + quality of life + patient satisfaction + health literacy. These outcomes refer to all

three aspects of health: physical, mental and social. The treatment process itself has to become more complex. The focus stays on effective treatment, but in order to optimize health gain, aspects of disease prevention, health protection and health development have to get due attention within treatment (systematically avoid risks, use opportunities to build health resources – biological, mental, social).

A practical example for empowering patients for co-production would be diagnosis- and treatment related patient information, training and counselling (e.g. by informing patients about how they can contribute to the recuperation process; by describing alternatives and side effects), in order to enable patients to participate in the diagnostic process (e.g. by providing all information needed); participate in treatment-related decision-making; participate in treatment and care processes (e.g. by complying with the prescriptions).

There is clear evidence that this type of patient empowerment can, e.g. for surgical patients, reduce post-surgical complications, and can speed up recovery [13].

Development of the Hospital into a supportive, health promoting and empowering setting for patients

The hospital does not only consist of service processes, but also of a context within which the services are provided. Just like the services produce (health) outputs / outcomes, the context / situation / setting has impacts that are relevant for health.

There are impacts of the material setting (hospital infections, quality of air, temperature, sick building syndrome etc.) and also impacts of the hospital as a social setting with its organizational structure and culture, that influence opportunities for co-production and self-care of patients and of course the professional treatment and care for patients.

What is the contribution of HP for settings development? Health promotion pays specific attention to supportive environments – physical as well as social, and enlarges the focus on results from clinical outcomes also to other dimensions of health gain.

An example for this strategy would be the provision of an agreeable view out of the window, which has a proven positive impact on health [15].

These three patient-oriented strategies, aiming at enhancing the quality of acute care hospital services by health promotion, have a

considerable potential to increase the health gain of hospital interventions. But since the duration of hospital stays where these interventions can be applied gets shorter and shorter, many hospitals are expected to also provide other types of services, securing the sustainability and long-term effects of hospital treatment.

New health promotion services for hospital patients

Empowerment of patients for health promoting management of chronic illness

Expert interventions in hospitals provide in general only a turning point in disease processes, and a basis for recuperation or the successful management of chronic illness.

The main part of recuperation or of the day-to-day illness management (prevention of aggravation, negative long-term effects, social consequences etc.) has to be performed primarily by the patients themselves – with specific professional support by the hospital, specialized services, the family doctor or other health care services and lay support. This phase of the illness career lasts much longer and is out of direct control of the hospital, but is crucial for the outcome of regaining health and quality of life. Professional support for this phase is in its core educative: primarily information, consultation, and training.

Hospitals have to take this mid-range perspective on the illness career into account by either providing necessary disease specific support by themselves or by referring patients to other, specialized providers in the health care system. The more complex and the more rare the disease and its treatment gets, the more likely it remains a task of the hospital itself, but this of course requires adequate legal and financial regulation which allows to provide these services systematically.

Within the International HPH network, there are many examples of effective interventions of this type of services, e.g. diabetes training, COPD training [16].

Empowerment of patients for health promoting lifestyle development

The health gain of hospital interventions can be even further increased when taking on a more long term perspective. Future health can be

improved by lifestyle changes – thus reducing disease-related risks and developing positive health potentials and resources [17] [18] [19]. It is primarily educative services (information, consultation, training) that can be utilized to influence individual lifestyles. These types of services can be offered by different providers, e.g. other providers in health care, social services and adult education.

Hospitals are in a good position to offer such services, having already developed a relationship with patients in a crisis situation, being centres of knowledge and having a high prestige in the area of health. Health education can become a module in a package of educational communication, using the opportunity of the relationship and the time in the hospital. Investments in this direction would help to develop hospitals into genuine health centres.

Participation in health promoting and empowering development of community infrastructures for specific patient needs

There is sufficient evidence that healthy lifestyles depend only partly on individual knowledge, skills and motivation, but to large extent on opportunity structures, resources and cultural incentives. This refers as well to the area of illness management as lifestyle development.

The hospital has much knowledge about problems for adequate illness management, and about specific risks – it can use information from anamneses to generate epidemiological knowledge for health reporting and it is in a good position to advocate for health interests of individuals or groups among the patients in different contexts of the community.

The hospital has to develop specific routines for these tasks and needs to have resources to carry them out – but it is rather difficult to think of an adequate substitution for an active role of the hospital in this area.

This strategy has not yet been researched systematically. But examples for implementation would be e.g. the support of patient self help groups, or the support of provision of specific medical goods or services in the community.

Promoting health of staff

Even if hospitals have the primary task to care about patients, they nevertheless have an important impact on the health of staff members, who account for at least 3% of the European work force.

From the viewpoint of health promotion, the influence of the hospital on the health of staff has to be taken into account by the general policy of the hospital organization. This is not only in the interest of staff and general health policy, but also of value to the hospital as an organization, as the health of staff is crucial in such an expert organization. In principle, the same strategies as for patients can also be applied for contributing to staff's health. There are three strategies to develop the health related quality of the hospital as a workplace for its staff, two of them directly oriented at individual staff members or groups of staff, one oriented at the hospital as a workplace setting.

Empowering staff for health promoting self-reproduction / self care

Before staff can use itself as an instrument for work, staff members have to reproduce themselves as individual human beings. So staff has to be empowered for health promoting reproduction / self care as long as present in the hospital (e.g. by breaks, nutrition, toilet use, well-being, social network).

Empowering staff for health promoting coproduction at work

Hospital work (treatment, care, and support services) has not only effects on the health of patients, but also an impact on the health of the providers of these services. This is well recognized (but not always adequately fulfilled) in working regulations and occupational medicine. The added value of health promotion is to draw the attention to self-control of the determinants of health in the work-process and thus the empowerment of staff by owners and management for health promoting work processes and behaviour.

Development of hospital into a supportive, health promoting and empowering setting for staff

The hospital as a material and social setting has an impact on the health of staff as well, much more intensive than on patients. They are dangerous workplaces, as they provide physical risks (e.g. exposure to biological, chemical, nuclear agents), mental risks (e.g. stress, night

shifts), and social risks (e.g. night shifts as an important influence on social life, conflicts).

Working conditions have an immediate health impact that has to be dealt with in the situation, and the hospital organization is responsible for this impact and should use these three strategies to improve the health of its staff. In addition, the hospital has – like with patients – three optional strategies to optimize its effect on staff health.

Empowering staff for health promoting management of occupational illness

The hospital can support staff to deal with occupational disease or illness by offering individual or group oriented services, empowering them for health promoting illness management [20].

Empowering staff for health promoting lifestyle development

The hospitals also has the potential to increase staff's health by improving health related lifestyles, especially if these are correlate with specific work related risks (smoking, alcohol, exercise, healthy nutrition). These services make especially good sense if they are to support individuals to follow general health-promoting policies of the hospital, like a smoke-free hospital, and enable staff to fulfil their expected role as models of good practice for healthy behaviour.

Participation in health promoting and empowering development of community infrastructures for specific needs of staff

As far as lifestyles are concerned, for patients as well as for staff, these do not only depend on individual characteristics, but also on living conditions in the community. In addition, living conditions have a general important influence on the quality of life. Therefore, the hospital can improve its potential health impact on staff through participation in staff-oriented community development. Classical examples would be the provision of kindergartens around the clock; the availability of public transport and housing for hospital staff, staff-friendly opening hours of shops and other community services.

Promoting the health of the population in the community

Of course the hospital is affecting the health of its community firstly by effects on its actual patients and on the health of its staff. But the

hospital has also effects on the health balance of the population in its neighbourhood / catchment area which can be targeted and improved.

Firstly, we have to introduce a distinction especially relevant for this discussion: To its patients and its staff, the hospital has a strong actual relationship. Concerning some aspects that also holds true for the bystanders. For many or all members of the community, the hospital can or will be primarily a potential provider of services.

Again, there are three strategies that can improve the quality of the relationship of the hospital to the population in the community.

Empowerment of community for health promoting self-care by adequate access to hospital services in case of illness

To be able to access and use hospital services appropriately and timely is an important element of personal self reproduction. Health promotion draws to our attention the fact that the hospital can actively contribute to improve access to its services.

Empowerment of health professionals and lay carers for health promoting coproduction in treatment and after-care for patients

Hospital stays are getting shorter and shorter; therefore hospitals have to accept the responsibility for continuity of care after hospital discharge. In this case they have to empower professional providers in primary care / extra-mural health services and lay carers for specific patients to optimally take over care after discharge from the hospital. The hospital has to accept its responsibility for managing the interface with those taking care of patients after discharge. The specific contribution of health promotion to this process is the focus on empowerment.

Development of the hospital into a health promoting and empowering setting for the community

The hospital as a material and social setting has not only effects on the health of people within its premises, but also on people living and working in the neighbourhood. From a quality perspective, primarily negative effects of hospitals on health (air pollution, waste, noise, traffic) would be dealt with. From a health promotion perspective, also possible positive effects would be focused. Hospital facilities can be made available also for bystanders and neighbours, and the hospital can serve as cultural centre, a sports and fitness facility [21].

In addition, the hospital has – like with patients and staff – three optional strategies to optimize its effects on bystanders in the community. The hospital can do this by opening access for specific health promotion services (in case of need) and engage in community development for the general population. This of course depends on the specific legal conditions and financial provisions that facilitate or hinder a hospital's engagement in these activities.

Empowerment of community population for health promoting management of chronic illness

The hospital can support the management of chronic illness also for non-patients by opening its individual or group oriented services aiming at empowering for health promoting illness management. The hospital would be in a good position to offer groups, even for rather specific or rare diseases, and thus empower patients by being able to share perspective (self-help groups).

Empowerment of community population for health promoting lifestyle development

A similar argument applies for lifestyle development.

Participation in health promoting community development for the general population

What holds true for advocacy in the community for patient needs and staff needs can also be generalized for living conditions for all community members. So the hospital can contribute their epidemiological database to urban planning, health at the workplace development programmes in business companies, advocate for ethnic minorities etc.

An overview of the 18 strategies for health promoting hospitals

By putting together the six general strategies for the three target groups: patients, staff and the community, we get a matrix of 18 core strategies for Health Promoting Hospitals, which are summarized in table 7.

Some general remarks:

- The strategies are (partly) overlapping.
- The strategies (partly) build upon each other.

- The strategies have to be planned in relation to each other (in order to make use of synergies).
- The approach is to bundle single measures around specific thematic policies (e.g.: smoking).

Although the strategies are related, they cannot be implemented just in a holistic way – all at once – but have to be specifically planned and realized.

Table 2: 18 core strategies for Health Promoting Hospitals

HP for/ by ...	Patients	Staff	Community
HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>self-reproduction</i>	Empowerment of patients for health promoting self care / self maintenance / self reproduction in the hospital (PAT-1)	Empowerment of staff for health promoting self care / self maintenance / self reproduction in the hospital (STA-1)	Empowerment of community health promoting self care / self reproduction by adequate access to hospital (COM-1)
HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>co-production</i>	Empowerment of patients for health promoting participation / co-production in treatment and care (PAT-2)	Empowerment of staff for health promoting participation / co-production in treatment and care (STA-2)	Empowerment of health professionals in the community for health promoting co-production in treatment and after-care of patients (COM-2)
HP quality development for health promoting & empowering hospital setting for stakeholders	Development of hospital into a supportive, health promoting & empowering setting for patients (PAT-3)	Development of hospital into a supportive, health promoting & empowering setting for staff (STA-3)	Development of hospital into a health promoting & empowering setting for the community (COM-3)
Provision of specific HP services - empowering illness management (patient education) for stakeholders	Empowerment of patients for health promoting management of chronic illness (after discharge) (PAT-4)	Empowerment of staff for health promoting management of occupational illness (STA-4)	Empowerment of community population for health promoting management of chronic illness (COM-4)
Provision of specific HP services - empowering lifestyle development (health education) for stakeholders	Empowerment of patients for health promoting lifestyle development (after discharge) (PAT-5)	Empowerment of staff for health promoting lifestyle development (STA-5)	Empowerment of community population for health promoting lifestyle development (COM-5)

HP for/ by ...	Patients	Staff	Community
Provision of specific HP activities – participation in health promoting & empowering community development for stakeholders	Participation in health promoting & empowering development of community infrastructures for specific patient needs (PAT-6)	Participation in health promoting & empowering development of community infrastructures for specific needs of staff (STA-6)	Participation in health promoting & empowering community development for general population (COM-6)

A hospital which wants to qualify as a “Health Promoting Hospital” definitely has to invest in strategies 1, 2, 3 for its patients, staff and community, and – depending on the situation of other health care services in the community and the legal and financial framework – also should invest in strategies 4 –6 (for patients, staff and community).

Putting health promoting policy into action

The distinction between HP quality assurance / development and new HP services as object of strategic planning is also relevant for implementation. In the latter case, the implementation of specific additional, mainly educative, health promotion programmes relating to strategies 4-6 (either for patients, staff or community) has to be done as well prepared and well done as any new service (based on principles of project management, etc.). Health promoting quality assurance / development in a comprehensive sense is more demanding.

Just like quality, the principles of health promotion have to be realised in all relevant decisions of the hospital (management and expert decisions by all professional groups of the hospital). To realize this total HPH approach, HPH needs a support system in the same way as it has been established for quality in many hospitals already. The specific HPH support system can either be integrated into an existing hospital quality management system, or be developed as a system of its own. There are examples of integration with already existing quality systems [22].

For implementing concrete measures, it will be helpful to work alongside specific policies (e.g. nutrition, smoking, stress management, continuity of care). These policies have to be anchored in the hospital strategic planning (based on specific relevant problems and expectations in the hospital’s environment).

The total HPH approach implies the following developments in the hospital:

Concerning outcomes

The wider definition of health gain as argued above, has also to be monitored; therefore there is a need for defining specific indicators for the health promotion interventions (clinical outcomes + holistic health, quality of life, patient satisfaction, equitable health and – health promotion specific – health literacy).

Concerning structures and processes relevant for producing these outcomes

In order to achieve health gain in the proposed sense, hospital structures and processes need to be further developed according to health promotion principles and criteria:

- Health promotion has to be an explicit aim and value in the mission statement of the hospital (should include reference to patients' rights, health of patients, staff and community etc.)
- There has to be clear commitment by top management towards health promotion. There should be a formulated health promotion strategic policy document, specifying aims, goals, targets and health promotion strategies, and policies to reach them. It is useful to specify an annual health promotion action plan with a specific budget earmarked for health promotion.
- A specific health promotion management structure or a reliable inclusion of health promotion principles, goals and targets into the existing management structure is needed. An example for such a management structure would be: health promotion steering committee, participation of hospital staff from all levels (inter-professional, inter-hierarchical, inter-departmental), patients and relatives as well as other relevant stakeholders should be safeguarded, health promotion manager / team, providing continuous support for HP interventions (professionals, departments), network of health promotion focal points in all sub-units of hospital, a specific health promotion organizational manual could be helpful in everyday practice.
- In order to influence everyday clinical practice, HP must be integrated into standards, guidelines, clinical pathways for routine decisions and actions.

- Staff has to be regularly informed and involved. Examples would be: health circles, employee suggestion system, implementation projects, newsletters, annual presentations, forum on website. Education and training for staff and leadership have to be provided for agenda-setting and creating resources.
- Networking with health service providers (liaison services) and other stakeholders in the community should be actively sought.

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Development of standards for disease prevention and health promotion (Anne Mette Fugleholm, Svend Juul Jørgensen, Lillian Møller & Oliver Groene)

The integrated activity of hospitals with regard to treatment, rehabilitation, disease prevention and health promotion forms a continuum and should be subject to the same requirements for quality development as other services of the hospital sector. In spite of the increasing evidence of the value of health promotion as part of hospital services few resources have been directed to the definition of quality goals for this area.

A working group under the HPH Network has thus developed a set of standards for the overall activity of HPH, defining the effort that should be made by hospitals and organizations in the health care sector with regard to disease prevention and health promotion. The principles and definitions that form the basis of the standards as well as the process followed by the working group are described in this chapter.

Underlying principles for work on HPH

The Vienna Recommendations

The Vienna Recommendations on Health Promoting Hospitals [1] (based on WHO's Health for All strategy, the Ottawa Charter for Health Promotion, the Ljubljana Charter for Reforming Health Care and the Budapest Declaration on Health Promoting Hospitals) establish that a health promoting hospital should:

1. Promote human dignity, equity and solidarity as well as professional ethics, acknowledging differences in the needs, values and cultures of different population groups.
2. Be oriented towards quality improvement, the well-being of patients, relatives and staff, protection of the environment and development of a learning organization.

3. Focus on health in a holistic perspective and not only on curative services.

4. Be centred on people and provide health services in the best way possible to patients and their relatives in order to facilitate the healing process and contribute to the empowerment of patients.

5. Use resources efficiently and cost-effectively and allocate resources on the basis of an assessment of contributions to health improvement.

6. Form as close links as possible with other levels of the health care system and the community.

Health promotion

Health promotion efforts should focus on:

- developing a policy;
- providing supportive environments;
- strengthening initiatives at community level;
- developing personal skills;
- reorienting health services so that disease prevention and health promotion become an integrated part of curative efforts.

Health promotion initiatives are thus oriented towards increasing the competence and the capacity of individuals and towards providing a basis for change through influencing surrounding environments and local communities. Health promotion, including rehabilitation and disease prevention, is seen as an integrated part of health care services in the same way as examination, treatment, and care.

Hospital services cannot provide the foundations for health promotion through their own efforts. This requires initiatives that cut across sectors. The Ottawa Charter defines health promotion as the process of enabling people to exert control over the determinants of health and thereby improve their health. It is described as a 'process', the purpose of which is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively to exert control over the determinants of health.

Determinants of health can be divided into:

- determinants that can be influenced by the individual, such as lifestyle or the use of health care services;
- determinants that cannot be influenced by the individual, such as economic and environmental conditions.

According to the Vienna Recommendations, health promoting activities comprise the following four perspectives:

- o patients
- o health care staff
- o the organization
- o environments and communities.

Thus, it is natural to base standards for health promotion on the Ottawa Charter and the targets of the Vienna Recommendations. And the standards are linked to activities targeted at these four perspectives. Furthermore, it is important that the finalized standards help provide a basis for assessing the quality of the conditions that play a role for the links between services within and outside the hospital sector.

Prevention of disease

Usually a distinction is made between three different kinds of disease prevention [2]:

- primary prevention which prevents disease from occurring;
- secondary prevention which identifies disease at an early stage and prevents it from developing;
- tertiary prevention which prevents worsening or recurrence of symptoms and secures maintenance of functional level.

Programmes can also be defined as:

- general programmes covering activities that should address all patients and should be part of any patient pathway;
- specific programmes addressing specified groups of patients and diseases.

General programmes address general determinants of health and disease (including tobacco, alcohol, nutrition, exercise and psychosocial issues). One instance of this is lifestyle intervention, which includes activities aimed at influencing the behaviour of

individuals (alcohol consumption, smoking etc). Lifestyle intervention includes advisory and support services for patients with a view to enhancing their competence as regards to preventing disease and changing behaviour.

Specific programmes address determinants or risk factors of importance for defined groups of patients. Examples are the prevention of late complications in diabetes, education of patients with asthma, cardiac rehabilitation etc. An important element is the activation of the patient's individual resources and competencies in coping with disease. Thus, health promotion and disease prevention form a continuum.

Traditionally, hospitals mainly take care of tasks that relate to secondary or tertiary prevention, whereas the primary health care sector takes care of primary prevention. But there is a growing recognition that also hospitals have an important role to play with regard to primary prevention. Existing knowledge on the importance of lifestyle factors for treatment and prognosis should have as a consequence that all hospitals establish advisory services and offer support for lifestyle changes as an integrated part of the individual patient pathway.

One instance of this is intervention in connection with surgery. There is evidence that smoking and excessive alcohol consumption increase the risk of complications in relation to surgery. Clinical testing of preoperative intervention confirms that the patients want and accept information and intervention and that such an initiative has an effect on the occurrence of complications in the form of, for instance, decreased rate of post surgical infections, heart and lung complications [3].

Similar evidence exists of the effect of, for instance, cardiac rehabilitation programmes following acute cardiac attack. Several investigations have proved that programmes containing advice and behavioural change strategies for exercise, diet, smoking cessation etc. reduce risk of a second cardiac attack, reduce readmission rate and improve life quality in patients.

Evidence as described above has led to an increasing focus on integrating disease prevention and health promotion activities in all patient pathways, not as a supplement to, but as part of treatment [4, 5].

Standards for Health Promotion

Perspectives

A common set of standards developed by the Network of Health Promoting Hospitals involves both national and international perspectives.

In a national perspective a common set of standards can:

- provide a framework for the objectives and for concrete disease prevention and health promotion initiatives;
- give hospitals a platform for the planning and establishing of activities and for documentation and evaluation of these;
- support systematic implementation and recognition of activities carried out;
- be part of the hospitals' quality management plans and be used for quality development;
- support learning processes internally in the organization;
- provide a platform for comparisons within the national networks and support mutual learning and exchange of experience;
- uncover new needs for disease prevention and health promotion;
- support cooperation between the primary and secondary health care sectors on prevention and health promotion; and
- support the need for training of staff.

In an international perspective, the standards may furthermore contribute to:

- establish a common platform for work in the Network of Health Promoting Hospitals;
- provide a platform for international comparisons and for mutual learning and exchange of experience across borders;
- support the underlying decisions (the Vienna Recommendations).

Concepts and definitions

Assessment of the quality of hospital services presupposes that the quality level aimed at has been established. This can be described in the form of standards. A standard is a target, which should be reached or maintained in a concrete situation and within a given time frame. A standard may express an ideal quality target or a quality target that is realistically achievable in a given situation and may be expressed in quantitative or in qualitative terms:

- Quantitative terms: The standard sets the level for what is considered good quality expressed in figures (e.g. "Each patient's educational needs are assessed and recorded in his or her record" (Joint Commission on International Accreditation)).
- Qualitative terms: The standard describes the level for good quality and states what elements constitute a precondition for this level. May be expressed in descriptive terms, e.g. in instructions or guidelines (e.g. "The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves" (Canadian Council of Health Services Accreditation)).

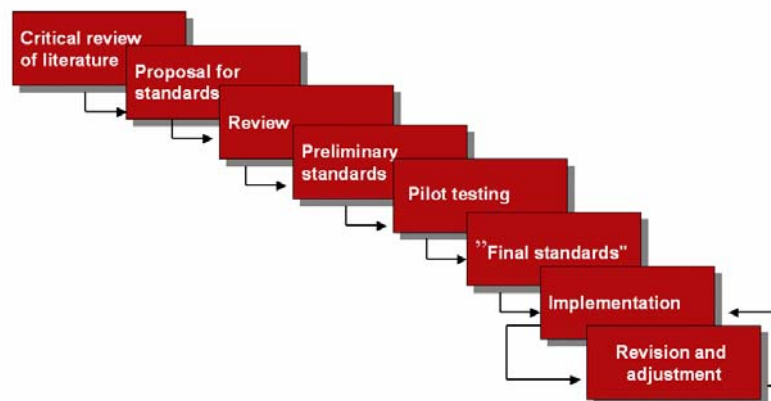
Standards may describe generic aspects, i.e. aspects that concern all patients, or standards may describe aspects specific to a certain disease that concern defined patient groups. They may be formulated for health professional, patient related as well as organizational quality. Standards may describe targets related to structure, process and outcome. A *structural standard* formulates requirements with regard to structure in connection with the delivery of a given service, resources available (e.g. physical setting, technical equipment, competencies of the health care staff, organization of work routines, cooperation structures both internally and externally etc.). A *process standard* relates to the activities that are carried out in connection with clinical tasks (examination, treatment and care) or the organizational support processes (e.g. the use of clinical guidelines, patient education etc.). An *outcome standard* describes the effect that is achieved with regard to the patient's condition (e.g. pain relief, quality of life, functional level or survival) or the effect of the organization's activity in a broad perspective (e.g. staff satisfaction, staff absence, occupational accidents, etc.)

Assessment of the achievement of a given standard may be carried out through internal and external audit, benchmarking or user assessments in a broad sense: patients, relatives, staff, healthy users etc. User assessment may be carried out through questionnaires or interviews. Standards should meet a number of requirements that secure that they constitute meaningful and clinically useful targets. They should be evidence based to the widest possible extent, valid, reliable and suited for generalization, accessible and unequivocal. A description of development process, testing carried out and planned implementation should be linked to the standards.

International principles for the development of standards

The process as outlined in the ALPHA Programme by ISQUA – the International Society for Quality in Health Care – follows the following steps (Figure 1):

Figure 1: ALPHA principles for standard development



Generally, the full development of standards from the very first stages is a resource and time demanding activity. The development and description of standards is typically taken care of by interdisciplinary groups whose composition reflects the perspective of the standard in question. Thus, professional standards are to be developed by health care professionals whereas the development of

organizational standards should also involve individuals with administrative and organizational competencies.

The first step in the development process is review of scientific literature within the area selected and the development of a proposal for 'preliminary' standards. Following this, the standards should be subject to review and pilot testing resulting in a set of 'final' standards. It is necessary to revise and adjust the standards on an ongoing basis in order to secure that they are updated and relevant.

The ALPHA programme was initially developed for use in international accreditation organizations that carry out external quality assessment of health care services based on standards. It sets internationally accepted requirements with regard to form and structure of the individual standards and their use. This concerns:

- focus of the standard including securing patient participation, compliance with patient rights, focus on continuing quality improvement, focus on current quality monitoring, requirements for systematic monitoring and follow-up;
- standard types including requirements for standards with regard to structure, process and outcome;
- the scope of the standards including requirements both for generic standards and for certain types of departments and patient groups, disease specific standards; and
- the formulation of standards, including requirements for a well-defined procedure for professional involvement, involvement of interested parties, integration of legislation and agreements, research and updating, requirements with regard to testing of standards and requirements with regard to evaluation and revision.

There are four significant aspects involved when a decision is taken whether to develop own standards or use standards developed by others: 1. resource use - time and economy (development and maintenance), 2. ownership and local basis, 3. approval in the organization and 4. possibilities for comparisons.

Standards and evidence

Standards should be evidence based to the extent possible. The specific disease preventing activity is concrete, well documented and, to a wide extent, evidence based, but in the case of health promotion the evidence available is limited. It is possible, however, to identify a number of areas in which evidence is available with regard to the effect of health promoting activity and in which the hospital sector should play an active role.

Thus, at the individual level there is evidence for the effect of counselling on health behaviour through so-called brief intervention, which is a cost-effective way of supporting individuals with regard to smoking cessation and reduction of alcohol consumption. This is also true of guidance on exercise especially for overweight persons, initiatives to reduce the risk of falls among senior citizens and education of asthma patients (asthma school), cardiac rehabilitation, prevention of late complications in diabetics through counselling, etc.

Against this background, in many European countries national initiatives have been established with the aim of supporting disease prevention and health promotion within the health care sector. One instance of such a national initiative is the report that was recently published by the Danish Society for Internal Medicine [5]. This report offers a review of existing evidence within *disease prevention*. In this report the Society recommends which tasks should be taken care of by any department of internal medicine in relation to various lifestyle factors. This concerns:

Tobacco:

- identification of smokers and the establishing of thorough tobacco case history;
- oral and written information for patients on the damaging effects of smoking and the beneficial effects of smoking cessation and opportunities for smoking cessation assistance;
- establishing of smoking cessation services or integration of smoking cessation counselling as part of treatment.

Alcohol:

- identification of patients with extensive alcohol consumption;
- brief intervention services or referral to alcohol unit.

Exercise:

- identification of patients that need advice on physical activity;
- advice on exercise in accordance with international guidelines;
- establishing of systematic exercise services for relevant patients.

Nutrition:

- identification of malnutrition and patients in risk of malnutrition;
- initiation of relevant nutrition treatment;
- communication of information on discharge (for own physician, home visitors, general practice).

Special patient groups:

- identification of patients with metabolic syndrome (cardiovascular disease and/or overweight), advice on prevention and referral to relevant intervention (diet, exercise etc.);
- identification of patients with hypercholesterolaemia, dyslipidaemia and hypertension, risk assessment and advice on prevention and initiation of relevant intervention (diet, exercise etc.);
- identification of patients with type 2 diabetes and glucose intolerance, risk assessment and initiation of relevant intervention (diet, exercise etc.);
- systematic screening of diabetes patients for late complications;
- identification of patients with osteoporosis, risk assessment (fracture marker, X-ray, hereditary predisposition) and advice on and initiation of relevant intervention.

A common set of standards for disease prevention and health promotion for Health Promoting Hospitals should contain standards that lay down requirements for an organization's overall activity that concern patients, health care staff and the general environment. Furthermore these standards should reflect the basic principles (the Vienna Recommendations) and objectives for activity adopted within HPH. Finally, it is relevant to provide opportunities for local supplementary standards. This may concern e.g. standards that reflect

national legislation, rules or local targets for the national networks and existing international standards/targets for disease prevention and health promotion.

At the same time it is important to include a suitable balance between standards that concern generic quality and disease specific quality. When selecting standards it is relevant to support the learning potential of the hospitals by including standards that secure that the hospitals themselves assess health professional quality.

Existing standards in the area of disease prevention and health promotion

In spite of available evidence for the effect of disease prevention and health promotion on the outcome of treatment, few resources have so far been allocated to the description of quality objectives, development of standards, with regard to disease prevention and health promotion.

At the 9th International Conference for Health Promoting Hospitals, Copenhagen, May 2001, WHO commissioned a working group to develop standards for health promotion in hospitals. Draft standards had been discussed with experts in health promotion and standards development during previous workshops in Bratislava, May 2002 and Barcelona, November 2002, and five standards elaborated, each consisting of a standard formulation, objective, definition of criteria and measurable elements.

In connection with the development of the new standards, the working group conducted a review of existing sets of standards from six large accreditation organizations in Australia (Australian Council of Healthcare Service), Canada (Canadian Council of Healthcare Service Accreditation), USA (Joint Commission International), France (Agence Nationale d'Acréditation et d'Évaluation en Santé), England (Health Quality of Standards) and Scotland (Scotland Board of Standards).

None of these organizations at the time of the review had developed specific standards for disease prevention and health promotion. Some sets of standards did, however, include issues relevant to disease prevention and health promotion (Table 1).

Table 1– Existing international standards concerning disease prevention and health promotion.

<p>Prioritization of the patient’s needs for prevention, palliative, curative and rehabilitation services is based on the patient’s condition on arrival (JCI). The hospital co-operates with the primary sector to secure timely and appropriate further referral. (JCI). Patients in risk of malnutrition are offered nutrition therapy (JCI). The hospital co-operates with relevant sections of the primary sector in order to promote health and prevent disease through information and guidance. (JCI). The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves (CCHSA). The department has carried out an assessment of risk factors in connection with the services and care provided within the past 12 months and has registered the results (HQS). The hospital carries out individual preliminary assessments adapted to special patient groups (including patients that show signs of drug or alcohol dependency) (JCI).</p>
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In addition to these specific standards, some standards were identified which address aspects that are **also** significant to disease prevention and health promotion, mainly standards that concern information. Table 2 shows examples of such standards.

Table 2 – Existing international standards regarding aspects relating to prevention and health promotion

<p>Patients and relatives receive information and guidance so that they can take part in decisions on treatment and care throughout the patient pathway (JCI). Patients and possibly relatives should receive guidance in a way and in a language that they understand (JCI) Guidance and training supports the patients’ continuing needs with regard to health (JCI) The team gives its clients and families all the relevant information about its services (CCHSA)</p>
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Accreditation standards concerning areas such as patient safety and infectious control are not shown here.

Process for the development of standards

The decision to develop a set of standards for health promotion and disease prevention in hospitals was a consensus decision reached at a meeting with representatives from all national networks forming the Network of Health Promoting Hospitals in May 2001. A working group was established and it was decided to follow the recommendations of the ALPHA programme for the development of standards. The first step was a critical review of literature focusing on evidence for the effectiveness of preventive and health promoting programmes and on existing standards for hospitals. There is solid evidence for the value of health promoting programmes and it was found that existing sets of standards only marginally address the issue of health promotion in hospitals.

The WHO working group followed all steps in the ALPHA programme in the development of the draft standards for health promotion in hospitals. It was decided to follow the patient's pathway through the hospital and describe the needs and activities appropriate to meet the patient's needs. Much weight was put on the responsibility of the leadership of the hospitals and on the role of the staff.

A first draft of standards was proposed in an expert workshop in Bratislava, Slovakia in May 2002. Following this workshop, the draft standards were discussed at the annual meeting for national and regional network coordinators in connection with the International Conference on Health Promoting Hospitals. The 2nd draft of standards was discussed and rephrased and a review form for the pilot test was set up in a new expert workshop in Barcelona, Spain, in November 2002. At the same time the set of standards was handed over to the international accreditation agencies and other bodies involved in quality improvement in health care for comments and suggestions. A pilot test of the standards was undertaken in February 2003. The pilot test resulted in a number of suggestions for improvement and clarification of the standards which were discussed at a 3rd expert workshop in April 2003.

Presentation of the standards, now regarded as the first edition of the final standards for health promotion, took place at the 11th International Conference on Health Promoting Hospitals in Florence, Italy, in May 2003, and it was decided to set up a WHO working group to develop an online self-assessment tool based on the final standards.

The pilot test

The aim of the pilot test was to assess the standards and not to assess the test hospitals. However, an anonymous analysis of the information on the hospitals' actual compliance to the standards was carried out in order to assess the need for these standards. Most standards complied moderately with the standards, which indicates that the standards are applicable in principle and that there is room for improvement with regard to the standards fulfilment. A review form was set up for the pilot test and 36 hospitals in 9 European countries tested the standards (6).

Standards 1 and 4 were assessed by the hospital management, whereas standards 2, 3, and 5 were assessed on the basis of an audit of 20 randomly chosen clinical records of patients admitted during the last three months prior to the pilot test, and being discharged. The term "patient's record" covered all kinds of documentation (medical record, nursing record, therapists and dieticians notes, etc.) that had to be taken into consideration in the assessment of the hospitals' compliance with the standards. It was recommended that the audit group should be an interdisciplinary group of professionals with good knowledge about the documentation routines of the unit.

The five core standards were considered relevant by the test hospitals as 32 out of 36 hospitals found all standards relevant and applicable. Valuable comments were given by the participating hospitals and by the national coordinators. The overall view is that the introduction of standards is proper and necessary and that the way they are structured makes the standards suitable for practical use. Although the criteria were generally accepted, few of them were met by the test hospitals, which leads to the conclusion that there is room for considerable improvement of the health promoting activity of the HPH hospitals. An assessment tool was commented on, and a draft was revised, restructured and redesigned before being pilot implemented for self- assessment and possible benchmarking in hospitals. Measurable elements and indicators were developed further for the self-assessment tool (7). The tool is accompanied by a manual and glossary of terms. Furthermore, specific guidelines may be developed to supplement the standards.

The standards

The final set of five standards concern: Management Policy, Patient Assessment, Patient Information and Intervention, Promoting a Healthy Workplace, and Continuity and Cooperation. The standards relate to patient pathways and define responsibilities and activities concerning health promotion as an integrated part of all services offered to patients in every hospital. Each standard consists of a standard formulation, objective and definition of sub standards (Annex 3).

Conclusion

The need for and the relevance of setting standards for health promotion in hospitals was realized in the European Network of HPH and over a 2-year period a set of standards was developed. The process followed the principles of the ALPHA programme set up by ISQua in order to make the standards applicable and acceptable in all hospitals and in order to make it possible to integrate the standards in existing quality standards for hospitals as established by several international and national quality and accreditation organizations.

The standards have now been through a pilot test, which has confirmed that they are understandable, meaningful, relevant and applicable. International quality organizations are encouraged to integrate the standards in their already established sets of standards and in the future use of the standards.

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Implementing the Health Promoting Hospitals Strategy through a combined application of the EFQM Excellence Model and the Balanced Scorecard (Elimar Brandt, Werner Schmidt, Ralf Dziewas & Oliver Groene)

Introduction

The Health Promoting Hospitals (HPH) concept offers an innovative and important model for the further development of modern hospitals in order to meet the demands induced by new financing systems, pressures for transparency and quality performance, and high employee workloads. Hospitals have to improve the health of both patients *and* employees to ensure the financial basis of the work and to contribute to the attraction and retention of engaged and motivated hospital employees. An increased provision of community-oriented health promotion strategies further improves the competitive advantage of a hospital.

So far, the HPH concept has mainly been introduced into hospital practice through individual projects that raised the awareness among hospital staff and managers for such strategies and ensured a place for health promotion in hospitals in many countries. In order to further support the development of health promotion services in hospitals, a better integration into the organizational structures and the culture of a hospital is necessary. This however is a question of strategy and of its control by management. For that reason, efforts to introduce the concept of health promotion in hospitals should focus more strongly on strategy implementation rather than on individual projects.

WHO has declared that the implementation of the concepts, values and standards of health care into the organizational structure and culture of the hospital is a main objective of the International Network of Health Promoting Hospitals [1]. This chapter describes a strategy to implement the HPH concept through a combination of the European Foundation for Quality (EFQM) model and the Balanced

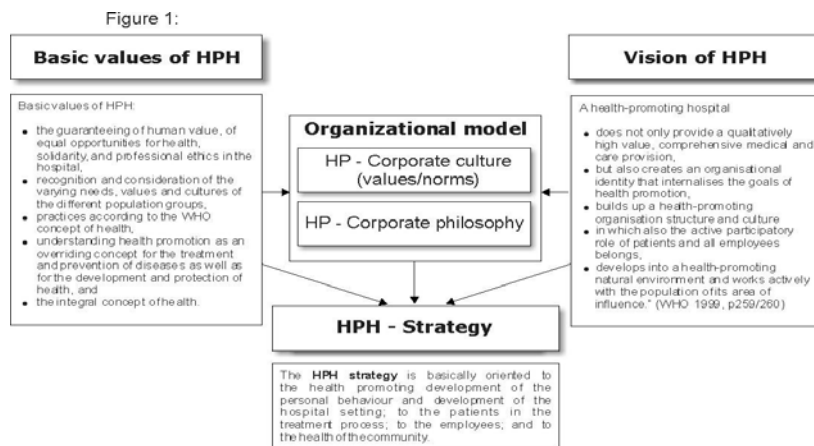
Scorecard (BSC) approach, which is being applied in a pilot project at Immanuel Diakonie Group (Baptist Group of health care centres in Berlin and Brandenburg, Germany).

From health promoting values to health promotion strategy

A business strategy must be derived from the mission of an institution. The mission describes the reason why the organization exists and how the individual business units are to be organized in the structure of the business. A business mission normally remains largely stable over long periods of time. Additionally, a well-formulated mission always has an external effect since it expresses how the business wants to be seen from “outside” by its customers. In addition to external addressees, the employees and potential employees, as internal receivers, assume the mission and can thus cooperate better in its realization.

A hospital’s mission is primarily determined by its commitment to care and by the prescriptions of its owners. However, a health promoting hospital should include in its mission, or at least in its business philosophy, basic values and guidelines, the general HPH mission: to promote the health of patients and staff, to improve the health promotion potential of the hospital organization, to provide health promotion services for the community they serve [2].

The basic values are incorporated in the corporate philosophy, the officially stated understanding of the organization. These include the guiding ideas of the business, the highest goal system, operational ground rules, concepts of values and norms, and other defining orientations which finally reflect and form the corporate culture, and which can be presented together with the mission in the organization's model. The corporate culture is a critical success factor for structural transformation and integration processes such as the implementation of the HPH concept [3].



Unlike the mission, the *vision* contributes to an image of the organization's future. It provides the direction in which the organization has to change itself, a formulated vision that clarifies the goal of the organization development and helps building up an understanding of necessary change processes in the employees. It shows them how and why they can and should support the organization in its development [4].

The preparation of a vision marks the bridge from a relatively static mission and basic values that only change over the long term to the dynamics of strategic changes. An important step in this is the definition of the "*strategic destination*". This is where the formulation is made of what the organization will look like in 3 to 5 years and how it will appear to the financial decision-makers, customers and internal employees. A hospital that sets out to become an HPH hospital must include this visionary orientation into its own vision and definition of its own strategic destination.

The *strategy* is the way an organization chooses to realize its mission and vision. A strategy has a number of clear target points and thus creates a unique competition position for a business [5]. As a starting point for strategy development, the vision, values and direction bases must be the model and strategic basic decisions of the business direction. With these measures, the business framework for applying the strategy is set out.

The strategy specifies the general direction (vision) of the business and sets priorities. It consists mostly of self-completing

themes (the so-called “*strategic key themes*” or “*strategic impulse directions*”) that make it possible to segment the strategy into different categories and to structure its application in the various business fields. In that respect, strategies provide information about what is to be done as well as what is not to be done. Once a hospital’s strategic destination has been defined, the identification of these key themes of the strategy is the important step to the subsequent deduction of strategic individual objectives and standards. The usual three to five key themes are what ultimately form the strategy given that they are the “business impulse directions” that should lead to the achievement of the strategic destination.

Implementing the HPH concept in the organizational structure and culture of the hospital

We distinguish two different models to implement the HPH concept in the organizational structure and culture of the hospital: the *addition model* and the *integration model*. The addition model embraces the integration of the HPH concept through project management and the organizational development with a “specific HPH subsystem within the hospital”, while the integration model refers to the implementation of the HPH strategy as a continuous organization development process in association with comprehensive quality management following the EFQM excellence model [6], the HPH strategy implementation through application of the Balanced Scorecard (BSC), and/or the combination of EFQM and BSC.

The Addition Model

Implementation of the HPH concept through project management

To date, the HPH concept in practice has mostly been introduced into day-to-day hospital life through separate projects. While it is a good starting point to introduce the idea of health promotion into hospitals, there are limitations regarding the impact and the sustainability of projects:

- It is often difficult for the medical-therapeutical employees to recognize the usefulness of the HPH concept for the treatment

process or to put the HPH requirements into practice in the busy daily routine. It often fails in the process of associating individual projects with the hospital's core process.

- Leaders and administrators often see no advantage in introducing HPH to ensure the institution's economic viability. Rather, a financial burden is perceived through projects for which no, or only marginal, significance arises for the strategic progress of the institution. For that reason, willingness to invest in individual HPH projects financially and with personnel is often minimal.
- The high and increasingly growing employee workload is raised as an argument against the HPH orientation of "health promotion of employees" and the requirement for "health-promoting workplaces". Therefore, many employees invest their free time or work overtime for the project activities.
- HPH activities in the hospital are largely carried out beside or outside the quality management. For that reason, the assumption and application of good results after the termination of the project is often lacking. In particular, the fact that the projects *are per se* limited in time can harm the lasting effect of the HPH implementation.

Upon consideration of this incomplete list of problems and barriers, arises the need for preparing a presentation of the HPH concept that should be understandable and motivating for employees and management: it should also be a convincing argumentation of its value for patients, relations and employees as well as the competitive advantage it grants the hospital. Health-promoting projects will further be a form of application of the HPH concept in hospitals. However, in light of the goal of introducing the HPH concept systematically into the structure and culture of the hospital, this approach is not sufficient.

Organizational development with a "Specific HPH subsystem within the hospital"

Implementing the HPH concept into the structure and culture of the hospital is a medium to long-term task because it demands integration of the HPH basic values and vision into the hospital's business culture and value system [3]. This knowledge is taken into account by the method that extends the HPH project management to "a comprehensive and continuous organization development

strategy... supported by a *specific, organizational HPH subsystem* within the hospital” [7].

The application of this model demands a high degree of personnel, financial and organizational commitment. Once health promotion has been explicitly stated as a value in the hospital’s model, it requires specific strategic guidelines for HPH, a specific annual HPH action plan, a specific organization handbook for HPH, and a specific HPH management structure with HPH steering committee, HPH project leader, and/or HPH project manager, as well as a network of HPH link-persons at sub-department level.

Moreover, a comprehensive implementation of the HPH concept in the organization process would have to be supported through specific employee participation in health circles and a hospital suggestion system through a specific HPH budget, specific HPH information strategies such as pamphlets and annual presentations, as well as specific HPH training for employees, and assured through specific HPH control measures such as regular questionnaires or a Balanced Scorecard.

However, if this model is properly applied, it approaches the HPH integration model which can nonetheless achieve a comparable transformation of the business culture through comprehensive quality management, an HPH-oriented Balanced Scorecard, or a combination of the two, without needing an HPH specific sub-system with its own HPH plans and HPH management structures.

The Integration Model

The handbook for “Quality Management and Health Promotion in the Hospital” prepared by the Berlin-Brandenburg Regional Network includes a practical guide that makes it possible to apply quality management, which is required by law, to pay special attention to the goals of the HPH concept and thus to discover and generate potentials for improvement in the hospital organization that are in line with the HPH strategy. By means of this procedure, which makes use of the compatibility of HPH strategy and quality management in accordance with EFQM, a hospital can experience a continuous process of approach to the vision of health-promoting hospitals.

Because HPH concept application to hospital practice actually involves the implementation of an HPH strategy, it is also basically

possible to use a modern management instrument such as the Balanced Scorecard for strategy implementation, which is increasingly being used in the public sector and hospitals in any case.

When BSC is being used for implementation of the HPH strategy in a hospital, a maximum of three to four strategically meaningful goals must be derived for the hospital in question form (the strategic HPH key themes), that can be adapted to the four perspectives of customers, finances, internal processes and innovation. As a rule, each objective requires that a measurement, a target value and a strategic initiative (measure, project) be established. Even a hospital that has limited itself to the use of the Balanced Scorecard for implementation of the HPH concept could develop into an HPH strategy-focused organization.

In the following, we describe how the WHO pilot project of the Immanuel Diakonie Group integrates the HPH concept into its organizational structure and culture through a continuous organizational development process in association with comprehensive quality management, according to the EFQM excellence model and using the Balanced Scorecard.

The WHO HPH/EFQM/BSC Pilot Project in the Immanuel Diakonie Group

Since 25 February 2002, the general WHO pilot project for implementation of the HPH strategy has been running in five care centres of the Immanuel Diakonie Group (IDG) under the overall control of the managing director of the IDG and chairman of the German network of health promoting hospitals. Each of the five institutions has a different profile and organizational culture so that a large number of experiences are to be expected from the pilot project.

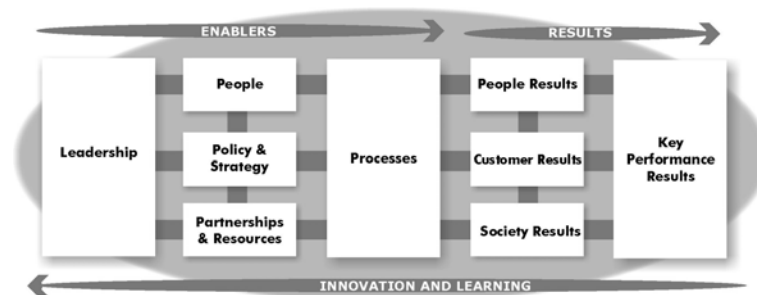
One of the institutions involved is a founding member of the German Network of health promoting hospitals and a member of the European Foundation for Quality Management, and carried out a self-assessment following the EFQM model in 1998. The other institutions are not yet recognised as HPH hospitals and for them, even Quality Management in accordance with EFQM is new territory. This also applies to the preparation of a Balanced Scorecard for all five hospitals.

Application of the EFQM Excellence Model

Basic information about the EFQM Model

The EFQM model is an open structure for evaluation and improvement of quality in businesses and institutions consisting of nine criteria and thirty-two sub-criteria [8]. Its basis is that excellent results relating to performance, customers, employees and society will be achieved by a direction that places a high value on policy and strategy, employees, partnerships, resources and processes.

Figure 2: The EFQM Model



The arrows emphasize the dynamics of the model and show that innovation and learning improve the qualifier criteria, which in turn yields improved results. Application of this model is an excellent precondition for the introduction of a comprehensive quality management in the hospital, since the EFQM model is the most comprehensive model in terms of content for evaluation of business quality on which other quality certifying models such as ISO, JCIA and KTQ are based. In our view, it is also the optimal Quality Management model for the comprehensive and systematic integration of the HPH concept into the hospital organizational structure and culture. Not only is it a diagnostic instrument for evaluating the current status of business quality, but it also represents a commitment to continuous improvement towards more quality.

A self-assessment following the EFQM model, i.e. a comprehensive, systematic and regular check of the activities and results of an organization, makes it possible to recognize and evaluate the strengths and potentials for improvement of an institution. On this

basis, improvement plans can be set up and put into practice, and progress in the direction of excellence can be measured periodically.

The EFQM model was originally developed for quality improvement in industrial companies, but the model has also shown its value in non-profit institutions and public administration, and has been tested and applied also in hospitals of the European region. Two problems have arisen that must be taken into account when introducing the EFQM model: a) the technology of the EFQM model derives from industry and needs a “translation” or transformation into hospital language and situations, and b) the evaluation process is found to be too complicated, especially by small hospitals.³

The integration of the HPH Concept into the EFQM Model

The use of the EFQM model in health promoting hospitals has been systematically promoted since the 7th International HPH Conference in Swansea through conceptual work [9] as well as through exchanges in HPH/EFQM workshops at all international HPH conferences since 1999.

The Berlin-Brandenburg Regional HPH Network has been actively involved in this development and prepared the handbook to EFQM introduction: Qualitätsmanagement & Gesundheitsförderung im Krankenhaus [6], which appeared in 2001. At the request of the German HPH network, 13 authors from 9 Berlin and Brandenburg hospitals put the handbook together with the goal of preparing a practical guide for the combined application of the HPH concept and EFQM model. An important starting point for this project was the obvious compatibility of the fundamental excellence concepts of HPH and EFQM.

³ In addition to national initiatives for solving these problems, a European EFQM Health Sector Group has been addressing such questions for some years (for further information Key Contact HPH/EFQM werner.schmidt@immanuel.de).

Figure 3: Compatibility of HPH and EFQM concepts



Experiences and results with the Self-Assessment Process following EFQM

To carry out the HPH/EFQM self-assessment according to the handbook in each of the five institutions of the pilot project, 8 criteria teams were assembled for the 9 criteria of the EFQM model, because under EFQM criteria 3 “employees” and 7 “employee-related results” are both dealt with by one team. Out of the total of 40 criteria teams, about 180 employees were working actively on the self-assessment; thus more than 10% of all employees of these institutions are directly involved in the pilot project.

The training was offered initially to all team leaders, the so-called criteria managers, and then to all team members to give the employees the possibility of finding out about the basics of the EFQM model and the purpose of the self-assessment. Since then, a quarterly four-page pilot project newsletter (“Pilot News”) has been printed to provide all the employees of the institutions with background information about the project and the current results.

For the organization of the whole pilot project, in addition to the project management, a coordinator and a local coordinator in each hospital were appointed to support the self-assessment process and advise the groups. Individual teams in the hospitals organize their meetings independently, while the inter-institutional experience exchange is managed by the project coordinator who also helps the local hospital coordinators with their work.

At present, interim results are available from the individual teams. The presentation of the completed self-assessments for the whole report was scheduled for December 2002, so that work could begin in January 2003 in evaluating them and prioritizing the processed suggestions for improvement. If one views the progress of the project to date with regard to the EFQM self-assessment according to the handbook Quality Management and Health Promotion in Hospitals, the experiences other institutions have had with the EFQM model are stated.

Quality Management procedures and terminology in accordance with EFQM are obviously difficult for the employees in hospitals to handle. In particular, EFQM terminology is strange in the hospital context and it is difficult for employees to understand why the self-assessment has to be done according to these procedures and what value the hospital expects from the exercise. Moreover, there is often scepticism about application of the improvement proposals and also fear that besides creating more work, the whole project could bring with it unpleasant changes for the working context. This problem becomes more serious because, in the case of combining HPH and EFQM, difficult concepts and terminology such as health promotion and empowerment, has to be dealt with. The available handbook does offer the necessary information in a basic form, but it would have to be related directly to hospital life and language in even more practical and relevant terms in order to avoid a high need for training all team members.

Quality Management in accordance with EFQM is also proving difficult in that it demands an unusually high degree of critical ability and analytical confidence from team members because it indirectly gives them responsibility for the institution and its future. The fact that a critical view of their own institution is called for in the self-assessments (because only an honest analysis can provide a safe basis for the future improvement process) contradicts the common hierarchical structure of hospitals, which often requires employees to perform and deliver what is expected "from above". This "problem" naturally, in the long term and for each institution offering EFQM, creates an unexpected potential of informed and involved employees, since it succeeds in making positive use of their critical ability and competence instead of devaluing them.

A further problem is bound up with the changeable pace of service commonly found in hospitals. This makes it difficult to carry

out continuous work in the self-assessment teams when these are occupied in interdisciplinary pursuits. The same is true of participation in institution-wide meetings and training sessions. Here the members of the teams need strong coverage in their work areas when it comes to freeing them up for EFQM activities.

All in all, it can be said that the organization and time requirement for an EFQM analysis is not inconsiderable. Consequently, a strong central project management is required that can overcome the daily business of hospital organization. Therefore, as is the case in our pilot project, the directors should be involved in the EFQM teamwork to reduce possible problems with the hospital hierarchy. Training requirements for the employees are high, but worthwhile because their competence and organizational knowledge are considerably increased by their work in the project.

Since internal Quality Management is required of hospitals in any case, the extra effort for the application of the EFQM model is tolerable, it provides a means for discovering the institution's HPH potential and developing it within the framework of the hospital's improvement process, a task which would have to be done anyway. Thus, based upon the present experience in the pilot project, it is possible to make known both the HPH concept and its significance for the business' future to a large number of people.

Furthermore, the whole business organization is confronted with the proposals of the HPH concept and examined critically for compatibility with this application. In this way, EFQM self-assessments provide a comprehensive base analysis for implementing the HPH concept into a hospital's business structure and culture. Applying the resulting proposals for improvement makes possible a notable development towards a health promoting hospital, if the choice of the suggestions to be applied is in line with the HPH application proposals. This is to be established in the Balanced Scorecard work of the pilot project run by the care centres of the Immanuel Diakonie Group.

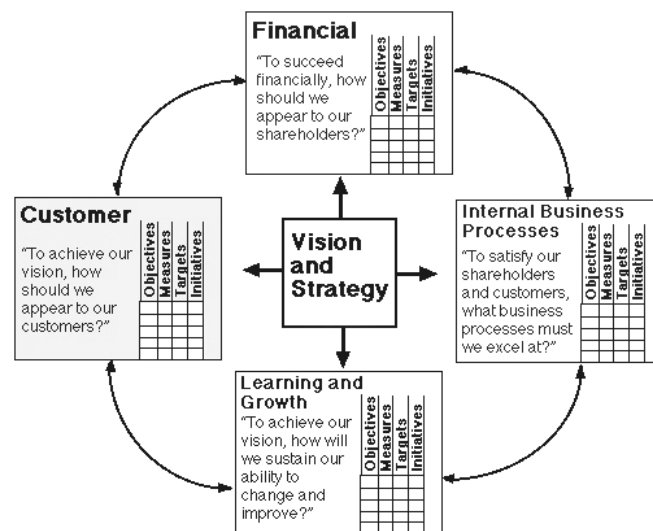
HPH strategy implementation with the Balanced Scorecard

Basic information about the Balanced Scorecard

The Balanced Scorecard is a management technique designed by Kaplan and Norton [4] to solve the problems of strategy transformation. Its goal is to unite a strategy thoroughly with the company's operational business. It is thus an optimal tool for the specification, presentation and follow-up of strategies [10]. As such, the Balanced Scorecard has developed into a management instrument that has achieved worldwide recognition in matters of strategy implementation. In the centre there are the selection and presentation of strategic objectives since these control behaviour in the strategy direction.

The BSC transforms the strategy into an integrated system made up of four basic business perspectives: the finance, the customer, the process, and the innovation perspectives.

Figure 4: The Balanced Scorecard

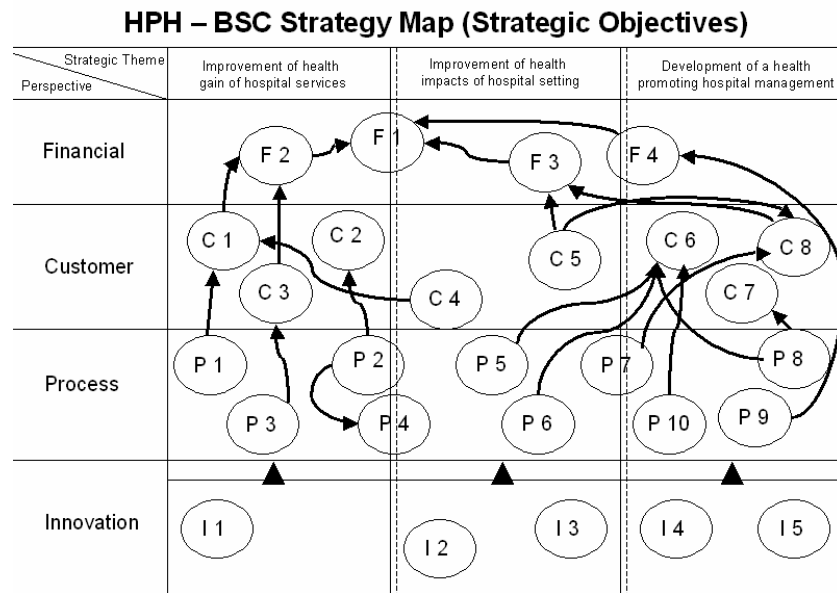


Horváth [10] distinguishes five phases that belong to the implementation of a Balanced Scorecard: first, one must create the organizational framework for its preparation, then clarify the strategic

bases, thirdly develop the BSC itself, then manage the rollout and finally assure the continuous implementation of the BSC. The goal of the five phases is to develop a business into a “strategy-focused organization” in which the Balanced Scorecard is firmly rooted in the management system.

Also in the international HPH network, we are ideally striving towards an “HPH strategy-focused organization” and can take advantage of our specific goal setting of experiences of hospitals in German-speaking areas and also in the USA. If a Balanced Scorecard for implementing the HPH strategy in a hospital is to be applied, for each of the maximum of five strategic HPH key themes, about three or four strategically significant objectives for the hospital in question would have to be derived and then adapted to the four perspectives: customers, finance, process, innovation (Figure 5).

Figure 5: Example for a HPH Strategy Map



* arrows indicate possible cause-effect relationships between strategy objectives.

- F 1 Secure economic situation & liquidity
- F 2 Increase patient loyalty
- F 3 Develop marketing for health promotion activities
- F 4 Assess effective and efficient employment of resources for health gain
- C 1 Empowerment of patients for health promoting self-reproduction

- C 2 Empowerment of patients for health promoting coproduction in treatment and care
- C 3 Empowerment of patients for health promoting disease management and life style development
- C 4 Develop hospital into a health promoting setting for patients and visitors
- C 5 Develop hospital into a health promoting setting for the community
- C 6 Improve staff satisfaction
- C 7 Pay attention to health promotion-related expectations of shareholders
- C 8 Improve hospital image in the community
- P 1 Identify and respect patients needs
- P 2 Document and integrate in patient records health promotion-related information
- P 3 Establish health literacy activities for disease management and healthy lifestyles
- P 4 Integrate health promotion activities in patient discharge and post-hospitalization
- P 5 Empower staff for managing the consequences of occupational diseases
- P 6 Establish guidelines and procedures for improving the physical and sociocultural workplace
- P 7 Improve the physical and socio-cultural environment for the population in the community
- P 8 Leadership Excellence
- P 9 Incorporate health promotion activities in the quality management system
- P 10 Integrate health promotion in personnel development
- I 1 Develop health promotion competencies for staff („strategic skills“)
- I 2 Develop hospital into a health promoting and empowering setting for staff („healthy workplace“)
- I 3 Increase staff motivation for participation in health promotion and quality improvement („climate for Action“)
- I 4 Incorporate health promotion in information technology
- I 5 Build up a strategic health promoting cooperation

For this overall maximum of 20 goals, the linking cause and effect relationships are shown in the BSC. This provides a graphic strategy card for the institution. As a rule, for every objective (which can also be formulated as a standard) a measurement, a target value (or several target values for different periods) and a strategic initiative (measure, project) are defined for which objectives need to be achieved. If these objectives correspond to the HPH concept and the strategic initiatives are aimed at its realization, a hospital develops automatically into an “HPH strategy-focused organization” with the implementation of a BSC oriented to HPH proposals. In the pilot project, the care centres that belong to Immanuel Diakonie Group, first develop an “HPH framework Balanced Scorecard” that then has to be broken down for the individual institutions. This HPH framework Balanced Scorecard should then inspire other hospitals with regard to their specific mission and strategy to integrate the HPH strategy into a business BSC of their own in such a way that they will thereby develop conditions into “HPH strategy-focused hospitals” in their specific competence.

Procedure to date and initial results with the Balanced Scorecard

- 1st phase: Creating the organizational framework

After all leaders had been informed by the Managing Director of the intention to implement BSC within the framework of a kick-off meeting for the pilot project, all employees received the first "Pilot News" with basic information.

For the actual preparation of the Balanced Scorecard, an interdisciplinary BSC core team of leaders of the five participating institutions was set up with the leader of the BSC project for the community care centres, who is also involved in the BSC working group of the Berlin-Brandenburg regional HPH network. The BSC core team then decided first to produce an HPH-oriented framework Balanced Scorecard for the community care centres, which would then serve as the basis for the subsequent specification of the BSCs in the participating institutions.

In order to define the strategic destination as specifically as possible, the BSC core team further decided to involve all senior doctors in the strategy process as early as possible by means of a questionnaire. Additionally, the managing director regularly takes part in the BSC team meetings, with the result that a close and always up-to-date liaison of strategy development and company management is assured.

- 2nd phase: Clarifying the strategic bases

The actual development of the BSC (3rd phase) begins with the determination of strategic objectives for the strategic key themes. These, however, cannot be determined before the mission, values, vision and strategic destination of the business have been clarified. Therefore, in the framework of the pilot project, the following steps were first taken by the BSC core team for clarification of the strategic bases:

- holding and evaluating an interview with the managing director;
- evaluation of available strategically reportable documents;
- interviewing 20 senior doctors about strategic destination 2005;

- definition of the mission and vision (strategic destination 2005) for the IDG and as a trial for one of the five participating institutions;
- preparation of the values of the care centres of the IDG;
- decision to distribute a personal copy of the complete draft of the institution's basic values to all employees for purpose of information and expression of opinion;
- preparation of “strategic orientations” and breaking them down to four key themes (1. health gain through comprehensive patient orientation, 2. process optimization and quality management, 3. partnerships and development of health centres and 4. developing health promoting corporate culture).

The significant outcome of this strategy development process is that the mission, values and vision of the HPH concept are strongly reflected in the strategy of the pilot institution as developed to date. Eleven of the seventeen basic values of the institutions showed clear relationships to the actual concerns of the HPH concept. This then breaks down into the assembled strategic orientations, of which eight out of ten are HPH oriented. Last, all four of the “strategic key themes” that have so far been discussed in the BSC core team are associated with the HPH concept.

It can thus be considered here as an interim result of the pilot project, that the Balanced Scorecard is obviously very appropriate for the implementation of the HPH concept when the leaders of the institution, who are involved in the BSC core team, bear the HPH proposals in mind and are influenced by them when developing the strategy of the business.

Note: Since the delivery of this manuscript, a Balanced Scorecard was developed and implemented for the Immanuel Diakonie Group (Phase 3-5). The results and experiences will be published in the near future.

Conclusion

The institutions participating in the pilot project began simultaneously with both the preparation of the framework Balanced Scorecard and the Total Quality Management (TQM) following the

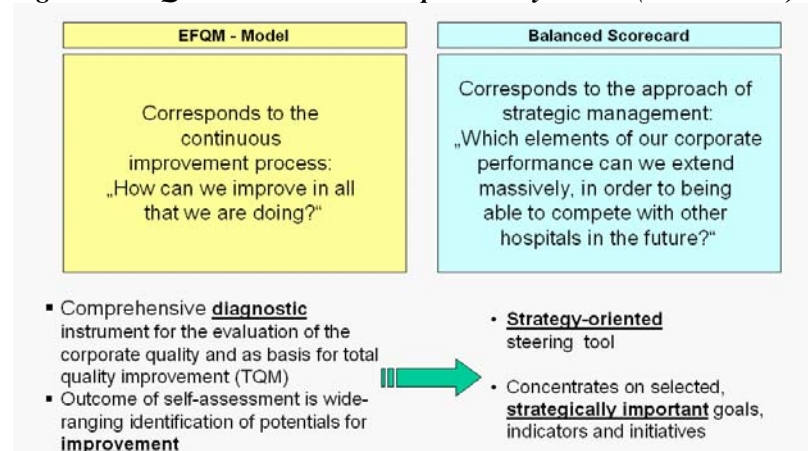
EFQM model. In this way, the two concepts should foster together the development of the five participating institutions into health-promoting hospitals.

Through the periodic thorough self-assessments in accordance with the handbook Quality Management and Health Promotion in Hospitals, an assessment is made each time on the extent to which the HPH concept is reflected in the business quality; that is to say, to what extent the concept, values and standards of health promotion are also implemented into the hospital's organizational structure and culture. In the self-assessment result, potentials for improvement are communicated and prioritized. They are the basis for the ongoing improvement process for middle- and long-term planning of measures, initiatives and projects in the "operative business". HPH projects that derive from such self-assessments are thus incorporated with goal direction into the relevant hospital's Quality Management.

However, EFQM self-assessments will provide input into the Balanced Scorecard if strategically meaningful business objectives are derived from the prioritized improvement potentials. Therefore, it is expected that the specified BSCs of the individual institutions in the pilot project will only be prepared once the HPH/EFQM self-assessments have been evaluated. It will then be possible for the suggestions for improvement obtained from the Quality Management to influence the Balanced Scorecards of the individual hospitals. These will then prepared from the HPH framework Balanced Scorecard for the business as a whole, which has already been prepared at the same time.

Everything from the experiences and results to date suggests that the agreed application of EFQM and BSC leads to synergies in the implementation of the HPH strategy. It is a matter of two complementary models of business management that complement each other with common applications. As a strategy-oriented steering instrument, the HPH Balanced Scorecard provides the direction in which the hospital is to move. The HPH/EFQM self-assessments contribute to the practical contents in the form of specific suggestions for change (Figure 6).

Figure 6: EFQM and BSC: Two complementary models (see Horvarth)



Thus, the permanent continuation of Total Quality Management following EFQM and the regular revision of the Balanced Scorecard do not only offer an excellent precondition for the lasting implementation of the HPH strategy in a hospital. Moreover, they can also develop institutions into continuously improving hospitals that serve patients, employees and their surrounding society following the health promotion strategy.

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Annex 1: Ottawa Charter for Health Promotion – First International Conference on Health Promotion, Ottawa, Canada, 17-21 November 1986

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource of everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their

fullest health potential unless they are able to take control of those things, which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:

- ***Build healthy public policy***

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

- ***Create supportive environments***

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and

their environment constitute the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

- ***Strengthen community action***

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

- ***Develop personal skills***

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is

essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

- ***Reorient health services***

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system, which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate, which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

- ***Moving into the future***

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health for All by the year 2000 will become a reality.

Annex 2: The Vienna Recommendations on Health Promoting Hospitals

Introduction

The new developments in the health promoting hospital (HPH) project, the changes in health policy and the health care reforms in Europe created a need to review the framework in which the project is based. The shift from the HPH pilot project (based on the framework defined in the Budapest Declaration on Health Promoting Hospitals) to a broader network, supported mainly by national and regional networks, and the Ljubljana Charter on Reforming Health Care provide the background for the new phase of the HPH project. The Ljubljana Charter was issued in June 1996 with the approval of the health ministers, or their representatives, of the Member States of the WHO European Region. The Charter addresses health care reforms in the specific context of Europe and is centred on the principle that health care should first and foremost lead to better health and quality of life for people.

Hospitals play a central role in the health care system. As centres that practice modern medicine, conduct research and education, and accumulate knowledge and experience, they can influence professional practice in other institutions and social groups.

Hospitals are institutions through which a large number of people pass; they can reach a large sector of the population. In some countries, up to 20% of the population come into contact with hospitals as patients every year, with an even larger number of visitors. In some cities the hospital is the largest employer; 30 000 hospitals in Europe employ 3% of the total workforce.

Hospitals can be hazardous workplaces. Hazards to health include not only exposure to various toxic or infectious chemical or physical agents but also stress arising from pressures related to the nature of the work and responsibilities involved.

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.

Traditionally, hospitals have offered a wide range of diagnostic and therapeutic services, including medical and surgical interventions, in response to acute or chronic diseases. As a result, hospitals focus mainly on illness and curative care, not health. Today, hospitals show a growing concern for patients' lives before and after their hospital stays; they show an increasing awareness of their relationships to other parts of the health field and to the community as a whole. Although hospitals have been only marginally concerned with health promotion and disease prevention, they have an enormous potential in these fields. Realizing this potential could optimize their use of resources, directing them not only to curative care but to health in its broader sense.

The growing need and new possibilities for treatment and care on the one hand, and tight public budgets on the other hand, create a situation in which health care providers and hospitals in particular have to increase their efficiency in using their resources. At the same time, the development of medical and information technology opens innovative options for health care services. As a consequence, substantial changes in the hospital as an organization are on the way, as are shifts in hospitals' responsibilities within the health care sector. A clear orientation towards health gain should contribute to services that better meet the needs of clients and consumers and to the rational use of resources.

The Vienna recommendations take account of the needs of health care reforms and the need for hospitals to be more concerned with health. They are divided into Fundamental Principles, Strategies for Implementation and Participation in the HPH Network.

Fundamental principles

Within the framework of the Health for All strategy, the Ottawa Charter for Health Promotion, the Ljubljana Charter for Reforming Health Care and the Budapest Declaration on Health Promoting Hospitals, a health promoting hospital should:

1. promote human dignity, equity and solidarity, and professional ethics, acknowledging differences in the needs, values and cultures of different population groups;

2. be oriented towards quality improvement, the well-being of patients, relatives and staff, protection of the environment and realization of the potential to become learning organizations;
3. focus on health with a holistic approach and not only on curative services;
4. be centred on people providing health services in the best way possible to patients and their relatives, to facilitate the healing process and contribute to the empowerment of patients;
5. use resources efficiently and cost-effectively, and allocate resources on the basis of contribution to health improvement;
6. form as close links as possible with other levels of the health care system and the community.

Strategies for Implementation

The HPH project provides opportunities throughout the hospital to develop health-oriented perspectives, objectives and structures. This means in particular:

1. fostering participation and creating commitment by:
 - encouraging participatory, health-gain-oriented procedures throughout the hospital, including the active involvement of all professional groups and building alliances with other professionals outside the hospital;
 - encouraging an active and participatory role for patients according to their specific health potential, fostering patients' rights, improving patients' wellbeing and creating health promoting hospital environments for patients and relatives;
 - creating healthy working conditions for all hospital staff, including the reduction of hospital hazards, as well as psychosocial risk factors;
 - enhancing the commitment of hospital management to health gain, including the principles of health in the daily decision-making processes;
2. improving communication, information and education by:
 - improving communication within and the culture of the hospital so that they contribute to the quality of life for hospital staff

(communication styles used by hospital staff should encourage interprofessional cooperation and mutual acceptance);

improving the communication between the hospital staff and the patients so that it is guided by respect and humane values;

enhancing the provision and quality of information, communication and educational programmes and skill training for patients and their relatives;

integrating the principles of the health promoting hospital into the hospital's routine through developing a common corporate identity within the hospital;

improving the hospital's communication and cooperation with social and health services in the community, community-based health promotion initiatives and volunteer groups and organizations, and thus helping to optimize the links between different providers and actors in the health care sector;

developing information systems that measure outcomes as well as serving administrative purposes;

3. using methods and techniques from organizational development and project management:

to change and reorient existing hospital routines to make the hospital a learning organization;

to train and educate personnel in areas relevant for health promotion, such as education, communication, psychosocial skills and management;

to train project leaders in project management and communication skills;

4. learning from experience:

exchange of experience with implementing health promoting hospitals projects at the national and international level should be promoted so that participating hospitals can learn from different approaches to problem solving;

health promoting hospitals should commit themselves to regional, national and international exchange and communication.

Participation in the WHO Health Promoting Hospitals Network

Hospitals that want to belong to the WHO Health Promoting Hospitals Network:

1. should endorse the fundamental principles and strategies for implementation of the Vienna Recommendations;
2. should belong to the national/regional network in the countries where such a networks exist (hospitals in countries without such networks should apply directly to the international coordinating institution);
3. should comply with the rules and regulations established at the international and national/regional levels by the members of the international network, the World Health Organization and the international coordinating institution.

There will be three types of membership:

- members of the national/regional networks
- individual members from countries where no national/regional network exists
- members of thematic networks.

Annex 3: Standards for Health Promotion in Hospitals

Preamble: The European Strategy of Health Promoting Hospitals

The Regional Office for Europe's strategy for work with countries "Matching services to New needs"¹ focuses on the analysis of needs and aspirations of the country in question and supports the implementation of strategies based on the best evidence available, considering the country's own capacities and possibilities of implementation. In line with this strategy, and upon request of member hospitals of the Health Promoting Hospitals network, experts from 25 countries have been involved in drafting the Standards for health promotion in hospitals.

The World Health Organization initiated the Network of Health Promoting Hospitals with the aim to reorient health care institutions to integrate health promotion and education, disease prevention and rehabilitation services in curative care. Many activities have been carried out and more than 700 hospitals in 25 European Countries and worldwide have joined the WHO network since the establishment of the network².

Health Promoting Hospitals have committed themselves to integrate health promotion in daily activities, i.e. to become a smoke-free setting, and to follow the *Vienna Recommendations*, which advocate a number of strategic and ethical directions such as encouraging patient participation, involving all professionals, fostering patients' rights and promoting a healthy environment within the hospital⁴. However, so far no tool or set of standards was available

1 Copenhagen, WHO Regional Office for Europe, 2002 (document EUR/RC50/10).

2 Health Promoting Hospitals (<http://www.euro.who.int/healthpromohosp>).
Copenhagen, WHO Regional Office for Europe, 2002 (accessed 4 March 2004).

4 Vienna Recommendations for Health Promoting Hospitals,
(<http://www.euro.who.int/document/IHB/hphviennarecom.pdf>) (accessed 4 March 2005).

to systematically assess, monitor and improve the quality of health promotion activities in hospitals.

Additional information on the project is available on the website of WHO Europe (<http://www.euro.who.int/healthpromohosp>).

Defining health promotion

Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter for Health Promotion⁵), and is here understood to embrace health education, disease prevention and rehabilitation services. It is also understood to include health enhancement by empowering patients, relatives and employees in the improvement of their health-related physical, mental and social well-being.

Hospitals play an important role in promoting health, preventing disease and providing rehabilitation services. Some of these activities have been an essential part of hospital work, however, the increasing prevalence of lifestyle-related and chronic diseases require a more expanded scope and systematic provision of activities such as therapeutic education, effective communication strategies to enable patients to take an active role in chronic disease-management or motivational counselling.

Changing public expectations, an increasing number of chronic patients requiring continuous support, and staff frequently being exposed to physical and emotional strains require hospitals to incorporate a health promotion focus as a key service for patients and staff.

In addition, hospitals impact on health not only through the provision of prevention, treatment and rehabilitation services of high quality, but also through their impact on the local environment and local economy through partnerships with the community.

⁵ Ottawa Charter for Health Promotion (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf). Geneva, World Health Organization, 1986 (accessed 4 March 2004).

The need for standards for health promotion in hospitals

The predominant approach to quality management in hospitals is through setting standards for the services. Health promotion is a core quality issue for improving health and sustaining quality of life, however, a review of existing standards for quality in health care for references to health promotion activities yielded little results⁵. Standards for health promotion in hospitals are necessary to ensure the quality of services provided in this area.

Furthermore, reimbursement systems do not yet facilitate the systematic incorporation of health promotion as an integral part of hospital activities. For the long-term benefits for patients and systems, health promotion activities should be facilitated by national and regional health policies. Standards will facilitate both the implementation of health promotion and the assessment and continuous monitoring for quality improvement.

Recognizing the need for standards for health promotion in hospitals, WHO established a working group at the 9th International Conference on Health Promoting Hospitals, Copenhagen, May 2001. Since then several working groups and country networks have been working on the development of standards.

As a result, five core standards applicable to all hospitals have been developed in accordance with international requirements established by the ALPHA programme developed by the International Society for Quality in Health.⁶ The process included critical review of the literature, definition and review of standards, pilot testing, revision and adjustment. It involved a wide range of scientists, health promotion experts and managers of health care organizations from the WHO European Region, as well as members of the international Health Promoting Hospitals Network.

⁵ WHO Standards Working Group. Development of standards for disease prevention and health promotion. *WHO Meeting on standards for disease prevention and health promotion, Bratislava, 14 May 2002.*

⁶ The International Society for Quality in Health Care. *Alpha and accreditation* (<http://www.isqua.org.au/isquaPages/Alpha.html>). Victoria, ISQua, 2003 (accessed 4 March 2004).

Format and application of standards

The standards presented in this document are the result of a series of workshops and consultations. They have been piloted in 36 hospitals in nine European countries and were assessed to be relevant and applicable. Based on the feedback from the pilot test, substandards and measurable elements have been amended and specified and steps for the further development and facilitation of standards have been planned.

Each standard consists of standard formulation, description of objective and definition of substandards. The standards are related to the patient's pathway and define the responsibilities and activities concerning health promotion as an integral part of all services offered to patients in a hospital. The standards are mainly generic with the focus on patients, staff and the organizational management. Disease specific standards are included for groups of patients with evidence for specific needs. The quality goals described in the standards address professional, organizational, and patient-related quality issues.

- Standard 1 demands that a hospital has a written policy for health promotion. This policy must be implemented as part of the overall organization quality system and is aiming to improve health outcomes. It is stated that the policy is aimed at patients, relatives and staff.
- Standard 2 describes the organization's obligation to ensure the assessment of the patients' needs for health promotion, disease prevention and rehabilitation.
- Standard 3 states that the organization must provide the patient with information on significant factors concerning their disease or health condition and health promotion interventions should be established in all patients' pathways.
- Standard 4 gives the management the responsibility to establish conditions for the development of the hospital as a healthy workplace.
- Standard 5 deals with continuity and cooperation, demanding a planned approach to collaboration with other health service sectors and institutions.

The following pages present the complete standards, including the description of objectives and substandards.

The way forward

In order to facilitate the practical use of the standards in planning, implementation and assessment of health promotion in hospitals measurable elements and indicators are being defined and a tool for self-assessment is being developed.

It is not the aim of WHO to externally assess the activities in hospitals in the European Network of Health Promoting Hospitals, but hospitals within and other hospitals are encourage using the self-assessment tool for improving their health promotion services.

The standards are considered public domain and quality agencies and accreditation bodies are encouraged to include the standards for health promotion in hospitals in their existing standards sets.

Management Policy

Standard 1. The organization has a written policy for health promotion. The policy is implemented as part of the overall organization quality improvement system, aiming at improving health outcomes. This policy is aimed at patients, relatives and staff.

Objective: To describe the framework for the organization's activities concerning health promotion as an integral part of the organization's quality management system.

Substandards:

- 1.1 *The organization identifies responsibilities for the process of implementation, evaluation and regular review of the policy.*
- 1.2 *The organization allocates resources to the processes of implementation, evaluation and regular review of the policy.*
- 1.3 *Staff are aware of the health promotion policy and it is included in induction programmes for new staff.*
- 1.4 *The organization ensures the availability of procedures for collection and evaluation of data in order to monitor the quality of health promotion activities.*
- 1.5 *The organization ensures that staff have relevant competences to perform health promotion activities and supports the acquisition of further competences as required.*
- 1.6 *The organization ensures the availability of the necessary infrastructure, including resources, space, equipment, etc. in order to implement health promotion activities.*

Patient Assessment

Standard 2. The organization ensures that health professionals, in partnership with patients, systematically assess needs for health promotion activities.

Objective: To support patient treatment, improve prognosis and to promote the health and well-being of patients.

Substandards:

- 2.1 *The organization ensures the availability of procedures for all patients to assess their need for health promotion.*
- 2.2 *The organization ensures procedure to assess specific needs for health promotion for diagnosis-related patient groups.*
- 2.3 *The assessment of a patient's need for health promotion is done at first contact with the hospital. This is kept under review and adjusted as necessary according to changes in the patient's clinical condition or on request.*
- 2.4 *The patient's needs assessment ensures awareness of and sensitivity to social and cultural background.*
- 2.5 *The information provided by other health partners is used in the identification of patient needs.*

Patient Information and Intervention

Standard 3. The organization provides patients with information on significant factors concerning their disease or health condition and health promotion interventions are established in all patient pathways.

Objective: To ensure that the patient is informed about planned activities, to empower the patient in an active partnership in planned activities and to facilitate integration of health promotion activities in all patient pathways.

Substandards:

- 3.1 *Based on the health promotion needs assessment, the patient is informed of factors impacting on their health and, in partnership with the patient, a plan for relevant activities for health promotion is agreed.*

- 3.2. *Patients are given clear, understandable and appropriate information about their actual condition, treatment, care and factors influencing their health.*
- 3.3. *The organization ensures that health promotion is systematically offered to all patients based on assessed needs.*
- 3.4. *The organization ensures that information given to the patient, and health promoting activities are documented and evaluated, including whether expected and planned results have been achieved.*
- 3.5. *The organization ensures that all patients, staff and visitors have access to general information on factors influencing health.*

Promoting a Healthy Workplace

Standard 4. The management establishes conditions for the development of the hospital as a healthy workplace.

Objective: To support the establishment of a healthy and safe workplace, and to support health promotion activities for staff.

Substandards:

- 4.1 *The organization ensures the establishment and implementation of a comprehensive Human Resource Strategy that includes the development and training of staff in health promotion skills.*
- 4.2 *The organization ensures the establishment and implementation of a policy for a healthy and safe workplace providing occupational health services for staff.*
- 4.3 *The organization ensures the involvement of staff in decisions impacting on the staff's working environment.*
- 4.4 *The organization ensures availability of procedures to develop and maintain staff awareness on health issues.*

Continuity and Cooperation

Standard 5. The organization has a planned approach to collaboration with other health service levels and other institutions and sectors on an ongoing basis.

Objective: To ensure collaboration with relevant providers and to initiate partnerships to optimise the integration of health promotion activities in patient pathways.

Substandards:

- 5.1 *The organization ensures that health promotion services are coherent with current provisions and health plans.*
- 5.2 *The organization identifies and cooperates with existing health and social care providers and related organizations and groups in the community.*
- 5.3 *The organization ensures the availability and implementation of activities and procedures after patient discharge during the post-hospitalisation period.*
- 5.4 *The organization ensures that documentation and patient information is communicated to the relevant recipient/follow-up partners in patient care and rehabilitation.*

Annex 4: Acronyms and abbreviations used

BSC	Balanced Scorecard
CCHSA	Canadian Council on Health Services Accreditation
COPD	Chronic obstructive lung disease
EFQM	European Foundation for Quality Management http://www.efqm.org/
HP	Health promotion
HPH	Health promotion hospitals
HQS	Health Quality Service
ISO	International Organization for Standardization http://www.iso.ch/iso/en/ISOOnline.openpage
ISQua	International Society for Quality in Health Care http://www.isqua.org.au/
JCAHO	Joint Commission for Accreditation of Health Organizations http://www.jcaho.org/
JCI	Joint Commission International http://www.jcrinc.com/international.asp?durki=7656
KTQ	Kooperation für Transparenz und Qualität im Gesundheitswesen
TQM	Total quality management

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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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