Feasibility, Effectiveness, Quality and Sustainability of Health Promoting Hospital Projects

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Edited by
Juergen M. Pelikan,
Karl Krajic,
Hubert Lobnig

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Editors: J. M. Pelikan, K. Krajic, H. Lobnig;
Ludwig Boltzmann Institute for the Sociology of Health and Medicine, Vienna, Austria;
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Preface

The 5th International Conference on Health Promoting Hospitals (Vienna, April 16-19, 1997) marked a major change in strategy – from projects (in a strict sense) to networks: The European Pilot Hospital Project of Health Promoting Hospitals ended its main project phase, which had started in 1993, and the European National/ Regional Network Projects of Health Promoting Hospitals took over the leading role. Given this situation, the general line of the program of the conference can be summarised as „Clarifying perspectives for the future of Health Promoting Hospitals in the light of experiences of the past“. Thus the reader of these proceedings will find that large parts are concerned with a critical appraisal of what has been achieved so far – what have we learned till now concerning feasibility, effectiveness, efficiency and sustainability of Health Promoting Hospital projects?

There is a first summary report on the experiences of the European Pilot Hospital Project (20 hospitals in all parts of Europe developing models of good practice). A major section of this book contains first reports from these Pilot Hospitals on their overall experiences in the last four years. Detailed reports on some of the 150 specific programs („sub-projects“) conducted in the framework of the Pilot Hospital schemes are included in the other chapters. These other chapters comprise descriptions and analyses of a wide variety of programs, conducted in the Pilot Hospitals, but also in many other hospitals. These programs address the health of patients, staff and the population of the community, and the development of “healthy hospital organisations“. A separate chapter collects contributions on theoretical and methodological issues of Health Promoting Hospitals.

But the conference has not only been concerned with the past – the reader will find many encouraging perspectives for the future of the Health Promoting Hospital as a vision and strategy for hospital reform and an asset for the Health Promotion movement. We would like to point out the strategic perspectives in the keynote lectures of Denis Doherty, Ilona Kickbusch and Milagros Garcia-Barbero and the contributions from other continents in the part on „Globalising Health Promoting Hospitals“. But also the many reports on practical projects in hospitals organised in the 19 Regional and National Networks established in the European Region lead us to assume that Health Promoting Hospitals is a movement that is gaining strength.

331 participants from 33 countries attended the conference, presenting over 100 papers and 60 posters. Compared with the past conferences on Health Promoting Hospitals, these figures demonstrate a growing interest and involvement in Health Promoting Hospitals.

The list of the international and national co-organisers of the 5th International Conference is another indicator of the attractiveness of Health Promoting Hospitals. We presume that we can speak for the many partners in the network, developing Health Promoting Hospital projects in all parts of Europe, in thanking the co-organisers and sponsors for their interest and their support:

- World Health Organization – Geneva
- World Health Organization – Regional Office for Europe, Copenhagen

- Commission of the European Communities
- Standing Committee of the Hospitals of the European Union
- International Union for Health Promotion and Education, Europe
- European Association of Hospital Managers
- Austrian Federal Ministry of Labour, Health and Social Affairs (as main sponsor of the Co-ordinating Centre)
- Austrian Federal Ministry of Science and Traffic
- Austrian Workers Compensation Board
- City of Vienna (as co-initiator and long-term sponsor of the WHO-Model Project in Vienna)
- Vienna Hospital Association
- Healthy Cities Project – City of Vienna
- Financial support came also from Bank Austria.

The editors would like to take this opportunity to especially thank the members of the Scientific Committee, who made this program possible: Milagros Garcia-Barbero, Hans Hagendoorn, Tamas Halmos, Dominique Jolly, Jerzy Karski, Kanwar Panesar, Matti Rajala, Kris Schutyser, Alois Stacher and Johannes Vang. The Co-ordinating Centre was represented in the committee by Jürgen M.Pelikan and Karl Krajic, assisted by Christina Dietscher.

On the local level, special thanks go to the members of the Organising Committee: Margit Ernst, Harald Gaugg, Brigitte Svoboda, Hannes Schmidl and Beate Wimmer-Puchinger. The Local Host was represented in this committee by the editors, led by Hubert Lobnig as the co-ordinator. Special thanks go to Alice Grundböck and Peter Nowak.

Finally, we would like to thank Martina Peclinovsky, who – besides her many contributions to the conference organisation – provided editorial assistance for this book.

Jürgen M. Pelikan
Karl Krajic
Hubert Lobnig

Part 1

Keynotes

The European Pilot Hospital Project on Health Promoting Hospitals – a Summary

Jürgen M. Pelikan, Karl Krajic, Hubert Lobnig, Christina Dietscher

Introduction, characteristics and partners

a) Introduction

The European Pilot Hospital Project of HPH was the most important strategy chosen by WHO to develop an International Network of Health Promoting Hospitals. Since we are dealing with a project, a beginning and an end should be identifiable. The project formally started in April 1993, and the 5th International Conference on Health Promoting Hospitals and the last Business Meeting of the project in April 1997 mark the end, at least of the main realisation phase of implementation.

What are we going to discuss in this presentation?

- First, we shall characterise the project by outlining the partners, the vision, aims and methodology.
- In the second part we shall argue to what extent the project has been successful in fulfilling its strategic aims. As the preparation of the Review Book, consisting of 19 case studies of the Pilot Hospitals and a summary of the European project, will take some more months, the character of this part is that of a draft summary.
- In the third part, we shall try to analyse to what factors the success of the European Pilot Project can be attributed.
- In summarizing, we shall focus on two main questions. The first one is relevant mainly to the health promotion side: Did the Pilot Hospital Project provide any additional evidence that it makes sense to develop health promotion also – or especially – in the hospital setting? The second question focuses on the hospital side: Does the Pilot Hospital Project provide additional evidence that health promotion is a useful strategy for hospital development – or even an especially useful strategy? Can hospital owners, management and staff be advised to invest in health promotion?

b) What are the characteristics of the European Pilot Hospital Project?

The European Pilot Hospital Project is

- primarily a project of social innovation, accompanied and supported by consultation and research – not a research project in itself;
- a project attempting to realise, document and evaluate the implementation of health promotion in hospitals, not a study on the effectiveness or even the efficiency of health promotion;
- a European network of co-production, a virtual organisation, an alliance of 22 very different partners;
- a project developed with the partners' own resources, supported by international leadership and co-ordination, but not by international funds – the partners did it on their own budgets;

- a learning consortium, mainly using exchange of experiences and mutual counselling, supported by some analysis of documented data and not a multi centre study with an experimental design.

As doing a project is primarily about setting limitations and focus – the next questions are:

- Who were the partners of the project?
- What were the common aims, objectives and targets of the project – what was the common vision and methodology?
- What were the common procedures agreed upon?

c) Partners of the project

The partners were 20 hospitals, the WHO-Regional Office for Europe (WHO/EURO) and the Ludwig Boltzmann-Institute for the Sociology of Health and Medicine.

20 Hospitals of many types and sizes were represented: small and large (2 hospitals with less than 200 beds, 9 hospitals between 201–500 beds, 5 hospitals between 501–1000 beds, 2 hospitals between 1001 and 2000 beds, 2 hospitals with more than 2001 beds), general (12) and specialised[1] (8), public (17) and private (3), hospitals offering standard services as well as university hospitals (3).

WHO/EURO acted as initiator, provided strategic leadership and gave its reputation as central asset for the project. The Ludwig Boltzmann-Institute for the Sociology of Health and Medicine as a WHO Collaborating Centre for Hospitals and Health Promotion supported the project by providing co-ordination, and technical support. This was made possible through funds granted by the Austrian Federal Ministry for Health.

Vision, aims and methodology of the Pilot-Hospital Project

a) Vision

Generally speaking, Health Promoting Hospitals aim to develop the hospital into a more health promoting setting, as defined in the Budapest declaration. There are four basic principles which can characterise this reorientation:

- Reduction of disease + improvement of health;
- Extension of target groups: Patients + staff + population of the community + hospital organisation as a social system;
- Combination of personal + organisational development strategies;
- Development through introduction of new services + reengineering of existing services (re-engineering is – as we all know – the more demanding challenge).

b) Aims

A health promoting hospital can develop in four main directions: it can aim at improving the health of its patients, accept the improvement of the health of its staff and the population in its community as relevant objective and attempt to become a „healthier“ organisation (in a metaphorical sense).

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[1] Specialisations: Children 2, Geriatrics 1, Intensive Care 1, Psychiatry 1, Pulmology + Cardiology 1, Rehabilitation 2.

What can be done to improve patients health?

Develop/re-engineer core services of the hospital: medical (diagnostic and therapeutic), nursing and hotel services, oriented at the following aims:

- Reduce risks;
- Improve the quality of professional interventions;
- Improve the quality of life and well-being of patients in the hospital.

Accept responsibility for the health of patients after discharge:

- Extend rehabilitation measures to improve healing and recuperation processes;
- Extend education measures: inform, consult, train and empower for prevention and coping with chronic disease and disability;
- Co-operate with other providers in the health care chain;

Increase health gain/ outcome orientation:

- Select services according to the health gain they provide;
- Re-allocate available resources towards those areas that will provide a maximum of health gain.

What can be done to improve the health of hospital staff?

- Put health of staff on the agenda of the hospital;
- Develop (re-engineer) hospital work so that health risks are reduced and health potentials of the personnel are fostered;
- Offer compensatory programs where necessary.

What can the hospital do to improve the health of the population in the community?

- Develop (re-engineer) the hospital to reduce ecological risks for the community;
- Offer community-oriented services and programs;
- Form healthy alliances.

What can the hospital do to become a more healthy organisation?

- Develop (re-engineer) the hospital into a „learning organisation“ with better coping abilities and strategic orientation;
- Improve the co-production between hospital units, professions and levels of hierarchy;
- Improve cost-effectiveness and efficiency of hospital services.

c) Methodology

What does it mean in practice to „buy the vision of reorientation“? Health Promoting Hospitals offers a concrete methodology, which contains the following elements:

- Implement the vision by organisational development and project management;
- Enter a developmental process of steps and phases similar to the logic of organisational development and quality management.

An ideal type health promoting hospital should use the following sequences:

- Start out by defining general aims, objectives and targets for development – perhaps in form of a mission statement;
- Identify problems – e. g. by a systematic assessment of the problems;
- Select the problems according to (perceived) importance and resources available;
- Analyse causal factors responsible for the problems – do a systematic diagnosis;
- Select specific solutions – plan interventions that are likely to contribute to solutions;
- Implement the measures in a social process including all hospital protagonists;
- Evaluate the implementation of the measures;
- Use the results for a redefinition of problems.

On which resources can this process build upon?

- Define a mission statement, aims, objectives and targets – building upon the vision of the Health Promoting Hospital;
- Use available systematic universal knowledge especially for analysing defined problems and specifying solutions and interventions;
- Make use of local resources and potentials in selecting problems and implementing solutions;
- Limit evaluation to certain areas of local implementation of the solution – do not try to demonstrate that measures have long term effects – you can do this if you select solutions and measures which have effects proved by medical and health science basic research!

We would like to give an example, focussing on the issue of protection and improvement of health of hospital staff as a central asset of the organisation and of course an aim in itself:

- Define a mission statement that includes health protection and improvement of the health of hospital personnel;
- Do an assessment of the situation; e.g. analyse the epidemiology of hospital personnel;
- Select a major problem (e.g. back problems; muscular-sceletal diseases);
- Do a diagnosis on the basis of knowledge from occupational medicine (e.g. problematic lifting techniques, lack of mutual support, non-ergonomically designed beds/rooms, lack of lifting support);
- Define interventions that will increase staff information, knowledge and skills, change work procedures, improve arrangements in an ergonomically sound direction etc.;
- Evaluate the implementation of new lifting procedures, information and training of personnel, ergonomical design of beds etc.;
- Redefine problems on the basis of those experiences for further development.

Specific aims, common framework and criteria for success

a) Specific aims

The specific aims and objectives of the European Pilot Project can be summarized as follows:

- Test and further develop the concept, along the lines of the Budapest Declaration;
- Develop and test models of good practice for health promotion in hospitals;
- Provide access to national/regional Pilot Hospitals for other hospitals;
- Develop national/regional support centres for a European Network.

b) Common framework

In a process that started in March 1992 and ended with the formulation of a formal agreement in October 1993, the partners of the European Pilot Hospital Project (EPHP) agreed on the following common framework:

- Operation of a common European Project for four years;
- Development of a comprehensive local Health Promoting Hospital (HPH) project by each participating hospital, according to defined standards;
- Each of the partners had to find own resources and sponsors for local and European activities (no European extra funds available for supporting co-operation);
- Contributions to the development of national/regional networks and the international Network:
  - Initiation of National/Regional HPH projects;
  - Presentations at International HPH-conferences, reports in HPH Newsletters, contributions to a Review Book on the EPHP;
- 12 of the 20 partner hospitals additionally supported the European project by hosting Business Meetings (3 during the preparatory phase of the project);
- Co-operation mainly by participation in Business Meetings twice a year and regular reporting (+ circular letter + bilateral contacts).

The following standards for local projects were part of the agreement:

- Project steering structure: project committee, appointment of a project co-ordinator, co-operation with an external institution;
- Creating visiblity through local public presentations, development of an HPH-Hospital newsletter;
- Effecting change through the definition and implementation of 5 subprojects in the areas of patients, staff, community and organisation. The subprojects should be developed using the techniques of organisational development and project management;
- Systematic documentation and evaluation.

c) To what extend has the EPHP been successful?

As any other project, success of the European Pilot Project can be judged according to the criteria of:

- Feasiblity – has it been possible to carry out the project plan?
- Quality: has it been possible to conduct the project according to pre-defined standards?
- Effectiveness: has it been possible to reach the effects the project had set out to attain? Cost effectiveness and efficiency might be included in this question if the project aims and design ask for this.
- Sustainability: Are the effects proving stable/ sustainable?

Implementing health promotion in hospitals: Has it proven feasible?

Implementing health promotion strategies and using health promotion as a developmental strategy for a wide range of hospitals in all parts of the European region has proven feasible to a very large extent. Several indicators support this assertion, but there is also some evidence of difficulties.

a) Has it been possible to find the necessary partners for the European Pilot Hospital Project?

- *Recruitment process:* At least in some countries, there were more hospital candidates than positions available in the project – a selection process had been necessary. Even after the formal start of the project, several hospitals had continued pressing for inclusion.
- *Geographic mix:* Hospitals from 11 countries have been participating (5 in Germany and 4 in the UK, in others less). European countries not represented were Belgium, Bulgaria, Denmark, Finland, Netherlands, Norway, Portugal, Romania, Spain and Switzerland. No representatives from the newly independent states.
- *Types of Health Care systems:* National Health Systems seem to be better represented (UK, IRL, I, S, GR, PL, H, CZ) than systems with a stronger insurance or private sector (exception: Germany, Austria).
- The mix of different *types of hospitals* (according to specialisation, size, ownership) seems to meet European distribution fairly well, although medium sized to large public hospitals seem to be overrepresented (exception: Germany).
- *Resources:* 21 of the 22 partners (19 of the 20 hospitals) found the necessary resources/sponsors to secure their continuous participation for the whole period. We would like to mention at this point that interest, enthusiasm, dedication and also probably a bit of stubborness of the protagonists of the project has proven a most important, indispensable resource for the project. Only Prague has not been successful, although there were several initiatives to assist in raising local support (e.g. linkage with the National Centre for Health Promotion, assistance in negotiation with the Ministry of Health by WHO and LBI). In our perspective, the lack of resources has been one of the main reasons why Prague decided to leave the project.

Besides this general success in finding resources for the local project, the amount of additional resources which the hospitals were able to raise or provide to buy professional support for developing innovative projects, for doing systematic evaluation studies and for extensively participating and contributing in international meetings,

varied substantially. Most hospitals had to conduct their projects on re-allocated own resources and also on the enthusiasm of health promotion activists and staff involved in subprojects. So it was not astonishing that fundraising was an important issue in several Business Meetings.

b) Implementation of local projects

Implementing health promotion by initiating new services and developing or re-engineering established services and procedures is at the very heart of HPH-projects. So one central question is whether the hospitals were able to successfully define and implement subprojects. The second question refers to the scope of subprojects realised – were the hospitals able to develop programs to improve the health of patients, staff, population in the community and the development of a healthy organisation, as suggested by the comprehensive approach of health promoting hospitals – or were they just continuing their normal operation under a new heading?

As a matter of fact, the hospitals have developed many more subprojects than agreed upon. In 1995, at a peak of the project activities, the hospitals have reported on 180 programs they were running or planning to run (instead of the required 100 subprojects). At the end of 1996, 149 subprojects were formally reported upon. Of these 149 subprojects, only 13 (around 10%) had been formally cancelled, 40 have been formally finished, 95 are still ongoing and one was still in the planning stage.

Of those 31 subprojects that got lost in the documentation between the end of 1995 and 1996, 5 were due to the end of Prague's participation, another 5 were re-integrated in other subprojects, 5 seem to have been stalled – practically cancelled – and approximately 15 have been downgraded to „other hospital activities" – a decision partly due to documentation recquirements of the European Pilot Hospital Project. If you had specified 21 subprojects – as one partner did – you have an awful lot to document!

A majority of subprojects focussed on improvements in the central areas of hospital activities:

- 101 of 149 subprojects (also) aimed at improving the health of patients.
- 67 subprojects (also) targeted the health of hospital staff.
- 54 subprojects tried to directly contribute to the health of the population in the community, which was quite surprising for us.
- 65 subprojects also aimed at the development of the hospital into a healthy organisation.

c) Examples: topics and problems elected within HPH projects

Patient Oriented Projects

- Reduction of the risk of nosocomial infections by establishment of a multiprofessional team for hospital hygiene (Vienna);
- Quality improvement of birth and perinatal care (Athens);
- Horseriding for psychiatric patients as a new, health promoting form of therapy (Riedstadt);

- Diabetics education – a club movement (Budapest);
- Psychosocial wellbeing of hospitalized children (Warsaw)
- Improving the living conditions of elderly people in the Hospital (Paris).

Staff Oriented Projects

- Surveillance of anaesthetic gases in the operating theatre (Milano);
- Personnel Check Up (Ustron);
- Complex projects of Health at the workplace (Hamburg);
- Prevention of burns in the hospital kitchen (Paris);
- A project aiming at changing lifting procedures in nursing (Llanelli).

Community Oriented Projects

- Childrens Education for accident prevention (Londonderry);
- Developing Healthy Alliances (Preston);
- Healthy shops in the hospital (Linköping);
- Raising acceptance of the hospital in the group of children and youth (Chemnitz);
- Improve waste management of the hospital (Dublin).

Organisation Oriented Projects

- Total Quality Management (Prien);
- Developing management towards a decentralised outcome responsibility (Linköping);
- Developing the hospital as a learning organisation (Hildesheim);
- Healthy food and nutrition (Glasgow and many other hospitals);
- Smoke free / tobacco free hospital (Padova and several other hospitals).

d) How successful have the projects been in involving relevant groups?

We have learned from the experiences of the Pilot Hospitals, that it is possible to involve all relevant professional groups and all levels in the hierarchy in Health Promoting Hospital projects. But we have also learned that the amount and stability of involvement varies between the groups: HPH projects have been quite successful with the nursing profession, hospital management (including medical directors) and of course health promotion/prevention/rehabilitation and counselling specialists like nutritionists, psychologists etc.

It has been more difficult to include clinicians (especially those in the very core of clinical diagnosis and intervention) and the large and important group of administrative and technical personnel and hospital workers.

We have also learned that the possibilities of co-operation between the hospital and external partners and involvement of groups and organisations in the community in Health Promoting Hospital projects varies to a wide extent between the hospitals. We still need to further analyse this issue, and would like to pronounce a thesis: those partners who could build upon traditions of co-operation in the health care sector

and multi-sectoral action seem to have been more successful in this area than those who had to start from the very beginning.

We would like to highlight at this point once more the importance of the Healthy Cities project for Health Promoting Hospitals. The Healthy Cities project had been very helpful in recruiting partners, and it had been helpful again in some cases by providing a network of partners for the hospitals used to co-operate for health.

How can the quality of the Pilot Hospital Projects be summarized?

a) To what extent did the Pilot Hospitals realise standards agreed upon?

- Joint project committee in all participating hospitals: varying in size and intensity of joint work, but in most cases good balance between representing all relevant groups and keeping a workable size;
- Project Co-ordinator established in all participating hospitals, varying in definition – in some cases with too little time for the project, in some cases too low in the hierarchy to have easy access to decision making procedures, in some cases with too many competing priorities and too little support;
- Involvement of external institutions supporting the projects in all Pilot Hospitals: wide variation of role in the project – from minimal counselling in specific areas to full management of the project. Several Pilot Hospitals seem to have managed to establish this co-operation rather late, which was problematic for instance for evaluation;
- Public presentations as instruments to create visibility: The standard of at least one major annual public presentation was fulfilled by nearly all Pilot Hospitals – several partners used this instrument more often and seem to have made good experiences;
- HPH Project newsletter or HPH-Section in a Hospital Newsletter: This standard was fulfilled by 75%, but there were explicit discussions at Business Meetings if other innovative media like audio cassettes etc would also be acceptable;
- Standards concerning development and organisation of subprojects using techniques of participatory organisational development and project management: Nearly all of the subprojects were documented to have been carried out by project groups, bringing together the people concerned, and most seemed to have had at least a minimal project plan. Nevertheless, for instance the experiences with working with partly large and very heterogenous groups seem to have been mixed, and the quality of project management (especially the clear definition of feasible aims, targets and schedules) seems to have varied extensively;
- Given the open character of the HPH vision and the intended maximisation of variation, the standards agreed upon concerning documentation and evaluation were rather formal and abstract – the realisation of plans and the implementation of interventions or solutions was to be documented and evaluated according to locally pre-defined standards, adequate to the problem/intervention. To safeguard scientific standards for evaluation, the Pilot Hospitals had agreed to get themselves expert support – and most of the partners have done so in this area. The result can be summarized as follws: Evaluation has been conducted and provided

results till now on 93 of the 149 projects specified. Only 3 projects are finished and not evaluated, but 38 are still ongoing and evaluation is – as we understand – planned. You will find much more information about the projects of the pilot hospitals in the presentations within these proceedings.

b) How were the procedures of European co-operation realised?

Participation in the Business Meetings was excellent – there were only very few cases when a partner hospital did not succeed to participate. Regular international reporting on progress was another requirement which was excellently fulfilled in the course of the project – starting from the second Business Meeting, there were written as well as oral reports on progress and problems in the different areas of the project. A synopsis of these reports was provided first in the form of minutes of the meetings, and, starting with the fourth Business Meeting, also in form of a summary progress report by the co-ordinating centre available at the Business Meeting.
Annual site visits by designated referees – a part of the agreement which had raised lively discussions – have not been realised due to lack of specific resources for this task.

c) How were the commitments to support regional/national and the International Network of Health Promoting Hospitals realised?

This has been a major area of success. Six hospitals are actively involved in the co-ordination of National or Regional Networks. In 7 more cases external institutions the hospitals have been co-operating with in their local projects now act as co-ordinators, and in the other 6 cases the hospitals have been at least actively involved in the development. As a result, there now are National/Regional Networks in all countries involved in the project – with the exception of the Czech Republic.

Concerning the international networking, this can also be considered as an area of success. Including the 5th International Conference on Health Promoting Hospitals, there have been nearly 100 oral presentations from Pilot Hospitals at the conferences plus approximately 70 poster presentations. In the HPH newsletter, there appeared 26 articles on local projects or subprojects since 1993.

These numbers of course can also be critically viewed, given the large number of subprojects specified – i.e. 149 – and the duration of 4 years. But again, we have to draw your attention to the fact that the hospitals have provided all this extra work primarily out of their own funds, and they have continued to do so in times of severe budget cuts and new challenges for hospitals all over Europe. So we think this has been a big success so far and we all have to thank these hospitals for their efforts they have put in sharing their experiences with this network.

Effectiveness and Cost-Effectiveness of the European Pilot Hospital Project

a) Effectiveness on the subproject level

Effectiveness of subprojects depends to a large extent on the specific problems the hospitals wished to tackle with their projects. As we have said before, subprojects are attempting to implement specific interventions, measures and solutions in the hospital organisation or in the networks between the hospital and its community.

So the first question that can be asked is whether the implementation process had been effective. We have heard about the good ratio of success before already.

The second question refers to the fact that it can be evaluated whether the subprojects contributed to the solution of the specific problem they were addressing – whether they were able to change lifting procedures, or could change the microbiological situtation of the hospital, or increase the level of patient information. So the specific subprojects had their specific criteria of effectiveness, and unfortunately we cannot provide a quantitative answer to this question. We can make a conclusion that seems plausible to us: Given the large number of ongoing projects or programs and the fact that hospitals are running these programs out of their own budgets, you can guess that these projects have been sufficiently successful so far either in reaching their defined aims or at least in producing such positive unexpected side effects that hospitals continue to run the programs implemented. In the review book to be published this fall, we will be able to give some more detailed quantitative and qualitative answers in this area.

The third question would refer to the effects of health promotion in an emphatic sense – in the sense that you could ask for the specific contribution to the health of the target group. Here again we have to draw attention to the fact that this has not been a multi-centre basic science research project with the necessary limitations in the design and sufficient funds to conduct this thorough enquiry. One cannot expect systematic results or answers in this area and in most cases we also would think that they are not necessary. Much of what the Hospitals have been doing was using established techniques for well analysed problems – but in their hospital, under the specific conditions.

b) Effectiveness on the local project level

The answer depends very much on the aims and objectives defined – on the specific way the hospitals have defined and specified the vision of the Health Promoting Hospital for themselves, and we are already very curious to hear and read the specific answers the Pilot Hospitals will give in the Review Book. Of course, we can also say something out of the perspective of an observer at Business Meetings, reader of progress reports and recipient of presentations and publications.

Our impression is that most hospitals have managed to initiate a process of re-orientation that expanded their operational criteria from the status quo they were at the beginning of the process. Most have at least tried to cover all four areas of expansion – trying to develop to promote the health of patients, of their staff, of the population in the community – although this might have been a difficult area for many – and most seem to have tried to become a „healthier organisation“ – and we are sure that already the participation in the European Project has made a significant contribution in the direction to become more oriented towards a strategy to create a health promoting hospital.

c) Effectiveness on the regional/national and international level

On this level, the project was a big succes. We have already underlined the importance of the Pilot Hospitals for National and Regional Networking and we would

like to add that without this work and without the hospitals' willingness to expose their experiences in front of an international public, most of us would not be here today and the Health Promoting Hospital Network would not stand on the threshold of globalisation.

d) Cost-effectiveness and efficiency of Health Promoting Hospital Projects

This question has not been part of the initial agreement as a general standard, and thus cost-effectiveness studies have been done only for some specific subprojects, like the project on the establishment of a professional team of hospital hygiene, which has managed to prove its success also in terms of savings through the use of cheaper antibiotics and a decrease in hospital acquired infections. Studies on efficency of health promotion conducted by the hospital – compared for instance with health promotion by primary health care providers – could not be measured, as the resources for such complex comparative studies have not been made available.

After this central part of our paper which attempted to discuss the complexity of successful and not so successful aspects of the Project, we would finally like to turn to those factors which we think were decisive or at least relevant for the successes of the project and also to some factors which have proven to create difficulties.

Factors decisive for the success of Pilot Hospital Projects

a) Involvement of WHO as an initiating partner

- Reputation and credibility of WHO legitimised the vision as initiating partner;
- Vision of the Ottawa Charter for Health Promotion;
- Provided experiences and support through the Healthy Cities Project;
- Recruited co-ordinating centre (funded by Austrian government) for project management.

b) Combination of an open vision, concrete example and concrete methodology

- Vision stated in the Budapest Declaration on Health Promoting Hospitals;
- Concrete example (WHO model project Health and Hospital at the Rudolfstiftung Hospital of the City of Vienna);
- Agreed upon methodology (agreement on standards for local projects).

c) A carefully conducted initiation phase

The first important step was to find „a Guinea-Pig with muscles" – that is, motivated partners with a high potential and the willingness to co-operate with others were necessary for a start. The next milestone in the development of HPH was the decision of the WHO to initiate a model project in Vienna. For this, a local sponsor (City of Vienna) was found, and the LBI was recruited as local innovation agency. All these partners together started the Vienna model project Health and Hospital at the Rudolfstiftung of the City of Vienna (1989). Together with international observers (health, health promotion and hospital experts, health politicians) of the model project, the next step – the establishment of the international network of Health Promo-

ting Hospitals – was undertaken in 1990. Scope and purpose of the network are outlined in a specific visionary document, the Budapest Declaration (1991) which was developed in co-production with the partners of HPH. The Declaration also contains a methodology of implementation (first criterion of the Budapest Declaration).

In accordance to this, a call for applications was issued, and the partners of HPH (especially the Healthy Cities Projects) were included in a snowball recruitment of interested hospitals. The next task was then to define criteria for the selection of interested hospitals, together with the partners. In a first business meeting, the hospitals started a process of negotiating an agreement for participation which took one and a half years. In Spring 1993, the European Pilot Hospital Project of Health Promoting Hospitals then was officially started with 20 participating hospitals. This project can be described as the enterprise to keep the balance between having an overall structure that is comprehensive enough to create „common space“ for the project as a whole and leaving enough space for local interests and developments on the level of the local projects. The project was supported by creating new social settings (e.g. International Conferences) where the necessary partners could find a position to co-operate with the project (on different levels: EU, HOPE, nationally, locally).

d) Agreement on co-operation and co-ordination structures: steering groups, business meetings, international conferences

The most important aspects of the project agreement were:

- Define specific steering structures of the project: project committee, co-ordinator and external institution; local media; public presentations, newsletters, subprojects as specific action areas;
- Creating visibility: „enhance your self-respect by finding other people who observe and respect what you are doing“;
- Organise feedback.

e) Sufficient support during the course of the project

The above mentioned factors are vital, but not enough for the success of the project. The following points summarise some additional support factors:

- Create a stimulating environment for the project;
- Keep going/expanding – do not stop: do not restrict yourself to core activities;
- Steps in expansion:
  - Do not only one model project, but a European Pilot Hospital Project;
  - Create a public for your project;
  - Do not only create a European Pilot Hospital Project, but also International Conferences and Newsletter;
  - Make your project visible;
  - Create possiblities for participation for others through national and regional networks;

- Create cognitive support structure: database, expert partners;
- Secure financial support.

f) Factors that have proven problematic

We also have to name some factors which we and our partners felt to be rather problematic at least at times:

- An open vision creates difficulties in developing evaluation criteria;
- In meetings, 20 hospitals is a very time-consuming number of partners;
- Heterogenity of projects proves an obstacle for work on specific content areas;
- Heterogenity of hospitals and health care environments restricted possible exchange;
- The project's lack of ability to raise specific international funds was disappointing;
- In some countries low national political support for health promotion;
- Support by WHO and the Co-ordinating centre could have been more extensive.

Conclusion

The European Pilot Hospital project has proven that health promotion specified in the open vision of the Budapest Declaration is a strategy for hospital development that makes sense to hospitals – that helps hospitals to cope with the challenges they are facing by initiating a developmental process directed at health as a highly valued goal, but open enough to enable necessary local adaptations.

The European Pilot Hospital project has also proven, that it makes sense for health promotion to invest in co-operation with the hospital – although the hospital is a very complex and difficult system, it is one of the most important organisations of modern society and central for the orientation of the health care system. The Pilot Hospital Project has provided strong evidence that hospitals are open for health promotion – health promotion cannot leave out this chance.

The experiences of the Pilot Hospital Project as a network of co-operation has provided very valuable insights for the initiators of any other project or network trying to work with hospitals. You can learn a lot from this experiences – from the good experiences as well as the problematic ones.

We are not writing about the future of Health Promoting Hospitals now – this topic is discussed in the article of Milagros Garcia Barbero in these proceedings. And we are also not writing about what can be learned for the development of HPH in a global perspective – this question is dealt with in the text of Ilona Kickbusch.

We are quite aware that much of what we were saying remains scetchy and abstract – so if you want to know more detailed what the Pilot Hospitals have been doing and experiencing in the last four years, we do invite you to read the reports on the experiences of the Pilot Hospitals in this book.

Evolution of health care systems

Milagros Garcia-Barbero

Health care systems in Europe are confronting important changes to adapt to the challenges that are presented to them within the main framework of the health care reforms in every country, focusing on effectiveness and efficiency to increase availability, patients satisfaction and quality of care and mainly the reduction of cost (1). The ageing of the population associated with higher levels of chronic diseases and disability, the increasing availability of new treatments and technologies and rising public expectations have exerted an upward pressure on overall health related expenditures. Most European countries have responded with a series of measures to control these cost pressures. Organizational arrangements that have originally been conceived to improve equity, access and ultimately health status have been increasingly been constrained by the concern for effective cost containment. This clash between, on the one hand, the moral imperative of maintaining solidarity and the social good character of health care, and on the other hand, the fiscal imperative of pursuing cost control, has been the driving force behind the health care debate in Europe in the 1990s.

The WHO European Office held in June 1996 a conference on Health Care Reforms with representatives of the 50 European countries (2). The Conference was held in Ljubljana where the Ljubljana charter on reforming health care was adopted. The charter stated 6 main principles for health care reforms:

- Develop health policy
- Listen to citizens voice and choice
- Reshape the health care delivery
- Reorient Human Resources for health
- Strengthen management
- Learn from experience

Within this framework hospitals in Europe have been confronting important changes to adapt to the challenges that are presented to them within the main framework of the health care reforms in every country. Hospital reforms are driven mainly by three issues: the need to reduce cost, the new market orientation and the higher demands and expectations of the population. The development of high technology for diagnosis and treatment is changing the face of the hospitals, diminishing the number of beds needed and the length of stay, which increases hospital expenditure by increasing the number of interventions and performing interventions more complicated and costly. While hospital expenditure increased steadily during the 80s, just the same as the PPP expenditure in health, the trend now is to decrease it.

The second point is the increasing demands of the population, the requirements for information and participation in the decision-making process. This is forcing a change in the relationship between health care practitioners, managers and administrators and patients. Patients rights charters and bills are being used or passed in several countries in Europe – and even if legal frameworks are not formally established the

health systems will have to adapt to the new demands on information and consent, confidentiality and privacy and the right to choose care and treatment (3, 4).

The third point is the need to bring the health care sector to a market oriented system, focusing on the relations between providers-purchasers-users and resources. Focusing on outcomes, efficiency, effectiveness and efficacy.

Hospitals as the main consumer of health care resources in the health care system, are encountering a difficult situation in most countries. The golden age when the hospital budget could cover every need and the losses were covered by the insurances or the state is ending. Hospitals have to be accountable for their expenditures, they have to provide better services at the minimum cost possible, and they have to comply with the increasing demands of patients, relatives and the community. Also, the free choice of patients and the packages offered by the health insurances are putting extra pressure on the management. Hospitals that will not accept the new challenges and modify their practice and provision of services accordingly will face serious difficulties in a very near future.

In response to the changing environment, hospitals are embarking on new trends of development which mark a break with the past. The tendency of hospitals development goes in two different and almost opposite directions: The highly technological institution with a curative function devoted exclusively to diagnosis and treatment, and a second converting the hospitals into health centres providing promotion, prevention and rehabilitation as well as curative services. Growing competition between secondary and tertiary care and ambulatory care providers threatens the revenue base of hospitals and diminishes the differences between the levels of care, with primary care practitioners performing interventions that were reserved for hospital personnel 10 years ago and hospitals providing services traditionally carried out by primary care providers. Hospitals tend to either increase their outpatient and ambulatory services in an effort to check the flow of patients towards alternative provider settings; or become highly technical institutions where primary care will not be able to compete.

Also, the new philosophy to get the hospitals as close as possible to the population they serve, not only in physical terms but also in meeting patients and community needs, makes them redefine their functions and roles and even their physical structures and architectural design. The terms “hospitals without walls”, “hospitals without beds”, “day care hospitals”, “hospitals at home”, indicate clearly the direction of the shift which hospitals are undergoing in terms of structures. The big hospitals that were built in the 1960s with around 2000 beds are being substituted by smaller hospitals closer to the communities, with fewer beds and better and more comfortable day care facilities. Some hospitals are converting some of their facilities into residencies or hotels where patients who have to follow treatments that do not require hospitalization can stay between sessions. Also, the day care hospitals are trying to accommodate the patients that need some kind of supervision during a day, such as chemotherapy treatments, minor surgery, or some diagnostic procedures, but do not have the need to stay in the hospital unless complications arise. General hospitals with acute and chronic patients are being split into two types of hospitals, the acute ones, and the chronic ones. The acute ones trying to maximise the use of their high technological equipment, reducing the number of beds and the length of stay to the

minimum possible, and the chronic ones providing better hotel facilities and more adequate care to the needs of their residents.

One of the WHO strategies to help hospitals in coping with the new situations is the Health Promoting Hospital Project : *The concept of a hospital as a health promoter does not mean that the hospital has to change its main function from curative to health promoting, but that it can incorporate into its culture and daily work the idea of health promotion of its personnel, patients and their families.*

The first attempts to connect hospitals with health promoting policies date back to the late 1970s, when the American Hospital Association issued a statement encouraging the development of health promoting services within the hospitals; by 1979, 32 public health units were introduced in Quebec hospitals (5) and the Australian Health Targets and Implementation Committee indicated the need to better distribution of resources and services to promote the health of the community including the hospitals (6). The European Office of the World Health Organisation has developed this idea, building a hospital network composed of hospitals which have incorporated in a large or small scale the idea of health promotion into their practice (7, 8).

It is obvious that hospitals are not the main agents in health promotion. However, as institutions where a large number of people work and pass through, they can reach a large sector of the population (personnel, patients and relatives). As centres which practice modern medicine, research and education, where a lot of knowledge and experience is accumulated, they can influence professional practice in other centres and social groups. As producers of large amounts of waste, they can contribute to the reduction of environmental pollution, and as consumers of a large amount of products, they can favour healthy products and environmental safety. Therefore, the hospital can be a centre of excellence for the development of concrete programmes, which focus on improving quality of health care, working conditions and satisfaction for staff, patients and relatives through an ample spectrum of strategies.

We can assume that the variety of possible programmes is almost infinite, ranging from provision of health promotion services on healthy lifestyles to staff, patients and relatives, provision of health education programmes for chronic patients and relatives, including psychological aspects of patient rehabilitation programmes, open facilities for physical exercise, provision of space for meetings of patients and relatives, improvement of board and lodging facilities, to reduction of environmental pollution through better control of hospital waste. We believe that the national HPH networks will improve the well-being of patients, staff and relatives and the quality of services, which will have a positive effect on cost-containment of the institutions, mainly due to reductions in length of stay, reduction in the hospitalization of chronic patients and absentism of the staff. The European Project on Health Promoting Hospitals objectives are:

- To develop health promoting projects-programmes at hospital level;
- To facilitate and encourage cooperation and exchange of experiences and programmes within the participating hospitals;
- To share programmes, making more effective use of resources;
- To identify areas of common interest, to develop programmes and evaluating procedures;

- To increase communication between the hospitals; and
- To develop documented and evaluated examples of good practice which could serve as examples for other institutions.

The development of the Health Promoting Hospitals project concentrated from now on on the development of the National/Regional Networks, following the 4 year Health Promoting Hospitals Pilot Project with 20 hospitals distributed in 11 European countries participating from 1993 till the closing of the project in April 1997 at the 5th International Conference. The main difference between the international and the national networks is that these last ones can focus on common needs, common priorities and sharing. Hospitals joining a network in their own environment have the advantage of a common language and understanding which facilitates communication, the possibility of developing and sharing materials, resulting also in a more efficient way of using resources, and the exchange of personnel to help in the development of projects and acquire the necessary skills to carry on programmes already running in other hospitals. Each national/regional network will have to establish their own membership strategies, rules and regulations. WHO's role in the development of the National/Regional Networks is as co-ordinating the different networks at international level, facilitating the exchange of experiences and disseminating information.

In summary, the concept of a hospital as a health promoting institution (which could suggest a complete change of the functions of the institution) is nothing more than an addition to the traditional curative function of the hospital. The two levels of the Health Promoting Hospitals movement, the international and the regional/national, have each one of them their own importance and advantages. Experiences can be exchanged at both levels, new ideas and strategies can be fertilised by international exposure, but collaboration in programme development and evaluation is better carried out at local level. Ideas can be exported but they have to be adapted to the local circumstances, needs and structures.

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Reorienting health care settings

Ilona Kickbusch

It is highly symbolic that we had our conference dinner at the Vienna Stock Exchange last night – because health care is heading rapidly in that direction. In studying the financial pages and the advice for investors you will increasingly find slogans like "you can ride the health care wave" or "pharmaceutical bonds are your best medicine". The health care market is rapidly expanding based on new technologies and products, new consumer demands and new geographic and demographic market segments. The world market in pharmaceuticals grows annually by about six percent and has a volume between 300 and 400 billion dollars. Indeed some market analysts contend that in terms of the so-called *Kondratieff cycles* of long-term economic developments, the information cycle will be followed by the health cycle. The adherents of this view see the extremely high profitability rates in the health sector, a sure indication of this major shift.

We are indeed looking at one of the world's largest industries after armaments and drugs. It includes not only pharmaceuticals but medical supplies, the health care information industry, biotechnology, the insurance industry and of particular importance for hospitals the "medical service industry" which in turn includes private hospitals and nursing homes which are increasingly "going public". It is estimated that the turnover in this sector will increase by up to 250% and profits will rise threefold.

The changes in the health care systems in the 'post industrial' countries are driven as much by this vast new market as they are driven by the epidemiological shifts (long life expectancy and chronicity) and by the need to restructure outdated and inefficient modes of care provision. Dennis Doherty has already outlined a range of the challenges faced by the health care system in his presentation. That makes it easier for me to concentrate on just a few. I will focus first on some of those that presently drive the market based health policy orientation and then introduce some that are based on an investment based policy orientation.

A market based policy orientation

An analysis carried out by the US Batelle Institute in 1996 produced a list of the 10 most innovative products to be available ten years from now, in 2006. Three of these products are directly health related and – if they come about as predicted – will have a profound influence on our everyday life, our health and the structure of our health systems.

Leading the list is a set of products called **GENETACEUTICALS** which result from a combination of genetic research and pharmaceutical responses. The Batelle researchers indicate that "*nearly everyone*" will be a consumer of these new drugs – and that they will provide the basis for **smart card** that each person would carry, containing information on their complete genetic make-up. They go on to say that *"you would bring this card with you when you visit your doctor and the doctor would use it to prescribe medicines or other treatments to meet your own specific needs!"* For

us it is interesting to note that without giving it a second thought the Batelle colleagues have presupposed that while the products change significantly the premise and organization of the medical system would not change (i.e. we go to the doctor, not he/she to us). Given other trends I will refer to later, I doubt this would be the case. But it shows entrenched views on the health care system even with futurists.

Later in their list the Batelle researchers indicate that another set of products, namely "home health monitors" – simple to use, non-invasive, moderately inexpensive tools for monitoring health conditions and recommending lifestyle changes – will bring about a significant shift in the division of labour within health care provision. I quote: *"In fact they will perform many of the jobs currently done by your family doctor – at much less cost"*. Again we are left wondering who will provide and pay for these tools – will your health insurance premium be reduced if you agree to monitor your own health? Who will place these monitors in your home? Or will you be expected to provide them yourself as part of the co-payment system and bad luck if you can't afford them? Despite many open questions and speculations one thing is definitely clear: developments such as these will lead to new relationships between providers and patients, as well as between different parts of the health care system, and following from that to new financing and reimbursement schemes. In designing, providing and financing services for a population that has increased chronicity there will need to be less delineation between what today we still see as separate responsibilities within the health care system: preventive/curative/rehabilitative action. A whole new range of services (as illustrated at this conference) and products will respond to this.

The Batelle study draws our attention to new products, such as "*enhanced foods*", that will aim to make ageing less traumatic and enhance, I quote, "*active retirements*". The year 2006 is not that far off and "prototypes" of these kind of products are already on our supermarket shelves. We see another delineation disappearing: the line between pharmaceutical products/food products/health products will be increasingly difficult to draw. Recently the designated chairman of a major European food company defined "*the active added value of health*" as the most significant futures market of the company. The present advertising campaign of a new company that emerged form the fusion of two large pharmaceutical companies gives an indication of this. It defines itself as "*the global leader in the science of life*" integrating three key areas: health, agriculture and nutrition with clearly overlapping research and development agendas. This overlap will start to reflect itself not only on the market place, but also in health care infrastructures, professional training and professional profiles.

As we have heard from many speakers in the last two days the growth of the health care market is taking place at a time when it is maintained that most countries are facing a "health care crisis" and as a consequence are involved in or subjected to a range of "health care reforms". Robert Evans, a leading health economist from Canada, maintains – and stated this clearly in his presentation to the recent WHO European Conference on Health Care Reforms in Ljubljana – that the expansion of the private sector and the "cost control" exercised through health care reform are interdependent and will in the long run lead not to spectacular savings but to spectacular costs – as can already be witnessed in the United States. He outlines that in order to main-

tain the high growth rates described above there is extreme pressure to establish a private health market, including the increasing private use of public mechanisms. That is one of the reasons why much of the health debate of the present is **not** structured around OUTPUT in terms of population health but in terms of the bottom line and why the reform mechanisms chosen tend to be more favourable to the private interest than to the public good. In Europe we are still further removed from some of the consequences that can be witnessed in the United States – but let us glance at them all the same because they can give us indications of changes to come:

1. Changing professionals

A major change in the role of the medical professional – away from an "autonomous profession" to dependency on the rules of the game set by large health care corporations (such as funds, HMOs, etc.). Within such a system of services with multiple players decision-makers it becomes fractionated, incomes fall and employment is no longer guaranteed. The shift to capitation rather than fee for service gives new emphasis to first-level providers (PHC, General Practitioners), but increasingly sees them as gatekeepers and subjects them to a range of controls with regard to treatment, expenditures etc. Capitation in turn becomes the inroad to defining minimal services for all with individual grade-ups expanding the private insurance market.

2. Distributions and equity

This leads straight into distributional issues: since (in the United States) the highest using 50% account for 58% of all expenditures, the private insurance market is not interested in insuring this easily identifiable part of the population which are elderly and chronically ill. Since the upper income groups (many of which are still young and healthy) are interested in reducing their contributions – you get a natural alliance between providers who want to privatize to expand costs and upper income groups who want to change the mode of funding in order to pay a smaller share.

In essence it is these distributional issues that "run" the health care reforms.

3. Location of Care

With the increasing chronicity through the changing age structure of our societies we will see a shift in the location of care away from hospitals to Primary Health Care/community care, family homes, alternative site providers, private nursing homes, hospices, new forms of ambulatory care. In other words, a diversity of care provision will emerge with ever increasing potential for privatization. This also includes a potential for medicine to become increasingly mobile again (like the old family doctor in his work) supported by new mobile technologies, PDA's, chipcards and the like.

4. Health promotion

This diversity is in turn complemented by an emerging new relationship between patient/consumer, providers of care and purchasers such as HMOs. The more the consumers increase their access to information and the more they themselves contribute to their own "upgrade", the more conditions they will want to set regarding the provision of services. The shopping around of the well-to-do consumers and the re-

sponse of the competitive purchasers will create a new environment which at first instance seemed to give more priority to health promotion, wellness and early detection. But recent studies show that HMOs have little incentives to act for long-term health gains since patients change health care plans every few years and the long-term health benefits will not necessarily translate into short-term financial gains on the stock market. This is one of the reasons why health promotion programmes have become a marketing tool to reach middle class consumers rather than a health investment strategy. This contributes towards the seminal attempt to define health as a limited personal good, i.e. the outcome of a certain insurance plan rather than as a *common social good,* i.e. the *outcome we as a society* expect from the health system.

An investment based health policy orientation

The rough outline given above shows that major shifts are underway without a societal debate about the key question that should lead reform: what is to be the place of health/medicine in our societies and what value do we as a society want to attach to it? As a society do we want to see health as an individual good or as a collective social good? Following from that we could then discuss and decide which is the best way to invest our health dollars so that we invest in health and provide health gain and health security.

There are attempts in some countries to shift the policy debate. For example Canada is debating how to restructure health system priorities around key determinants of health. The starting point of this reorientation is the argument that much of the health care budget is "unproductive" in that it does not support the creation of health. This policy direction calls **for investment** in those areas of society where health is best predicted:

- a widely-shared economy prosperity (low social gradients)
- a supportive community life
- investment in people (education)

It also calls for a **total reorientation of health services**, giving priority to those that maintain and promote health, prevent disease and contribute to population health. A clear premise in this policy proposal is the statement (based on international comparisons) that spending more on health care will not result in further improvement in population health.

The "**Quebec Policy on Health and Wellbeing**" has attempted to develop a policy based on determinants of health and many of the provincial health strategies in Canada are moving in the same direction, most recently British Columbia. Let me therefore introduce this policy to you as an "exemplar" which has taken the health field concept several steps further.

To begin with, the policy defines three principles that lead it:

- interaction between the individual and the environment
- shared responsibility for creating health
- public health and wellbeing is a fundamental investment that creates healthier societies, both in economic and other terms.

The policy paper is divided into three parts: the *issues*, an analysis of the existing situation, followed by *19 objectives* which are grouped into *five priority areas: social adjustment, physical health, public health, mental health, social integration*. But even more important is the fact that section III on strategies bring 19 objectives together into an integrated strategic approach. It identifies six overall strategies which will support the achievement of all targets and those of you familiar with health promotion will recognize the action areas of the Ottawa Charter:

- encourage the reinforcement of the individual's potential
- provide support in social settings and develop healthy and safe environments
- improve living conditions
- act for and with groups at risk
- coordinate public policy and action to promote health and wellbeing
- orient the health and social services system towards the most effective and least costly solutions.

The World Health Organization with its Health For All (HFA) strategy, its promotion of primary health care approaches and the innovations in health promotion has significantly contributed to policy development in Member States. A new step in the Health for All development will be reached soon. A policy paper "Health for All in the 21st Century" has been prepared in the process of the renewal of the HFA Strategy and is to be adopted by Member States in May 1998. It focuses on a political commitment to two key policy orientations:

- "**Health Security**" meaning an investment in health strategy that sees health as a common social good and a means to enhance the quality of life within a community.
- Design elements for what we now term "**Sustainable Health Systems**".

Health – as stated in the WHO Constitution – is a basic human right. That does not imply (as some would make us believe) that WHO calls for the unachievable goal that medicine should provide total health – what it does call for is the willingness of societies to give all members – even the weakest – access to leading a socially and economically productive life. If that has at the end of the 20th century moved further from reality than when it was first formulated by the public health pioneers, then we also have ourselves to blame. We have become caught up in debates and reforms that neglect the essence of what we are about : health. Therefore, let me end with a quote from the American economist Robert Solo and urge you to keep it in mind every time you are faced with the discussion of Health Care Reform:

"When a man walks into your office, sits down in front of your desk, and tells you that he is Napoleon Bonaparte, do not get drawn into a discussion of cavalry tactics at the battle of Austerlitz. The man is mad. Focus your attention on how he got here and what you're going to do about it."

It does seem increasingly absurd to enter the 21st century without making use of our vast knowledge on what creates health.

Challenges for hospital policy in Europe – What role can health promotion play?

Denis Doherty

Viewed from the threshold of the new millennium Europe has never had it so good. Economic prosperity is at an all time high, the threat of war has seldom been so remote and the introduction of a single currency, signifying a further major advance in the unification of Europe, is imminent. But, the solidarity which has resulted in impressive economic progress is not so evident in the social sector. Poverty related to unemployment is proving to be an intractable problem. The high rate of unemployment , is considered to be a contributor to the growing substance abuse problem. Paradoxically, affluence is also considered to be a contributor to the same problem. The main causes of death and morbidity are life styles related. Suicide rates, especially those for young men, are growing and injuries resulting from violence, in our so called peaceful society, are consuming significant amounts of scarce health care resources. In every member state in the E. U. the health care system is struggling to satisfy expanding needs with limited resources. The imperative of needing to be seen to do something is resulting in re-organisation of delivery systems. The question is how will history judge the changes that are taking place? Is there a good evidence base for what is occurring? Will the reforms contribute to improvements in population health?

Membership of the European Union has expanded to 15 and is set to expand further early in the new millennium. Let us consider how we, proponents of the Health Promoting Hospital, would respond to the following hypothetical development. One of the new member states anticipates significant economic development to result from its membership of the Union through the inflow of structural funds and improved trade opportunities. This member state has in past decades invested the bulk of its scarce health care resources in developing its hospitals. The citizens are proud of these fine buildings, the services provided in them are of a high standard but the huge investment involved is not producing noticeable improvements in the health of the population. The government has adopted the U. S. Department of Health and Human Services, Centres for Disease Control (C. D. C.) Vision Statement „Healthy people in a healthy world through prevention“ and seeks our advice on how it should go about giving effect to that vision. The government accepts that investment in health care must be provided largely from its own resources since the competence of the European Commission, in health care, is a minor one and dates only from the signing of the Maastricht Treaty.

By adopting the C. D. C. vision the government has, we presume realised that health is much broader than health care and that health care is much broader than hospital care. By changing the emphasis from health care to population health suggests that fundamental change is required and that the hospital system, which traditionally attracted the bulk of the health care resources will feel threatened by the new vision. Realistically health care is heavily reliant on the hospitals network and in any new arrangements hospitals will play a central key role. It follows, therefore, that hospitals have a key role to play in promoting health as well as in health care.

By adopting the C. D. C. vision the government has, we presume, committed itself to measuring results. Concepts such as social return on investment, health gain and social gain have been devised to facilitate measurement of results on investments not amenable to measurement in financial return terms. Our advice ought to strongly recommend that the treatment services be subjected to measurement at least as onerous as the measurement the preventative services will be subjected to. The lack of success in some aspects of prevention should not be judged any more harshly than failures in some aspects of treatment are judged. In a more dispersed health care system performance measurement will be important to ensure that the hospitals need to contain costs does not displace quality of care as a priority.

Information or the lack of it will greatly influence progress in improving population health. Hospital information systems, if designed to inform population health intelligence gathering, can make an important contribution. Morbidity data available from hospitals can be important at a number of levels. In an epidemiological sense it can be a useful source of reliable data. In a service development sense it can be a major influence also. For example:

- Many hospitals everywhere incur sizeable costs in treating the complications of diabetes. The realisation that the treatment of the complications of diabetes accounted for 14% of their total spend prompted one U.S. health care provider to introduce integrated education, prevention and treatment protocols which resulted in measurable health gain for people with diabetes and lower costs for the health care provider.
- In another example from the U.S. the incidence of head injuries suffered by children through cycling accidents being treated in their hospitals prompted that provider to promote and fund the wearing of helmets by children while cycling and produced dramatic results. In a five year period the use of helmets increased from 4% to 48% and was accompanied by a 67% decrease in bicycle related head injuries.

The quality and comprehensiveness of the information available influences, in a material way, the extent to which the prevalence, incidence and burden of disease can be determined. Information is also the key to being able to select the highest priority health problems for prevention. Investment in information systems and in the training of users, researchers and epidemiologists is not all that is required. Issues around concerns about confidentiality, ownership of data, freedom of information and so on frequently occur. The balance between protecting the rights of the individual citizen and the common good need to be settled at a level higher than the health care system.

The method of funding hospitals for the services they provide can influence significantly their attitudes and approach to health promotion and disease prevention. If a maternity hospital is paid a fee for every baby delivered it would be a remarkable example of public spiritness on the part of the hospital if it were to seek an active role in reducing the incidence of pregnancies in adolescents. Without the active involvement of hospitals maternity delivery services other parts of the health care system would be likely to experience great difficulty in successfully tackling the problem. Studies in the U.S. have shown that cancers of the breast, cervix and colon as well as melanoma were detected at earlier stages in Health Maintenance Organisations than in the traditional fee for service systems. Health maintenance organisations have dis-

covered that, having regard to the way they are funded, maintaining the health of their populations is an important way to improve their cost effectiveness.

Health care systems which seek to maintain or improve the health of the populations they serve should not be satisfied with increasing inputs, outputs or even outcomes. Quality processes must be considered necessary to monitor, correct and enhance their services. Increasingly external validation or accreditation is being seen as a necessary check to satisfy evolving accountability criteria. In the U. S. A. H. M.O's use a system known as the „Report Card" to evaluate the quality of the services and care they provide. The best known of the „report cards" is the Health Plan Employer Data and Information Set (H. E. D. I. S.) developed jointly by H. M. O's, purchasers and customers under the guidance of the National Committee for Quality Assurance, an accrediting organisation for H. M. O's. Of the nine indicators of quality of care in the 1995 version of H. E. D. I. S. seven are preventive. They include the incidence of low birth weight infants and utilisation figures for vaccinations, mammography, screening for cervical cancer, ante natal care and retina examinations for persons with diabetes. Hospital policies ought to have regard to the contribution it is expected to make to improving population health.

The management of the transition from a hospital dominated health care model to a population health approach is a difficult and demanding task. Assessing need, determining priorities and designing effective communication and marketing programmes demands high level skills, good research and sufficient resources. Hospitals themselves can serve as useful research laboratories.

It is estimated that the 15,000 or so hospitals, in the member states of the European Union, employ in excess of 5,000,000 staff. When their immediate and extended families are added they amount to a very sizeable population. In our hypothetical new member state the comparable hospital staff population would be even greater, in relative terms. These populations are more likely to have heard the health education and health promotion messages than the general population. A high proportion of that population are familiar with the language or jargon of the health care systems and many of them encounter daily the pain, suffering, disabilities and deaths caused by preventable illnesses and diseases. They ought to be more susceptible to the health messages and more likely to act on the messages they receive than the general population. But, how true is that notion and what steps do we take to test such theories? I would suggest the answer is, we don't know and we are not doing sufficient to find out. There are some notable exceptions, most notably the way American doctors, by giving up smoking, demonstrated that cardiovascular disease can be significantly reduced by that measure alone. It is equally remarkable that other health care professionals in possession of the results achieved by doctors who changed their behaviour have not emulated the doctors.

Healthy eating is a proven contributor to health. One would assume that staff would not choose foods not considered to be health giving at work or at home and that hospital owners and managers would back the health promotion message by serving food considered to be health giving to patients. Can we expect to be taken seriously if we promote health through health promotion programmes and contradict the message by tolerating practices considered damaging to health in delivery settings?

Occupational health is an area where hospitals should excel and in so doing demonstrate the potential other employers should recognise in their places of work. Staff in hospitals should be spared health and safety risks of a kind which result in admissions to their accident and emergency departments caused by accidents resulting from inferior practices in other employments. Hospital staff experience post traumatic stress more than their counterparts in many other employments but how good are hospitals at diagnosing and treating this symptom of contemporary employment? They ought to be ahead of other employments in that regard.

The vision of healthy people in a healthy world could hardly be realised if hospitals, dedicated to the role of healing, were also contributors to damaging the environment through pollution or poor management of waste. An emphasis on prevention on avoiding pollution by specifying least harmful packaging, reduction and segregation of waste, adopting best practice in harmful waste disposal and economical use of energy hospitals can set examples for others to emulate.

Hospitals generally are greatly respected and valued by the communities they serve who are keenly aware of the healing and caring they provide. But, it is less well understood that hospitals, because they cater for sick people, many of them suffering from infections and transmissible diseases, are not free of risk to their users. Hospital acquired infections and drug induced illnesses are causes of growing concern. Emphasis on quality through constant validation and improvement of protocols aimed at minimising hospital risks to patients are necessary in every hospital. It is sometimes necessary to recognise that quality improvement is not synonymous with or dependent upon investment in or greater use of high technology. The achievements of hospitals operated by Inter-Mountain Healthcare in the State of Utah in the U.S.A. are noteworthy. Their hospitals achieved measurable quality improvements by developing protocols which progressively reduced the periods of time patients were supported, post operatively, on respirators thereby reducing dramatically the incidence of post operative respiratory infections.

I referred earlier to the role hospitals can perform in identifying the causes of injuries and advocating and supporting health promotion programmes which can reduce the incidence of injuries. In some situations it may be financially attractive for the hospital to fund the health promotion programme. The cost of providing cycling helmets free or at reduced cost may, in some situations, be less than that of treating the injuries suffered by children who were not wearing a helmet. In other situations the hospital data base may contain within it a rich vein of unmined information on social problems ranging from family violence, to drug and alcohol abuse, industrial risks and child abuse. Transmissible disease, which 15 years ago was considered to be no longer a major problem in many countries is once more a source of concern. It is no less acceptable now than in the past that hospitals would deal only with those presenting with an infectious disease and not seek to trace and treat others who may have incurred a risk of infection. The vision of healthy people in a healthy world requires hospitals to perform two key roles. The immediate one involves diagnosing and treating the symptoms of ill health and the ongoing one is to collect, interpret and communicate the intelligence hospitals encounter daily and which can amount to a sizeable contribution towards developing understanding of the causes of ill health, assessing health need and promoting population health.

This initial personal reaction to the request for advice and guidance from the hypothetical new member state is based on my own experience of health care management, policy formation and my perception of current trends. The advice would have to be validated as to its appropriateness to the needs and opportunities in the new member state. It would be necessary to consider if, in that situation hospitals would be asked to expand their role to include localised primary care provision, including health promotion and care for the chronically ill or whether some entirely different approach should be recommended. Alliances are necessary but local circumstances will determine which permutation is most appropriate.

The more important consideration would be to get the function of the new system agreed and understood in terms of its contribution towards „healthy people in a healthy world". In any event form (structures) ought to follow function. How relevant then would the checklist drawn up from that initial reaction be to the situation in one of the existing member states? The checklist, would, I expect, be broadly speaking valid in each of the member states but the current status of that checklist would no doubt vary from member state to member state.

Health care systems in the member states have evolved over time from very different origins, in response to needs which differed greatly in many cases and in response to different political and health service priorities. The laws, regulations and institutions of the union have impacted on health care providers and on health care provision but to a much smaller extent compared to other areas such as agriculture, fishing and employment creation and support. The interpretation of the principle of subsidiarity places health care firmly within the domain of the member states alone. Yet, the citizen, accustomed to mutual recognition and parity of provision in a range of other areas does not always differentiate between the greater level of competency afforded the commission in areas other than health and not surprisingly seeks equal access to health care and equity with the provision made for other citizens of Europe in other member states. There are well articulated links between poverty and ill health. My colleague, Professor Win de Gooyer, President of the Economics and Planning Committee of the Standing Committee of the Hospitals of the European Union (HOPE) in a major address, on the Reform of Health Care Systems, when he was installed as Professor of Comparative Health Care Studies at the University of Leiden last September identified the significant implications for, 'the healthy people in a healthy world' vision of the economic and political philosophies of the developed world in the eighties and nineties and of how the reforms of the health care systems are impacting on the health status of poor people in developed countries. This address, which will be published in English by HOPE very soon, is worthy of careful consideration by proponents of the 'healthy people in a healthy world' vision everywhere.

Health care systems throughout Europe either have been reformed or are in the process of being reformed. The number of hospitals is declining, demand, even need, is outstripping supply, lengths of stay in hospital are shortening and the ratio of day procedures to in-patient procedures is expanding. Primary care is seen as the preferred location for delivering health care with the hospital seen as ideally providing a range of services which cannot be optimally provided in a primary care setting but with an emphasis on discharging patients back to primary care as speedily as possible.

Two years ago the Standing Committee of the Hospitals of the European Union (HOPE) carried out a fundamental review of our constitution. Our Committee is comprised of the national hospitals associations or national institutions which are responsible for the hospital sector in the member states but significantly our constitution now refers to hospitals, in its aims and objectives, in the context of the health systems in which they function. When I became President a year ago I sought and obtained the approval of the Plenary Assembly that during the three years of my Presidency the emphasis of HOPE will be on improving quality. In the pursuit of that approach the main emphasis is on quality improvement in the delivery systems area rather than in the clinical areas. We are, of course, fully supportive of quality improvements in clinical practice and the work of clinicians and other health professionals in that area. However, we consider ours to be a complementary role aimed at quality improvement through systems delivery enhancement. In the current year alone quality considerations will dominate our Plenary Assembly in May, our young managers exchange programme in May, a major conference devoted to the theme of quality in Limerick, Ireland in June and at Agora IV in Odense in Denmark in October. At all of these events the role of the hospital in the context of the health care systems in which they function will be explored and developed. Hope is in an unique position of having access to all of the 15,000 hospitals in the union, to their 5,000,000 staff and through them to the 370,000,000 citizens of the community. This represents a significant opportunity to promote health on a community wide basis. We are currently exploring actively ways and means of doing that in co-operation with other European wide and member state partners.

In conclusion, therefore, I trust that the view of the Health Promoting Hospital I have conveyed to you is far removed from the small office in a remote part of the hospital with the health promotion sign on the door. Rather, I trust we are approaching a stage of development where hospitals, view health promotion as their raison d'etre. At that stage health care systems will be viewed as having a lead role in promoting population health. Dr. Mahler, former Director of W. H. O. once said, „those who know must inform those who need to know“. In the case of health care systems that duty could extend to informing economic, social, fiscal, employment, education and agricultural policies. Within the health care sector the system would recognise the major role hospitals can perform in promoting health. Their contribution can be divided into two categories, one concerned with promoting health directly in a variety of hospital settings, and one as a source of intelligence capable of being a major influence on system wide health promotion policies and programmes. There are many ways in which health promotion can play a role in enabling hospitals to address the policy challenges they face. Hospitals can themselves be a major influence in informing future health promotion policy and in promoting health. I trust I have succeeded in demonstrating how, in my view, the two are inextricably linked.

If that hypothetical new member state were to emerge as real, what a fantastic opportunity it would present, what a scramble there would be for the opportunities it would offer to effect real change and add great value. Perhaps equally challenging opportunities exist in our hospitals now. If they do they'll still be there next week and we really will be able to make a difference.

Part 2

Globalising Health Promoting Hospitals: Contributions from other Countries

Health Promoting Hospitals in developing countries

Ghada Hafez

A mere concept today

The word hospital brings to one's mind a rather dismal picture of rows of beds occupied by agonized human beings eagerly awaiting the healing of their sufferings and to return home. The thought of going to hospitals is so depressing that many individuals, inspite of their sufferings refuse to go to hospitals. Yet, hospitals are the felt need of highest order of every community. It is not often remembered that establishment and maintenance of hospitals with modern technologies in a developing country takes away a disproportionate share of health budget, which is invariably meagre. Today, hospital beds are extremely scarce even for acute and emergency, such is the load on hospitals.

That maintenance of proper health, through adoption of a proper life-style, will greatly minimize the need for taking recourse to hospitals, is not clearly understood by the common man. Hospitals do not have the objective of going beyond the hospital premises and to counsel common man how to protect and promote. Most often, the primary objective of all hospitals is to acquire high-tech gadgets for sophisticated diagnostic and curative work. In other words, health promoting hospitals, at least in the developing countries today, is a mere concept.

Early attempts – Extension to communities

It must be conceded that in the fifties, most developing countries started to convert this concept into reality, though with a different objective, by "adopting" urban and rural communities as the "practice fields" of all teaching hospitals. This was done purely as an extension for the teaching of preventive and social medicine, later renamed as community medicine, in the medical schools. Through this, the discipline of community physician was born.

The initial goal of such practice fields was to get exposed to the people in the community – both urban and rural – with a focus on how they live in their own environments – and how within these constraints their quality of life could be improved. In other words, instead of focussing attention on the sick patient, it was focussed on the environment which made them sick. Health protection and promotion in their own environment was the key word. In a large number of developing countries, these "community practice fields" received national and universal acclaim through their excellent research studies. The concept of extending the impact of hospitals, beyond their indoor beds and out-patient clinics, to the outside community was gradually established. Fortunately, almost all teaching hospitals in the developing countries today are following this concept, and are indeed promoting health in the community.

Attempting health counselling

Regrettably, the laudable move, mentioned above, by the teaching hospitals had little influence on the thousands of hospitals scattered over a given country, whose main

motto was basically curative. Health promotion counselling, it was argued, was not the responsibility of the hospitals, excepting as an advice in the curative regime of patients, who have been discharged from hospital, e. g. dietary restriction in obesity or diabetes and fat restriction in cardiac cases.

Over the years, and with the gradual emergence of diet- related chronic clinical disorders as major causes of morbidity and mortality, and with the increasing realization that the life-style of an individual is the major factor in influencing the individual's health, several approaches are being tried out to spread the message of healthy life-style through various approaches. The health sector, and to some extent the social welfare sector of the government of many countries are spearheading such campaigns.

Counselling services in hospitals

In many hospitals, counselling clinics have been established in the out-patient departments, initially as diabetic or cardiac counselling services, but later on emphasizing the total life-style which is health promotive in nature. In many hospitals in several countries of this Region (e. g. Kuwait), such counselling services are extremely popular among community at large. An area which is coming into sharper focus is the need for having regular outpatient counselling services for elderly individuals – not as a geriatric clinic but to make the elderly individuals aware of the ageing process and how to cope with it. Many of the geriatric disorders could be taken care of by the elderly themselves, if they know what to do. In fact, the hospitals in many developing countries extend their helping hands to Day Care Centre for Elderly.

Hospitals' role in information, education and communication

Another important step which has been taken by a few urban hospitals, but which needs replication widely, is to organize from time to time small "health fairs" or exhibitions in the hospital campus to undertake information, education and communication measures designed for the protection and promotion of health. So far, the hospital-based exhibitions have been focussing attention on promotion of breast-feeding, on the need for fertility-regulation, and in recent years on the dangers of smoking, drinking alcohol, drug-abuse and recently and most widely on AIDS. Hospitals have a high degree of credibility in the community, and as such any health promotion messages have all chances to be effective.

How to go about it?

Hospitals have a great potential for health promotion, but one should confess that this potential is vastly untapped. There is an urgent need to develop a strategy for this purpose enlisting other partners, among whom schools in general and secondary schools in particular and social and women's welfare sectors are the major ones. Health promoting schools are already getting adequate attention. Targeting adolescents for health education is now recognized as an urgent need. The schools and the MCH set-up have major responsibilities. Needless to say, the hospitals will have to undertake the spearheading role in most situations.

Health Promoting Hospitals in Australia

Judith Dwyer

This paper gives a brief overview of how health promotion is structured in Australia and three examples of successful HPH projects, and then draws out some thoughts on the major problems and challenges we face.

The overall impression of health promotion in hospitals in Australia is one of a vigorous but unco-ordinated field of activity. This is not uncommon in Australia, which is a set of states and territories, federated in 1901 from separate British colonies. We enjoy 3 levels of government – national, state and local, with difficulties in co-ordinating anything nationally. With a population of 18 million, clustered largely around the coasts, and a country of our relatively large size with 8 major jurisdictions, this is not surprising. We also tend to be very pragmatic as a nation, and this tendency is clear in our approach to public policy on health. We have a strong history of success in healthy public policy interventions at a very concrete level – such as seatbelt legislation, anti-tobacco measures, protection of the food supply etc; and a history of community action for the establishment of public health services, such as hospitals, maternal and child health services, family planning etc. Australia is undergoing a shift to the right in politics, and as part of the emphasis on individual as opposed to collective responsibility, we are also experiencing some rolling back of traditional public health protections.

In spite of this history of success in what I will call "applied policy" we tend not to write a lot of policy on how the health system should actually work. What we have instead is a lot of rules and legislation and practices about how health care is financed. With a mixed public and private system and 2 levels of government directly involved, life is very complex for your average hospital manager. In this environment, there has been little policy (other than financial policy) relevant to hospitals, whether or not they wish to be health promoting. We do have some of the necessary infrastructure, including good national health statistics co-ordinated through the Australian Institute of Health and Welfare; a University-based National Centre for Health Promotion in Sydney, which is a WHO collaborating centre; and some progress towards a national network of health promoting hospitals, through a major project of the New South Wales Health Department.

With that very quick overview of the policy context in Australia, it is relevant to turn to a few short case-studies of HPH practice at hospital and regional health service level.

Improving the Health of Aboriginal Australians: Hunter Area Health Service and Awabakal Aboriginal Co-operative, New South Wales.

The Hunter Area Health Service serves a population of about half a million, including about 10,000 Aboriginal people, though very few direct descendants of the original people remain. The Goori people of the Hunter came from several tribes, the largest was the Awabakal. The creation or dreaming in this region is from Biami, who gave life to the first goori person. Biami stepped from the sky onto a mountain, which

has a distinctive flat top. On the surrounding ridges are carved footsteps and other designs marking the Creator's journey. One of the best known and sacred sites is a painting of Biami with his outstretched arms covering approximately 5 metres. He is the creator and "the guardian of the valley". The goori people recorded their genealogy through hand-stencilling, or what is known as a birth registry, where people registered their belonging and custodianship to the land.

The Aboriginal community was decimated when the Hunter Valley was invaded in 1797. It is perhaps fitting that this year, the bi-centenary of white settlement of the Valley, Aboriginal people are at last being encouraged to make decisions about their well-being. Marilyn Wilson, the Aboriginal Health Co-ordinator for the Area who is the author of this material, advises me that Goori people do not use the word health as it is not in their language, they use 'well-being' thereby incorporating "all aspects of our being…our living".

The Hunter Area Health Service, in conjunction with the Awabakal Aboriginal Medical Service, developed an Aboriginal Health Plan for the region in 1995. While this exercise was undertaken in response to a health department requirement, the partners in this project took a very positive approach in this case, and set up an Aboriginal Health Service Development Group, chaired by the Chief Executive of the Aboriginal Medical Service and with broad representation of the Aboriginal community. Over 10 months, this group developed both the plan itself and a basis for a more productive partnership between Hunter Health, the Awabakal Aboriginal Medical Service and the local Aboriginal community.

Importantly the plan recognises the significance of "200 years of unfinished business" and proceeds from a recognition that attempts to address the serious health problems of Aboriginal communities must be based on acknowledgement of invasion and dispossession. The plan has several aims and has already made significant progress. There is now an Aboriginal member of the hospital Board, several training positions have been established for young Aboriginal people, and in 1997, Marilyn Wilson took up her new role as Aboriginal Health Co-ordinator, with responsibility to oversee the implementation of the policies and strategies of the plan. Four Aboriginal Health Liaison Officers have been appointed to the major hospitals of the region, and they are promoting the view that "as health workers we need to practice what we are teaching and encourage others to do the same". Marilyn summed up the material she gave me for this talk by saying "Much can be achieved by a few as long as we work together…but much more can be accomplished by many with respect, co-operation, understanding and acceptance of differences".

Transforming a Country Hospital: Denmark District Hospital, Western Australia. (Jenny Thompson, Health Promotion Co-ordinator)

Denmark is a small community south of Perth in Western Australia, with a population of approximately 4000 people. The hospital has 16 beds, and provides a range of primary services, including hospice care, midwifery, emergency care, health promotion and general medical care.

This tiny organisation has developed its own Denmark Health Promotion Plan, based on authoritative sources such as the Ottawa Charter, and on extensive consultation

with the local community. The plan has 3 key priorities, one of which is Injury Prevention. The aim is to reduce the incidence of preventable injuries in the Denmark community. One of the keys to the success of this project has been strong community participation, in this case in the form of a Reference Group, which includes representatives from the local school, the Shire Council, the Police, the general practitioner, Tourist Bureau and individuals. This group is seen as the key to an effective program, ensuring that issues relevant to the community are taken up, and it was established in May 1995.

Assessment was carried out by staff who collected information on injuries presenting to the Emergency Department and the local general practitioners, and they found major injury rates in children 5–14 and people over 65 years as would be expected, but also among tourists. The group started small – their first achievement was to get a particular play area at the school resurfaced, and there has since been a reduction in soft tissue injuries to children. Next they conducted a hazard audit on proposed changes to the highway through the town, and this has led to a feasibility study on building a bypass for heavy vehicles.

Denmark is a popular tourist destination in summer, with beautiful Karri forests and fabulous beaches including Williams Bay. A high injury rate at this beach was identified, and a hazard audit was conducted by the reference group, in conjunction with the local government and the Parks authority. Steep steps leading to the bay, which end on a large rock, were identified as a major hazard, causing slips and falls. The beach is surrounded by rather high sand dunes, which are unstable, but people tend to sit right underneath them. There have been a couple of major incidents in Australia in recent years with several people killed by the collapse of sand dunes, so this was an obvious problem. In the end it has been agreed with the authorities that the steps will be moved to enter the beach at a safer point; and the dunes will be reinforced in some places and revegetated to stabilise them. Warning signs have been erected in the interim while the re-vegetation program is underway.

Flush with success, the Injury Prevention reference group has developed an ambitious forward program. There are several other projects underway in this small but vigorous organisation, and I am advised that the hospital has decided to change its name to more accurately reflect its broader role in the community, and it is now called the Denmark District Health Service.

Public Advocacy for Health: Women's and Children's Hospital, Adelaide, South Australia. (Anne Johnson, Health Promotion Co-ordinator).

The Women's and Children's Hospital, a major tertiary centre in Adelaide, developed a "Framework for Action for Health Promotion for the WCH" in early 1994, which included a policy on public advocacy for health and committed the hospital to an advocacy program.

The hospital has since implemented a strong series of policy and practice interventions to improve the health and safety of children. The first arose from the work of the Child Protection Unit, which was seeing consistently about 30 babies a year admitted as a result of their carers shaking them and unintentionally injuring them. With financial support from a service club and the involvement of many agencies

concerned with children, they developed a public campaign called "Never Shake Your Baby". The program was launched in December 1993, and since then only one baby injured by shaking has been treated in any hospital in the state. The program received a national Violence Prevention Award in December 1995, and has since been used in other states of Australia.

The next initiative arose when Jesse, a young boy just 17 months old died from choking on a carrot stick in a child care centre. Staff upset by this event worked with Jesse's parents to bring about a change in food policy at child care centres. The coroner had identified that Jesse should never have been given raw carrot to eat because he, like all other children of that age, did not have the back teeth to chew and grind the carrot into small pieces, but did have the incisor teeth to bite the carrot into chunks. Injury Surveillance data from the South Australian Health Commission was checked, and showed that incidents of young children choking were becoming more severe, with increasing lengths of hospital stay. The common food problems were raw sticks of carrot, raw apple pieces, celery, popcorn, hard candy and chicken.

With financial support from the state's health promotion foundation, the hospital worked with Jesse's parents, the local Department of Education and Children's Services and other agencies to develop a Safe Eating program aimed at preventing choking on food. The program enjoyed enormous support from other hospitals, primary health care workers, the dental profession, publishing companies and the media. The pre- and post- campaign evaluation identified quite significant changes in knowledge levels of parents, child care providers and health professionals. State-wide data indicate a significant reduction in numbers and severity of choking incidents. This program has now been taken up nationally by an organisation called KidSafe, and won two awards for the communication strategies it used. Ironically, because of the use of capped Casemix funding for the hospital, the success of this prevention campaign, which has theoretically saved about $180,000 in 8 months from reduced admissions to hospital, has lost the hospital revenue. So this has been a real test of commitment to health promotion.

Conclusions

These case studies are aimed at providing some feeling of the style of work being undertaken by health promoting hospitals in Australia. They also tend to illustrate some underlying themes.

Firstly, as good pragmatists, Australian hospitals which seek to reorient their services to health promotion set about first of all to get some runs on the board, to have a few projects which demonstrate the value of the health promotion approach. This is an activist rather than a theorist style, and tends to focus on what may be seen as the easier components of the Budapest Declaration, that is on external, community-oriented programs.

Secondly, in common with hospitals elsewhere, organisation development and change is in many ways the biggest challenge. Of the three organisations I have described probably Denmark District Health Service has come closer to really integrating health promotion into its mainstream operations, but that is not surprising given its small size. Other speakers have reviewed the common major reasons why organisa-

tion change is the hardest plank of the HPH program, so I will simply reflect on how some Australian hospitals are seeking to make inroads on this issue.

Health promotion has quite a long history in Australia, and we witnessed the transition from the health education model to a fairly simplistic early approach typified by social marketing on life-style risk-factor issues targeted at the individual. Evaluation of several of the early projects showed the predictable results – the campaigns were more successful with those who needed them least (in both health status and socio-economic status terms), and almost totally failed to reach important target groups. Other aspects of what is now embraced by the term health promotion were going on under many labels including the community health program, the women's health movement, primary health care and the new public health.

One of the results of this diverse debate and activity is a legacy of confusion about concepts and language. Health promotion as a term suffers from a perception that it is really about patient information leaflets and social marketing of healthy messages. There is experimentation going on with other terms, and currently significant interest in a new policy initiative called the "public health partnership". This emerging government policy embraces all the territory that the Ottawa Charter for health promotion claims, with perhaps more emphasis on the regulatory, protection measures of the old public health.

At Flinders, we are still trying various terminologies, but consistently find that the term health promotion is a turn-off for most clinicians, largely because of its history in Australia. We find it more useful to talk about health – health gain, health outcomes, health status, health and wellbeing, and about illness prevention rather than about health promotion. The aim is to find ways of thinking and talking about health promotion, and the kind of cultural and organisational change required by the re-orientation goal, which will be effective in our environments, particularly large teaching hospitals.

The third major theme arising from review of activity in Australian hospitals is the conviction that mainstreaming health promotion goals will only happen when it is seen to be strongly related to the managerialist and financial goals of current government policies. Without limiting health promotion in hospitals to those areas of activity which have the potential to directly and immediately reduce the demand for acute care services, it is important to make the link between health promotion and illness prevention and reduction in some aspects of personal health care needs. The next step is a fuller exploration of what this really might mean in practice.

Health Promoting Hospitals in Canada

David A. Korn

The Canadian Context

Over the past 25 years, Canada has demonstrated strong leadership in the development of health promotion concepts. In 1974, Canada's Federal Minister of Health, Marc Lalonde, issued a landmark report entitled *A New Perspective on the Health of Canadians.* It introduced the health field concept which outlined 4 determinants that strongly influence personal health. In 1984, a major international conference was held in Toronto, called *Beyond Health Care.* It expanded the Lalonde determinants to include the concepts of healthy communities and cities, and healthy public policies. In 1986, the WHO Charter on Health Promotion was formed in Ottawa, Canada as an extension of the widely accepted WHO definition of health. This was followed in 1987 by a document issued by the federal Ministry of Health and Welfare entitled *Health for All: A Framework for Health Promotion*. In 1989, the Faculty of Medicine at the University of Toronto, one of Canada's leading universities, established the Centre for Health Promotion, a WHO collaborating centre. The Ottawa Charter was particularly important in the evolution of health promotion strategies in Canada. The Charter encompassed 5 broad themes, each of which received expression through various initiatives.

- In the area of Building Healthy Public Policy, Canada was among the early leaders in developing a National Drug Strategy based on harm reduction principles.
- To help Create Supportive Environments, Canada developed a Tobacco Strategy that encouraged smoke-free workplaces and restricted tobacco advertising.
- Participaction, a non-profit national organization led the way in a social marketing approach to promoting physical fitness. Participaction illustrates the third theme of Strengthening Community Action.
- There has been a wide variety of examples of Developing Personal Skills. For example, Canada initiated its periodic health exam by providing primary care physicians with a range of health promotion / disease prevention tools.
- Re-orienting Health Services remains a major challenge. The prime focus of Canada's national health care system has been universal access to illness care. As a consequence, there has been considerable tension between community health promotion and hospital illness care.

Health Promoting Hospitals

Hospitals in Canada have been slow to embrace health promotion principles. However there have been some recent developments worthy of note. In 1989, the Canadian Hospital Association issued a report on hospital-based health promotion. It argued that the purpose of hospitals is to improve health and not just provide sick care. In 1995, the Canadian Hospital Association was renamed the Canadian Health Care Association in an effort to broaden its role by incorporating community-based organizations that are active in health promotion. In 1995, the Canadian Council on Health Facilities Accreditation issued a set of health promotion standards that would

henceforth become part of its accreditation process. In 1996, a network of Health Promoting Hospitals, linked with the international network, was established across Canada, with 47 hospitals participating.

An Example of Local Health Promotion

Toronto is a city which illustrates at a local level how planning for health promotion has developed recently. A report was prepared in 1995 by the District Health Council for Metropolitan Toronto, a regional health planning body which consists of many stakeholders including hospitals. The report, entitled *Towards a Healthier Tomorrow: A Strategy for Promoting Health in Toronto,* recommended that all health care deliverers, especially hospitals, be health promoting organizations by establishing corporate policies, fostering staff health, marketing health promotion to clients, and incorporating disease prevention into clinical service delivery. It also recommended that hospitals form partnerships with other community agencies in health promoting projects.

Within Toronto, local hospital networks are being formed. In one case, 12 hospitals and the local public health department have come together to form an alliance called HealthNetNorth. The hospitals consisted of a broad spectrum of institutions including community hospitals, teaching hospitals, rehabilitation centres, pediatric specialty organizations and my organization, a centre for addictions. It initiated a major review of health promotion practices in member organizations, and developed a proposal for a health promotion strategy directed to hospital staff. Although the project was not sustained in a climate of hospital restructuring, closures and downsizing, it did lead to increased awareness of the issue within all member organizations.

Looking to the Future

I am optimistic that Canada will continue to show leadership in health promotion generally and will strengthen its efforts in the hospital sector. Health care reform and restructuring, which is well underway in many provinces of Canada, provides an opportunity to imbed health promotion principles into the core values of a more integrated delivery system for health and health care. I foresee that more local health planners will emulate the Toronto example by establishing standing committees on health promotion as part of their planning structures. Fiscal constraint will continue to put pressures on the health care system to embrace disease prevention interventions in order to reduce high cost hospital utilization. There are some positive signs that individual hospitals are willing to become non-dominant members of community coalitions committed to promoting health for the people and communities they serve. I believe that the Canadian Network of Health Promoting Hospitals, which has been a recent grassroots development, will continue to gain stature and acceptance amongst a wide range of health care professionals, leading to a major value shift in hospitals across Canada.

I began by referring to the landmark Canadian document of 1974, *A New Perspective on the Health of Canadians*. As we look towards the year 2000 and beyond, it is interesting to note that the Minister responsible for that report, Marc Lalonde, is now the Chair of a Montreal Hospital. I see his willingness to take on this role as a wonderful example of how health promotion strategies and practices are becoming more influential in the hospital sector.

Part 3

Health Promotion
For Hospital Patients

Introduction

Tamas Halmos

The topic of "Health Promotion for Hospital Patients" covered various important questions in order to visualize the changed role of both patients and hospital staff.

Four topics were discussed, each the focus of a session:

- **Patients' Rights:**. It became clear that this is a major theme of what is called 'information-education-communication' in health. The problem is still unsolved, because it contains at the same time issues relating to civil and political, as well as economic and social rights. In this session, we were also given an overview of the German situation, which clearly pointed out that there is at present no law dealing with patients' rights.
- **Health Education:** It became clear that the successful treatment of chronic non-communicable diseases can only be carried out by increasing the knowledge of patients (and relatives) about their disorders. Different forms of education for different diseases were presented.
- **Services for Women and Families:** This topic is multifaceted, since it involves medical, psycho-social and economic problems. This session discussed many problems, from breast-feeding culture to sex education among adolescents. It also underlined the changing role of hospitals and how to move from a traditional to a women-friendly hospital. This should include patients' rights and more humane behaviour towards patients.
- **Patients Surveys:** Models and experiences of patient surveys were introduced. In general, the answers offered a good picture of care in hospital, but because of certain difficulties, the validity of replies seems to be rather questionable.

Patients' rights: An international approach

Michel Belanger

Do actual international texts really and completly set up the link between the assertion of patients' rights and the promotion of health? In this respect, we must underline the importance of hospitals, for which international cooperation now is one of the essential missions. And, in fact, international organizations are privileged tools for the accomplishment of this mission.

a) The interest of the international approach of patients' rights can be found on a double level. On the level of the method, it completes the approach of compared law, by the study of standards established by the intergovernmental and non governmental organizations. On the level of the aims, it influences the choices of the countries, but on condition that international texts express early enough the new orientations.

b) There are three stages of international approach in patients'rights. The first stage shows the precursory aspect of the international texts about patients'rights. General international texts (in the fifties and the sixties) did not accept specificity, at that time, to patients' rights: the universal declaration of human rights (UN, December 10, 1948), the European convention of human rights and fundamental freedoms (Council of Europe, November 4, 1950), the European social charter (Council of Europe, October 18, 1961), the international covenant on civil and political rights and the international covenant on economical, social and cultural rights (UN, December 16, 1966). Some specific texts constitute the international texts of the first generation of the recognition of patients'rights (in the late seventies and the early eighties): they have been adopted by intergovernmental organizations (for example the European Economical Community, with the charter of the hospital user patient, Hospital Committee of the EEC, May 9, 1979, or the resolution of January 19, 1984, of the European parliament on an European charter of patients'rights) and non governmental organizations (for example the World Medical Association, with the Lisboa declaration of 1981 on patients'rights).

The second stage shows the gap between the international texts and the national texts about patients'rights (in the early nineties): the main explanation is the irruption of the national texts about health ethics (for instance in France with the bioethical laws of 1994).

The third stage is characterised by the actual effort of the international organizations to modernize patients'rights. In reality, international reflexion started in the early nineties (and even before), centered on the question of bioethics, but came off in the middle and the second part of the nineties. Four main texts have to be pointed out, two of them being adopted by intergovernmental organizations and the two others by non governmental organizations:

- the declaration of the World Health Organization on the promotion of patient's rights in Europe (Amsterdam, March 30, 1994);
- the convention of the Council of Europe on human rights and biomedicine (Stras-

bourg, November 19, 1996, opened to signature on April 4th , 1997, and already signed by 21 countries);

- the Bali amendment at the Lisboa declaration of the World Medical Association (September 1995);
- and the declaration of patients'rights of the European Forum of Medical Associations (Stockholm, February 2, 1996).

c) Patients'rights are an essential part of the promotion of health. The question of patients'rights is thus a major theme of modern international health law. But a certain number of questions have not been solved yet.

The globalisation of patients'rights by international texts favours the promotion of health.

There are two main trends:

a) Actual international texts tend to take into account the global dimension of patients'rights. As for the procedure, the emphasis is put on the fundamental principles of the person, especially his autonomy and the respect of his private life. Strategies have been established (see the Amsterdam declaration), not only through the legal texts (legislative or reglementary dispositions, codes and charters), but also by the social, economical and cultural activities (as the participation of the media or the promotion of research).

As for the basis, not only the identification of patients'rights is carried out (see the Bali declaration) with particularly the distinction between social and individual rights in the field of health (see the Amsterdam declaration, section 2–1) or the complementarity between rights and duties (see the Amsterdam declaration), but also the definition of the role of physicians (see the Bali declaration) with the notion of partnership (see the Amsterdam declaration, section 2–2) and, more widely, relationship between physician-patient and society (the Bali declaration). The concept of equity applied to the fact of giving health care is interesting (see the Amsterdam declaration, point 5–5, and the convention on biomedicine, art. 3 with the report, point 25): the aim is to overtake the geographical and financial discriminations, as well as the social and cultural ones.

b) Actual international texts also tend to favour the link between the assertion of patients'rights and the promotion of health. Promotion is more than the information-education-communication (IEC). The idea of high quality medical care or appropriate care is used (see the Bali declaration, point 1, and the convention on biomedicine, art. 3). The setting up of patients'rights is promoted (see the Amsterdam declaration). Two contributors are favoured, such as physicians (see the Bali declaration and the Amsterdam declaration, point 1) and medical associations (see the Stockholm declaration).

However, international texts haven't yet been able to solve a number of questions.

a) Is the definition of the patient impossible? It appears that the definition chosen by the Amsterdam declaration («user of health care services, whether healthy or sick»)

is unsufficient. The final text of the 5th conference at Warsaw of the member states of the Council of Europe helds a contribution, by defining the patient as at the same time a consumer, a client, a user and a citizen.

b) The globalisation of patients'rights is uncomplete. It must take into account the other health professions, and not only physicians (health law goes beyond the frame of medical law). Moreover, the preventive dimension in the health promoting policy must be favoured. And the patient's representation must not be forgotten.

c) Promotion has limits. There is a risk of putting aside the creation of new rights (see the Amsterdam declaration, section 2-1a/). Limitations are brought to some patients' rights: superior interest of a third person, with the doctrine of the «conflict of obligations» (see the Amsterdam declaration, section 1-1a/), or to evitate a serious damage to the patient, that is the «therapeutic exception» (see the Bali declaration, point 7). And local culture may be a brake to promotion (see the Bali declaration: «the information must be given in order to respect local culture», point 7 c).

However, the general aspect is positive. The international organizations participate not only to becoming aware of the evolution of the patients'rights, but also to bringing together the conceptions and the national systems, in the way of recognizing and putting into practice these rights as much as possible.

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The patient charta of the hospital “Alten Eichen“ as part of the strategy towards patient orientation and quality

Wolfgang Mursa, Oliver Martini

Introduction

The discussion about patient rights, their guarantee and implementation, are increasingly being focused in the social and political discussion.[1] The matter is often exclusively raised in connection with faulty treatment and its persecution. Besides the aspects of free access to medical care and consumer protection, there is the enforcement of patients’ self-determination.[2] The alteration is aiming at activating the patient’s healing- potential by strenghtening his role in the recovery-process.

In Germany exists extensive jurisdiction which derives from citizens’ fundamental rights guaranteed in the constitution, but it lacks a knowledge of these rights and patient support systems nationwide. Institutions offering medical care, the hospital at the forefront, have got the opportunity to make a significant contribution by setting up and publishing a Patient Charta. Apart from the information it is the self-committment of the service-offering institution and its employees to treat patients in a specific way. Despite political considerations and objectives the Patient Charta of a hospital ought to consider the following aspects:

- Making the market more transparent for the demander.
- Increasing the quality of service by consistently translating its contents within the service-process.
- Increasing the patient’s participation in the recovery-process (empowerment).

Increasing the transparency of the market

The demand of hospital service necessitates the patient to abandon his self-determination. This entails a high level of uncertainty about the outcome of the service. The patient places himself in the hands of doctors and nurses, who carry out certain actions on his body. He has no means of participation in their performance- or at least only to an unsignificant extent. (This in any case is the patients’ predominat opinion). The demander cannot – or only to an unsignificant extent – assess or control the quality of service before making the decision of demand that is before he decides on a certain hospital. He only acquires a promise of service. As it is not possible to restore things into their original state a cover by guarantee doesn’t seem useful for the demander. The demander’s risk is consequently very high, as his chances to evaluate the service ex post ist very limited.

Demanding of hospital services constitutes building a relationship of trust for the patient. The more serious the illness seems the more serious also the service of the hospital seems to influence the patient’s life so that uncertainty may influence the de-

[1] see Declaration of European health secretaries, Warsaw, November 1996
[2] see Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen, 1992

mander. Such anticipated uncertainty results in the demander's wish to reduce that uncertainty. Patients need alternative or substitute criteria to compensate their cognitive dissonances. To achieve this they for example turn to an opinion-leader (family doctor or specialist), fall back on experiences being made by the group of people close to them or rely on quality check-ups from outside.

The Patient Charta as a signal of quality

Communicating quality directly and convincingly is a difficult task for the hospital which can hardly be done by itself as hospital services are goods of experience and trust. In the framework of classic communication there are incentives for the hospital to put recordable substitute criteria in the foreground (e.g. hotel service). There is a danger of adverse selection in the medical sector. Therefore the hospital would have to commit itself to performing the quality of service as it promised to. The hospital loses a serious part of its reputation if it fails to meet its obligations and faces higher costs than meeting them in the first place thus making its self-commitment credible. The Patient Charta can be such a credible self-commitment and can be used to reduce uncertainties for the patient. The danger of a possible loss of reputation also has, however, a directly quality-promoting effect on the actual service process of the hospital.

Increasing the quality of service by self-commitment

As a result of the potential negative external effects it is necessary to make its contents into the guideline for the employees and the organisation. A particularly urgent aspect is the communication between doctor and patient. On the basis of the patient's right of self-determination all processes of informing and explaining to the patients would have to be examined and re-engineered. A necessary and up-to-date presupposition that has to go along with the establishment of patient rights is to change the traditional „benevolent paternalistic“ doctor and patient role model into a model of partnership. In the center of its establishment there is the principle of informed consent. It should be the doctor's aim to convey competence to the patient to help him make the choice for a specific therapy. The patients'engagement and sense of responsibility is being increased if their rights are being respected by doctors.[3] Apart from the right of self-determination, preservation of the personality and protection of the private sphere are in the centre of the Patient Charta. The hospital has to ensure that the patient's private sphere is preserved consultation.

Increasing the patient's participation in the recovery-process

The realization of the „model of partnership“ has also the target to convey more competence to the patient. Medical progress increasingly widens the gulf between the doctor's and the patient's knowledge. This adds the task of improving the patient's ability of judgement to the task of changing the doctor-patient relationship. The patient can be freed from his passive role and take over an active one thus becoming in-

[3] See concluding declaration of the 5th Conference of the European health secretaries (Warsaw, 11/1996)

volved in the process of shaping his recovery-process. Valuable potentials for healing are no longer buried and possibly promote salutogenic effects in the patient's recovery. In future it will be the doctor's task by using his medical knowledge to build a framework within which the patient can make a decision with the doctor's help. This way the patient is forced to take over responsibility for himself.

The Patient Charta can contribute decidingly to implement the point of the Budapest Declaration that recommends to „encourage an active and participatory role for patients according to their specific health potentials." Medical consultation is not limited to risks and alternative medical treatment being explained to the patient but the patient's support to handle the disease ought to be included too. The decision to back the therapy by one's own effort is a part of it.

The projectproup „Patient Charta" at the hospital "Alten Eichen"

Apart from the preceding remarks, developments within the Diakonie Krankenhaus Alten Eichen led to the blueprint of the Patient Charta. The results of two patient surveys (carried out by Prof. Trojan, University of Hamburg) showed a lack of information and some uncertainty on the part of the patient. In four meetings seven members of the WHO-project team have worked out a Patient Charta – written in the form of a patient information –and a recommendation which should ensure its internal implementation.

The Patient Charta itself is worded in such a way as to commit the hospital rather than to advise patients legally. It offers the patient the chance to make others recognize his rights. This demands that he plays his role actively. Every patient receives such a booklet on the admission into the hospital before medical treatment starts.

Table 1: Contents of the Patient Charta

The following subjects are part of the Patient Charta:

1. All employees are obliged to wear name-plates
2. Information on confidentiality and data protection
3. Protection of the private sphere
4. Information about procedures
5. Information and explanation
6. Anticipation of property and the patient´s will
7. Consultation before discharging the patient
   Representing the patients interests

The hospital commits itself to explain and advise the patient on those risks and alternatives that are related to treatment in a kind of language understandable for the patient. It is being pointed out to him that he has time enough to refuse measures being proposed. He is asked to enquire whenever he doesn't understand anything. A real innovation is the information of foreign patients by external specialist interpreters. Alten Eichen cooperates with the interpreting service of the sociological department of the University of Hamburg.

In a hospital quality survey[4] it was clearly stated that almost all hospitals can only deficiently advise on dealing with an illness, its further course and the course of recovery. The doctors of Alten Eichen are going to try to give priority to these consultations**.** A consultation of discharge at an earlier stage makes further enquiry possible for patients or their relatives in order to create the right conditions at the patient's home and its surroundings. In order to improve an effective and patient oriented complaints-management Alten Eichen decided on cooperating with the Consumer Advisory Service Hamburg (Verbraucher-Zenrale Hamburg) the patients can turn to with problems they don't want to disscuss with employees of the hospital. For this matter the Consumer Advisory Service has its own telefone service whose number is indicated in the patient booklet. They are being advised there and the Consumer Advisory Service acts as mediator if the patients wish so. Besides, the Consumer Advisory Service regularly hands over the reports made to them anonymously before.

From the hospital's point of view there is another target furthering our very own interests: risk-management. We hope that the internal effect the charta will have on the house will help to minimize the probability of faulty treatment and the damage caused for the house thereby.

It is our aim to stimulate patients to become actively involved. The value of rights depends essentially on the fact of their existence and people knowing about them rather then on patients being aware of them and exercising them every moment. The mere fact of their existence already determines the behaviour of all people involved. At all, cost reduction by making stays in hospitals shorter, less input expenditure and increased health potentials of the patients could be the result of introducing a Patient Charta.

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[4] The DAK Insures Survey on Hospital Quality in Hamburg, 1996 carried out by Hildebrandt GesundheitsConsult GmbH

Health promotion as a form of counseling – Psycho-educative patient and family groups

Hartmut Berger, Hans Gunia, Rainer Paul

Health promotion in the field of psychiatry is oriented towards patients aims to stabilize the personal and social identity of the patients and to enable their reintegration. This is best achieved with the instrument of psychoeducative group work.The implementation of psychoeducative groups for patients and their relatives in the form of a patient-centered subproject focusses on enabling the patient to live with the mental disorder and relatives, partners and friends to live with the patient.

The interest in psychoeducative groups for patients has suffered to date from the question of whether patients are able to consume and process information adequately. Psychoeducative efforts in an inpatient setting have developed despite this, aimed at improving patients' compliance with medication treatment and achieving their goal, as a number of empirical studies have shown. All these studies impressively counter the above-mentioned question. They agree that psychiatric patients are very well able to consume information about their disorder. In the meantime, a different question arose whether the effect of psychoeducative groups might not far exceed the increase in compliance. In the course of the discussion on the quality of life, it was asked to what extent patients, on the basis of such groups, would be able to better inform themselves with regard to medication, to recognize relapse warning signs, to learn social skills and self-management procedures, to improve their individual well-being and to better maintain their social functioning (see Atkinson, 96). The current types of psychoeducative work endeavor to systematically use the effects of psychoeducative groups that go beyond compliance coeffects and to avoid the disadvantage of work centered exclusively on relatives. They point to experiences gained as early as the 1970s from efforts to inform patients and relatives about medication by means of joint groups.

Development and Founding of Group Work with Patients and Relatives

Psychoeducative groups for patients and relatives developed among others from the discussion of research results which showed that the course of a psychosis could be positively influenced by certain styles of communication within the family. This field of research is known as „Expressed Emotion“ , or „EE“ for short. The degree of „EE“ (high or low) is assessed by means of specific, structured interviews on the basis of three indicators: criticism, hostility and overcaring. The risk of relapse for patients in families with a high degree of emotional involvement on the part of relatives (high emotional EE Index) appears to be at least four times that for patients whose relatives are less emotionally involved (Leff, 1984). Proceeding from this concept of expressed emotions, intervention strategies were developed whose aim was to lower the rate of relapse by influencing the family environment, above all the level of EE, through psychoeducative measures.

Patient and Family Work as a Counseling Project within a WHO-Subproject Group

Similar positive effects were expected from the Patient-Family Groups planned and instituted in 1996 at the Philippshospital within the framework of the WHO project. It was hoped that their quality would exceed the known effects (improvement of illness insight, increase of medication compliance and lowered relapse rate) in separately conducted groups. It was also hoped that the disadvantage of separate treatment of patients and relatives could be avoided. In the context of the concept of expressed emotions it seemed feasible to vary the emotional involvement by including members of other families so as to gain the necessary distance to the disorder, the family or the patient. It was hoped that this would improve the intrafamilial problem-solving behavior. Given this background the project activists formulated in 1993 the following goals together with the hospital administration:

- Development, standardization and evaluation of concepts for the information-centered and health-promoting work with patients and relatives.
- Development of a model for integrating work with patients and relatives.

Setting of psycho-educative work at Philippshospital

Current or past inpatients and their relatives participate in the groups, which consist of 4–10 members and meet a total of eight times at weekly intervals. The groups are moderated by either a doctor or a psychologist. As a rule there are two moderators. A corresponding easy-to-understand list of literature is recommended to support the active search for and retrieval of relevant information (Bäuml, 1994; Finzen, 1993; Hell-Gesterfeld, 1993). The material for the communication exercises, the crisis- and problem-solving diagrams, as well as the course tables for the early warning signs are handed out in the family groups. The exercises and role games offered in the family groups are borrowed from common programs for establishing „social competency“ (Gunia, 1992) and offered according to behavior therapy guidelines. This means that particular attention is paid to a climate of emotional acceptance, the group makes suggestions for improvement and the participants leave the group with a feeling of success.

Structure and Course of Group Meetings

1st Meeting: Mutual getting acquainted, introduction of the concept, expression of desires and needs

2nd Meeting: Information on psychosis, categorization, genesis (vulnerability-coping model), course and prognosis, options for the family (EE concept).

3rd Meeting: Information on medication treatment, physiological and biochemical foundations of medication therapy, side effects

4th Meeting: Nonmedication treatment methods, forms of residence, coping, perspectives after release, professional rehabilitation.

5th Meeting: Early warning signs: recognition and their use in relapse prophylaxis, crisis plans

6th Meeting: Introduction of a concept of problem-solving

7th Meeting: Role games proceeding from a concept of problem-solving

8th Meeting: Role games proceeding from a concept of problem-solving and final discussion.

The program consists of an informal section (Meetings one to five) and a training section (Meetings six to eight) and the blocks proved useful in our hospital. In the meantime the WHO group has developed a treatment manual (Gunia, 1996), according to which the meetings are conducted.

Experiences with Group Work-Evaluation of Effects

The experiences from the perspective of patients and their families were assessed in an initial evaluation study. A structured interview and a self-evaluation questionnaire covering changes in knowledge, self-confidence and individual and familial problem-solving behavior were used. Results of the first interview show trends towards an increase in theoretical knowledge about the disorder, increased self-confidence in dealing with relatives and a positive assessment of the problem-solving behavior within the family. This could mean that the participants are able to exhibit more trust in their own family, thanks to the discussions within the group. In answer to the question as to what they found positive, the reply was the mutual work of patients and relatives, literally, „that patients and relatives sit down together“ and, „that my mother is aware of what is going on.“ The most listed the information received as positive. In the foreground is the aspect of being able to talk about the disorder and its consequences in a setting other than the usual one.

The experiences from the perspective of the group moderators were also assessed by means of questionnaires. Their report indicates that it was a great relief to the families to discover that other families had similar problems. They also seemed to benefit from the model of the therapists in dealing with difficult situations. It was evident that the patients in the respective families considered themselves to more partner than patient. Especially fruitful was the therapeutically induced trade between relatives and patients (a type of intervention that in this form is not possible in either family therapy or homogeneous patient or family groups). By means of such a trade it was possible to work on current conflicts without the pertinent „familial conflict history“. The emotional distance was greater and the conflict thus easier to resolve.

Experiences in Implementing the Group

It was no easy task to implement the group, based on experiences to date with psychoeducative group work, into the pattern of everyday hospital life, despite its desirability. The framework of the HPH Project helped both formally and informally to guarantee the continuity in implementing group work. Formally, because the hospital administration donated both staff manhours by allowing members of the subproject group a certain number of hours for work on the project, and material support.

Informally, because the reputation of the HPH project made it easier within the hospital to engage staff members for work on the subproject and to „sell“ the group program „in house“.

The framework of the WHO project thus aided a program which could be promoted throughout the hospital only thanks to the cooperation of all involved (nursing staff, doctors, psychologists, patients, families) (WHO project image as „door opener“). In doing so, the informal work on the part of the very much involved participants in the subproject group was essential. By their continual weekly discussions and occasional evening meetings, by specifically addressing interested colleagues working on the potentially interesting wards, they have managed to implement psychoeducative groups for patients on all seven admission wards to date (September 1996). All general psychiatry wards participate in addition in a system of regular information evenings for families, thus guaranteeing every patient who so desires, the opportunity to participate in a psychoeducative group.

Final Evaluation

Our experience with group work has shown that patients with mental disorders (in this case, firsttime patients with a diagnosis of schizophrenia) benefit highly from a program of group work that will enable them to better cope with their disorder. The patients’ responsibility for coping with their disorder is strengthened and the information on relapse prophylaxis is discussed and explained. The experiences with an integrated psychoeducative group program for patients and their families are still new. Nonetheless it can already be said that all participants consider it an enrichment that allows both patients and their relatives and the moderators a different view of the dynamics of familial interaction which can lead to new opportunities in the productive resolution of conflicts. Patients are given a stimulus for active coping strategies. Together with their families, they experience a strengthening of the family help system as the primary and essential crisis intervention network. The program of psychoeducative family intervention (PEFI) is well integrated into the pattern of everyday hospital life and meets with acceptance on the part of all those involved. Moreover, the experiences to date lead us to expect that greater attention will be paid to the information distributed within the constructive environment of the meetings on topics such as early warning signs and the opportunities of prophylactic medication, and that a corresponding learning effect will thus prevail.

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The role of patient education for the successful treatment of chronic non-communicable diseases

Tamás Halmos, László Kautzky

Epidemy of chronic, non-communicable diseases stand now in focus of clinical and preventive medicine. In the last decades clinicians realized, that successful treatment can be carried out only with active involvement of patients, suffering from different chronic diseases. Diabetes mellitus is an increasing public health problem in westernized societies. By estimation, the prevalence of diabetes seems to be more than 5% among the population. Diabetes mellitus, and, in a broader aspect, carbohydrate intolerance has a strong linkage with other metabolic diseases, and with severe cardiovascular alterations, mainly myocardial infarct and stroke. Early diagnosis, regular medical care need the patient's active cooperation. This can be achieved only when the patients (and relatives!) know much more about their disease, the potential dangers, and the possibilities how to avoid them. In the field of diabetes, many teams started to educate patients in different forms, in order to obtain an excellent metabolic state and to avoid the late specific complications.

The situation is similar in other chronic diseases, like asthma bronchiale, chronic bronchitis. The number of asthma patients is steeply increasing, because of industrial pollution, smoking, cars, etc. Alcohol consumption is a great complex problem, which has medical, social, and psychological aspects, as well. By estimation, the number of alcohol-dependent individuals is roughly about 5% in our country. Successful fight against alcoholism is an extremely difficult one, but the increasing number of liver cirrhosis in Hungary makes it clear, that we have to concentrate on this problem. In our patient-education program we have chosen three different types of chronic diseases:

- Diabetes mellitus
- Chronic respiratory diseases
- Chronic alcoholism

In all three patient groups we performed three types of education:

- Individual educational form
- Small group teaching form
- Club movements

The design of these different diseases is of course rather heterogeneous. In educating diabetics (and relatives!) we focused on teaching patients how to keep their diet, how to carry on blood sugar self-control, how to use the sophisticated insulin-injecting devices, etc. Special attention had been put on chronic complications, how to detect them as early as possible, etc. In dealing with asthmatic patients, respiratory gymnastic played an important role. Alcohol patients needed strong psycho-social support, apart from detailed medical information, for alcohol patients usually die (as a consequence) from severe liver, cardiac or pancreas organic diseases. Individual and small group education needs no further explanation. Club events were the focus of our teaching programs. The design of the three club events were different:

1. In the diabetes club, there were three short presentations (one of nutritional problems), afterwards there was a discussion, the patients put questions to the lecturers. Finally there was a food-presentation from selected health-foods. There was also a possibility to check sugar, blood pressure, sometimes blood cholesterol.
2. In the "asthma club" attention is focused towards respiratory gymnastic, how to avoid severe asthmatic shubs, how to eliminate "status asthmaticus" by involving family members, when necessary.
3. The anti-alcohol club event reminds mostly of a "real" club. There is absolutely no strict frame, people are liberally chatting about their personal problems, and a psychologist and/or a social worker tries to find some solution to their uneasy worries.

We evaluated the efficacy of the three different disease groups by using questionnaires. Best results could be achieved in the diabetic group (based on theoretical and practical knowledge and manual skills). Less good results were obtained in the asthmatic group, and the worst in the alcohol group. Due to different educational forms, best results were documented by individual teaching forms, worse in the small group, and the worst in the club events.

In spite of these results, all the patients insisted to continue the club-educational form, probably because:

- It is a "social event"
- They can talk about their personal problems with people, who have very similar problems.
- At club events – especially in diabetic clubs – they have the opportunity to measure blood pressure, blood-sugar, they can buy healthy nutritional materials, etc.
- They are encouraged to put questions to the lecturers, partly according to their personal complains, etc.

In summary: Education programs for different chronic diseases seem to be useful in treating better the patients. Individual teaching-forms proved to give the best results, but club events also have their specific role. Best results could be achieved in diabetic patients, while the worst were among chronic alcohol consumers.

Health education as a benefit of health promotion in the Upper Silesian Rehabilitation Centre 'Repty' – Tarnowskie Góry

Anna Zieliñska, Krystian Oleszczyk, Urszula Mizerska,
Ewelina Kosiewicz-Nosowicz, Bronislaw Buczkowski

The aim of this study is to present the benefits and results of education in the Upper Silesian Rehabilitation Centre 'Repty'. Our hospital consists of two parts: the main Centre in Tarnowskie Gory and the Annexe in Ustroñ. The main Centre is situated in a beautiful park surrounded by an old forest. Underground, there are old 13th century silver mines which are a tourist attraction for patients and their guests. Our hospital consists of 14 wards: 5 neurological departments (including 2 wards for patients with hemi- and tetraplegia), 4 cardiological departments, 3 orthopaedic departments, the Clinic of the Silesian Medical University and a department for children with orthopaedic and neurological diseases. More than 7,500 patients are treated annually in our Centre. A Health Education School was created for them in 1994. This was the beginning of health promotion in our Centre.

In 1992, when the European Health Promoting Hospitals Network first started, our Annexe became a member in this Network, but staff from the main Centre were not interested in that problem. So our Director began working in health education outside the hospital in primary schools, during the meetings of self-government of the town Tarnowskie Góry and our 'voivodship' (county) (Katowice State). People working in Hospital Administration, specially in the Director's office, were involved in helping the Director in preparing slides and copying texts for presentations in order to better understand what health promotion is. Then he asked the heads of Cardiological Departments to give lectures within hospitals, for patients. This was the beginning of Health Promoting Schools. Lectures took place once a week.

When the Health Promoting Schools programme was established, a special committee to oversee diet was created. They checked if food was healthy for patients who suffered from hypercholesterolaemia or hypertriglicerydaemia and for patients with hypertension and for patients after cardiac events. Subsequently, a medical doctor was employed as co-ordinator. The Health Promoting Group consisted of 10 people; the hospital became involved with the Polish National Network in 1995. When the programme for fighting waste was created, the hospital joined the European Health Promoting Network.

Now there are abut 40 people in the Health Promoting Group. More than 20 of them work in health education. The lectures take place 2-3 times per week and are carried out by doctors, nurses, psychologists and physiotherapists. We use the following methods: lectures for our staff, patients and their families; individual discussion; video cassettes; books; and leaflets.

Every Wednesday we have special lectures for patients and their families. The topics of these lectures are:

- What do you know about your heart and how to support it?
- What should you eat to be healthy?

- How can you give up smoking?
- Physical training and health;
- How to fight stress;
- How to manage menopause (for women);
- Osteoporosis – the quiet thief of bones.

There are also demonstrations on how to prepare healthy food. During these presentations, slides and video cassettes are used. Individual discussion is provided by nurses, doctors, psychologists and dieticians. Nurses have been trained by doctors and psychologists for this type of discussion. Patients can also receive advice on social issues and law.

In some wards, small libraries of materials on health have been organised; for example, including advice on how to live after a myocardial infarction, how to manage hypertension, how to protect oneself against AIDS. Our hospital has different kinds of leaflets because of the co-operation with the following Polish foundations: The Foundation for Healthy Nutrition, The Foundation Against Smoking, and also the Department of Health in our voivodship. Because of our work patients know more about their illness; can manage themselves when they feel ill; and know how to change their life style and bad habits.

Once a week, concerts are organised for patients' guests and hospital staff. Entrance is free. These are much enjoyed by participants. They sing with the singers and clap their hands. They can also learn a lot about the history of music and the composers whose music is presented, because there are interesting introductions before every concert.

Patients can also learn how to deal with stress. Special counselling groups are organised, where they can discuss the main problems in the new situation caused by their illness. Practical lessons are given, in which the techniques of good respiration are demonstrated. In addition, music therapy is available every day.

The Health Promoting Schools programme has tried to reach out to the environment outside our hospital. There are lectures for teachers of kindergardens, directors of schools, and sometimes in private industrial factories.

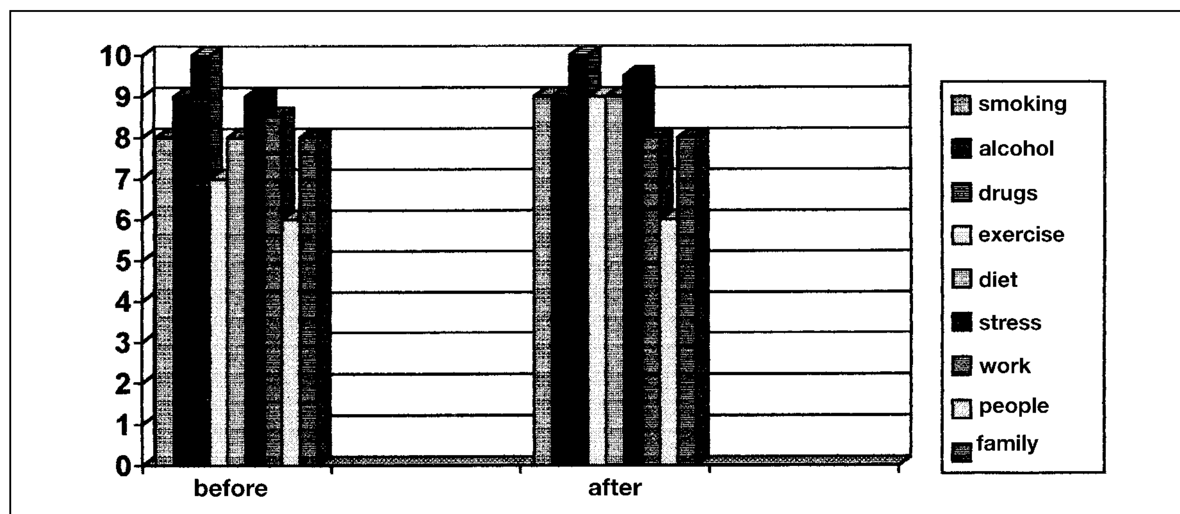

Figure 1 Answers received from people before and after lectures.

We have also tried to evaluate the results of our activity. Krystien Oleszczyk – Director of our Centre, designed a simple questionnaire. It was divided into two parts: detailed and general. In the first part, we asked about: smoking, indulging too freely in alcohol, taking uncontrolled medicines, taking drugs, low exercise activity, stress and fears, bad organisation and atmosphere at work, bad personal relations between people, bad atmosphere at home. As we can see, the answers did not differ greatly. Does that mean that our listeners know about risk factors and do not need education?

We observed a completely different situation in the answers to questions in the second part. In this part, we asked how life style, environment, medical care and inborn traits can influence health. Figure 2 presents the answers:

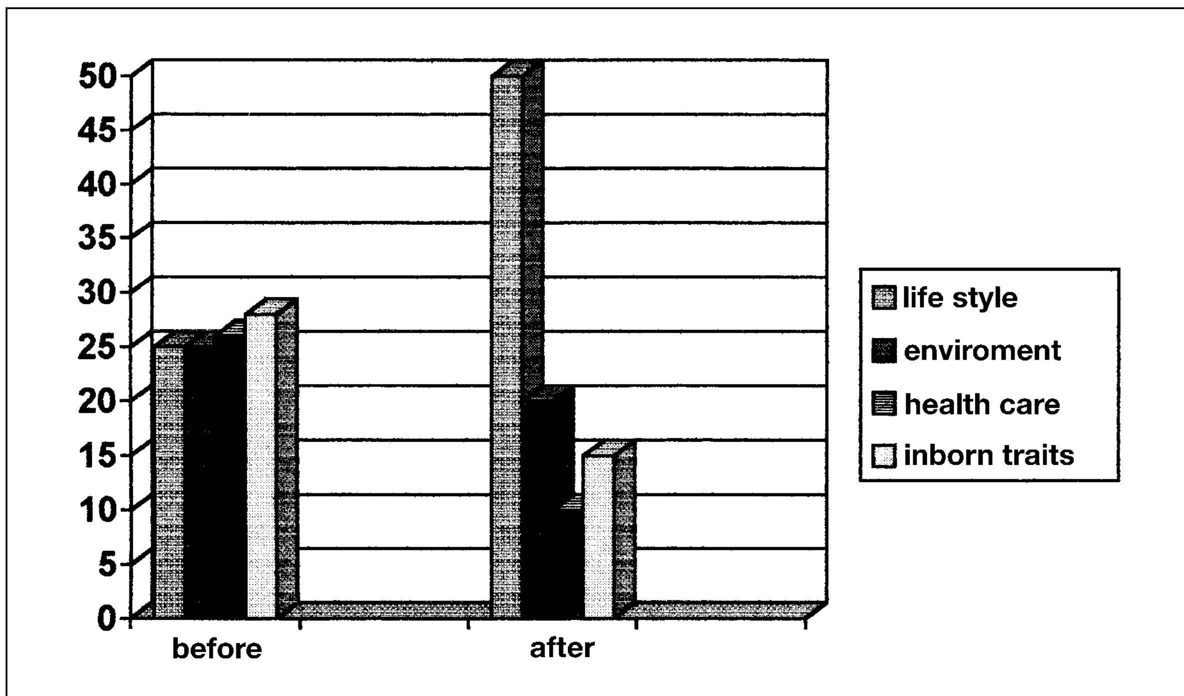

Figure 2: How do lifestyle, environment, health care and inborn traits influence health?

As we can see, the results of education and health promotion were needed to show people how life style can influence health. For this reason, Health Promoting Schools are necessary for patients and other people outside of hospital. Following lectures, they understand that not only inborn traits, but medical health care or environment can improve their health. Looking at the results in percentages, we can see that those factors independent from us decrease in importance in all three groups (the answers as between groups were not significantly different).

To conclude the presentation, we would like to introduce the 'model ward'. In our opinion, the health promoting ward based on education should offer: information about healthy food; how to overcome smoking; leaflets which patients and their families can take home; a board with information on how to cope with illness treated in the ward. For example, a cardiological department should teach patients all about coping after cardiac events. In our hospital this is possible only because of collaboration with the Polish Foundations: The Foundation of Healthy Nutrition, The Foundation Against Smoking, and also the Department of Health in our voivodship.

Some results of the patient satisfaction survey at the Prague University Hospital

Helena Hnilicová

Introduction

The history of patient satisfaction surveys in the CR is not very long. Just in the last 3–4 years, such surveys are proceeded in some hospitals. Patient satisfaction surveys are usually the first step in introducing systematic quality assurance (QA) programmes in hospitals. Very often such surveys are stimulated and organized by the hospital directors who have participated in international health care management courses. Under the influence of quality management ideas in international perspectives, some managers tried to develop their own hospital QA concept. At present (1997) there are about 10 hospitals – mostly teaching hospitals – where such surveys are being regularly organized by the hospital QA departments. The School of Public Health at the Postgraduate Medical School, in cooperation with the management of the largest Prague University Hospital, organized one of the first such surveys in 1993/4. This survey was an initial part of the larger research project that was scheduled up to this year. (See Janècková, H.: Patient Satisfaction Surveys as a Part of QA in the Czech Hospitals.)

Methodology

Description of survey: Sample of respondents: 8 clinics/100 patients from each clinic – 3 internal clinics, surgical, gynecological, dermatological, ORL, eye clinics were included in the survey. As a methodological tool, an anonymous questionnaire of our own construction was used. The questionnaire was based on a rating scale with 7 points. Only the poles of the scale were verbally expressed. Number 1 expressed „very satisfied“ – number 7 expressed „unsatisfied“.

Data collection: In cooperation with the hospital director, a final version of the questionnaire was elaborated and a data gathering procedure was organized. An information campaign about the survey was created for middle management (head of clinics, wards, and nurses). All details of procedure were personally discussed with responsible staff. In addition information sheets about the survey were provided to all health personnel. Patients received the questionnaire immediately after the decision was made about their discharge from hospital and very short time before the were leaving. Head nurses were responsible for the distribution of the questionnaires in the wards. This process continued 2 to 3 months. Nurses gave the questionnaire to all patients who were discharged from the hospital after the particular starting date. Only people with mental disorders were excluded (e. g. there were few patients with dementia in internal clinics). Before leaving the clinics patients put the filled in questionnaires into special closed boxes installed in each clinic. Anonymity of questionnaire respondents was protected. The response rate was 53%.

Description of sample: GENDER: 37 % Males , 50% Female and 13% without gender identification. AGE structure of respondents: 30 years and less (13.2%), 45–59

years (30.4%), 30–45 years (19.2%), 60–74 years (25.2%) and 75 years and more (8.7%). EDUCATION: distribution was similar to the distribution of education in the total population. Most of the respondents were with apprentice or with high school education (66%).

Results

In most items on the questionnaire a relatively high level of patient satisfaction was found. (See Figure 1). There were no statistically significant differences among pa-

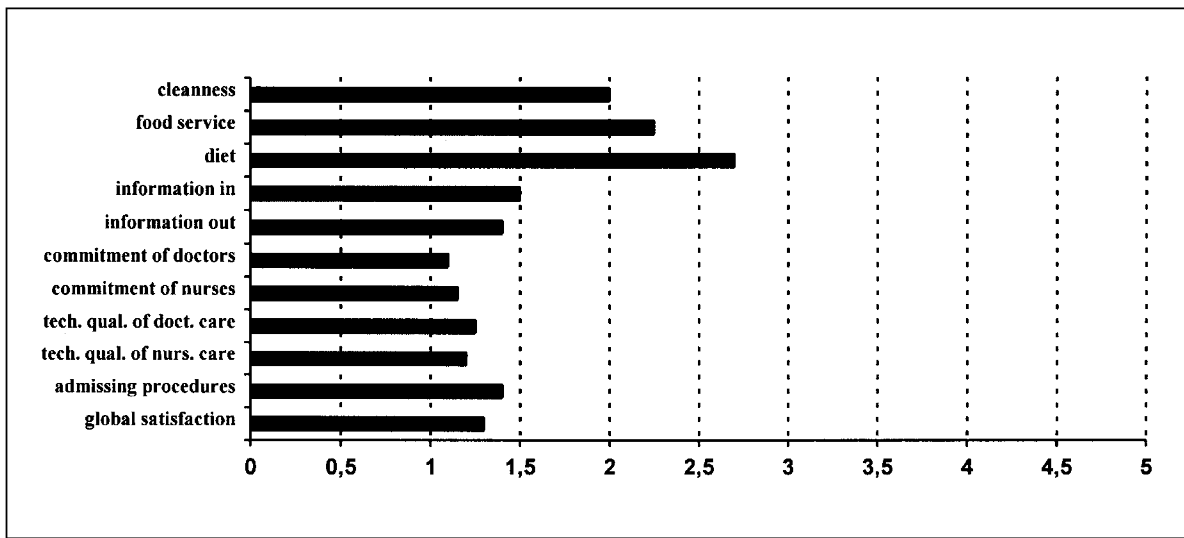

Figure 1: Mean values of individual items obtained in our questionnaire

tients according to age, education and gender. However, detailed analysis showed that, in some respect these characteristics could influence patient satisfaction. In our sample, the younger patients with higher education and hospitalized in the gender separated departments showed a tendency to be more critical and less satisfied with provided hospital care. Two categories of outcomes seem to be most important in our survey:

a) Identification of the patient satisfaction factors: Factor analysis showed, that items of the used questionnaire are closely related to three areas of hospital care. They can be identified as the factors of hospital satisfaction:

- First factor – „hotel services“ shows satisfaction with hygiene condition and comfort of accommodation including the quality of foods.
- Second factor – „information“ means satisfaction with information at the beginning of the hospitalization, nature of disease, diagnostic and therapeutic procedures and before discharge from hospital (how the health care should continue, how to organize rehabilitation, if necessary…).
- Third factor – „quality of care“ expresses satisfaction with communication and commitment of physicians and nurses as well as satisfaction with technical quality of medical and nursing care. In spite of the fact, that we asked separately about satisfaction with interpersonal aspects of care and its “ technical quality“, it is possible to conclude that, for patients, these two aspects tended to merge into one

common factor. Patients did not distinguish between these two aspects. Figure 2 illustrates the value of satisfaction in three main factors of satisfaction for all clinics.

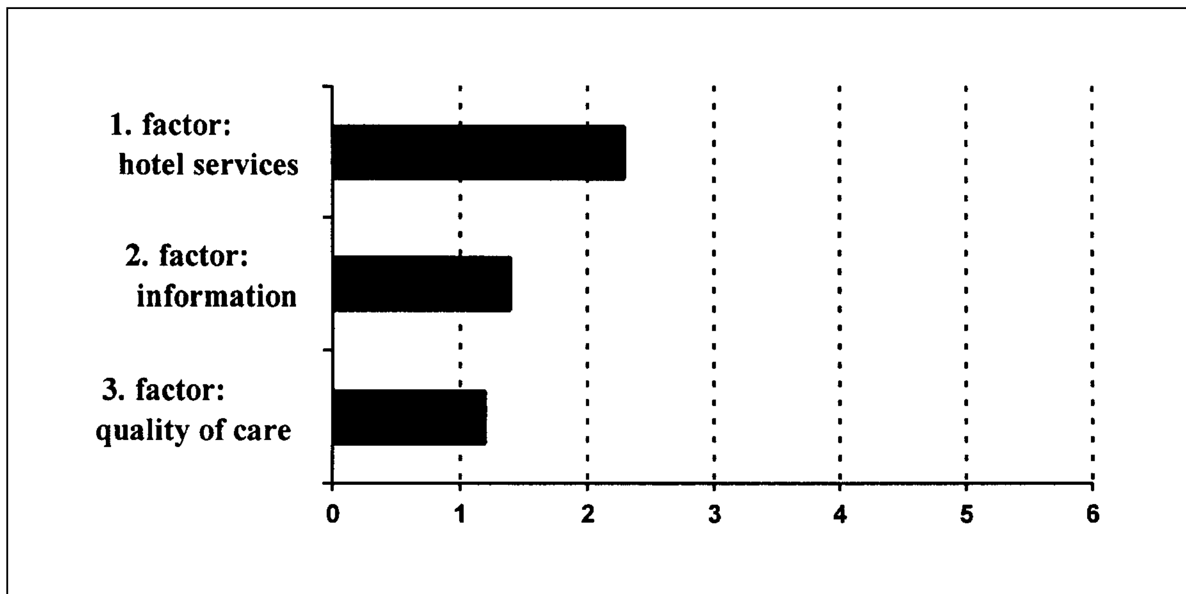

Figure 2: Average values in factors of satisfaction

b) Differences among clinics: There is a statistically significant difference between the best (5th clinic) and the worst (3rd clinic) in global satisfaction with care (see Figure 3). In the same way, data related to all items of questionnaire in all clinics were proceeded. There were some statistically significant differences among clinics – usually according to those of the best and the worst.

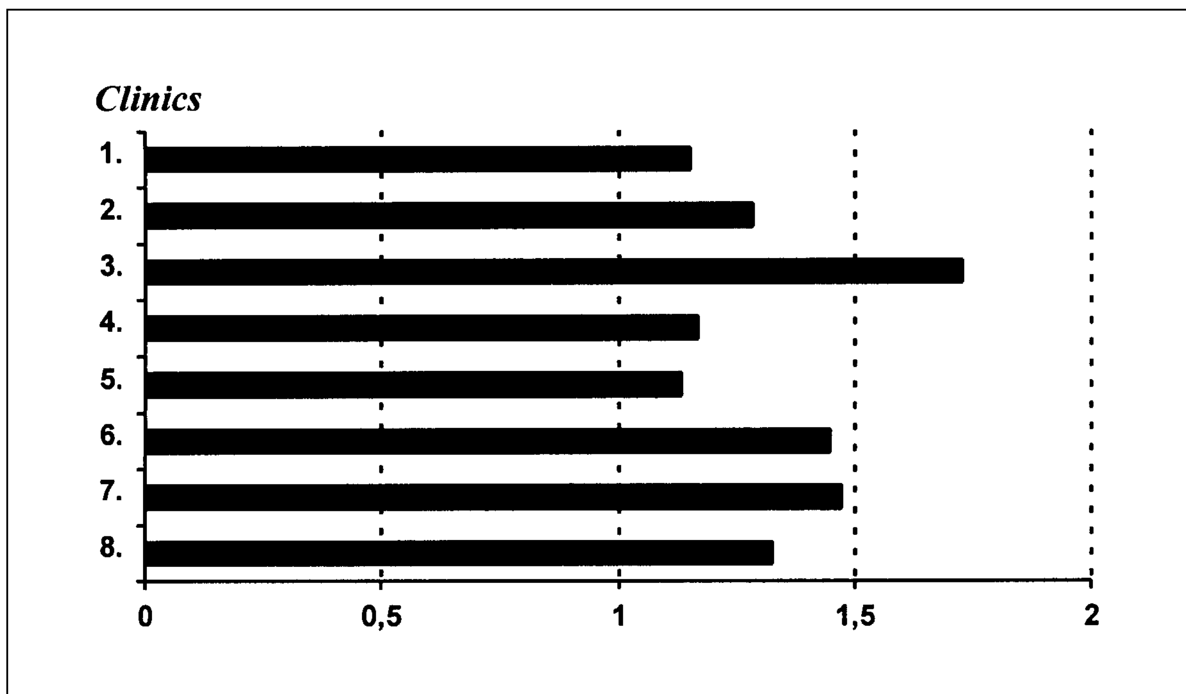

Figure 3: Global satisfaction in individual clinics

Discussion

It is not surprising, that the least satisfaction was identified in quality of hotel services in hospital. Patients expressed many comments regarding the quality improvement in this area (in open-ended question). In spite of this fact, it seems that, in our conditions, they are able to tolerate some problems and shortages in these services regardless to their negative impact on the global impression and satisfaction with hospital care.

The best value in satisfaction was reached in the 3rd factor – quality of care. There is the strongest relation between this factor and global satisfaction. Patients are as equally satisfied with the hospital care as they are satisfied in this aspect of care. In this factor, there was closely connected satisfaction with „technical" quality of procedures provided by the physicians and nurses with interpersonal behaviour of both groups. It is possible to conclude, that satisfaction with interpersonal aspects of care could be considered as type of filter through which patients perceived the „technical" quality of care. When patients are satisfied with interpersonal behaviour of physicians and nurses, they believe that physicians and nurses really want to use all their professional competence in caring for their patients.

Information: The items of this factor are in the second position from the point-of-view of satisfaction with hospital care. The results of our survey verified that appropriate and understandable information about illness and its treatment determines significantly positive patient experience with hospital care.

Conclusion

Satisfaction in this concrete hospital is quite high. But there are some differences among clinics in all aspects of care. In our survey, differences between the clinic on the first position and clinic on the last position were mostly statistically significant. These outcomes could be very useful and inspiring for hospital management as well as for health personnel.

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Patient satisfaction surveys as a part of quality assurance in Czech hospitals

Hana Janècková

On the basis of previous experiences from the study of patient satisfaction in 1994 (Hnilicová, 1994), a research project has been prepared for 1997-1998. The purpose is to describe the present situation of patient satisfaction research in the Czech Republic and to develop the methodology which would allow comparison of patient satisfaction in different hospitals. Finally, several types of hospitals will be compared, using innovated methodological tools.

Situation in hospital care

The approach to hospital care has changed radically in the Czech health policy. From the broadly liberal approach and rapid privatization, emphasis has moved to more coordination, public interest, cost-effectiveness and standardization. There is a sort of financial crisis in hospital care, which is just a part of the global financial deficit in the whole health care system. The costs of hospital care have increased enormously during the last five years. They represent about 60% of the health care budget, including in-patient and out-patient hospital care. Although the number of hospital beds has decreased, as well as the length of stay and even the number of physicians, the costs have increased as a result of growing wages, growing cost of medicine, medical technology, energy, etc. In addition, increased solidarity and a fee-for-service payment system for medical care have caused a huge increase in the cost of health care in this country. It is generally accepted that the previous, very liberal transformation of health care relying solely on market mechanisms has not been successful, and the system does not work effectively enough.

A new concept of reform has been prepared for the government by the Ministry of Health and new principles have been suggested regarding hospital care:

1. The centre of health care must be moved from hospitals to primary care. Primary care must overtake the role of gate keeper and must be improved in quality.
2. Hospital care must be provided mainly when any other type of health care is not effective enough. The type of care must be appropriate to the actual condition of the patient.
3. Hospital beds will be restructured and reduced to the European level. The number of expensive acute beds will be transferred to long-term beds or even to social beds (belonging to the sector of social affairs).
4. A network of health services and the standardization of hospitals will be implemented
5. Investments from the state budget on high technology and building will be strictly regular.

6. Changes in the manner of payment will bring a cumulation of procedures to more global units of payment (DRG, hospital days, global prospective budgets). Co-payment will be asked in given cases such as direct access to a specialist or long-term care.

Although some of the mentioned points are still to be discussed and can be changed only before the new law will be approved in 1998, quality assurance is being emphasized in all proposals of the reform. Effective care of high quality is seen as the way of saving money in the hospital sector of health care. Concern in quality will be necessary in the process of restructuralization of beds, reduction in the number of hospitals, the accreditation process, competition for public orders, contract negotiations with insurance companies, preparing standards for hospital care, guidelines for the most important and most frequent diagnoses and competition for patients to influence their choice of hospital.

What has been done regarding patient satisfaction?

The present situation in hospital care shows that patient satisfaction surveys will become an important part of quality assurance in Czech hospitals. Until now, we can identify two periods in the application of these surveys. In the first period (1990-92), only rare and unprofessional attempts to investigate patient satisfaction were performed. In the second period (1993–97), rapid development of patient satisfaction surveys started spontaneously, depending on the initiative and the motivation of the hospital management. Only a few surveys were an integral part of the quality assurance program in a hospital. There is no information about the effectiveness and quality of the surveys, about their continuity and utilization or about the number of hospitals which have performed patient satisfaction surveys. We know nothing about the validity and reliability of questionnaires. There is very little information about the results of the surveys, what factors of patient satisfaction were identified or how the results were used by the management of the hospitals.

Description of the current situation in patient satisfaction research

We realize that the good contacts of the School of Public Health with many hospital directors who have participated in our courses make it possible for us to collect information regarding the surveys which have been done in Czech hospitals. A sort of meta analysis of patient satisfaction surveys performed in three large hospitals will be done through the expert's study. In an additional 200 hospitals, the directors will receive a questionnaire in which they will try to evaluate the surveys executed in their hospitals by answering the given questions. Both the meta analysis and the questionnaire will be oriented to the description of the attitudes of the hospital management to patient satisfaction surveys, to their understanding of the aim of these surveys in relation to quality assurance and to the utilization of the results in practical management. In addition, we shall evaluate the methods used in patient satisfaction surveys in the Czech Republic and the contents of these surveys according to the following scheme:

Evaluation of methods

Way of application: questionnaire – given to patients and collected in the department before discharge or sent and collected by post after discharge

interview – personal or by telephone

Length of questionnaire: how many items

Return rate: percentage of collected questionnaires from number distributed
Anonymity

Assurance: Way of control of possible influence of personnel

Sample of respondents: selection, number, representatives

Time specification: Time limitation of data collection

Periodicity: Frequency of repeating the inquiry

Any problems with application Quantitative analysis of obtained data: Level of classification, correlations, factor analysis

Evaluation of contents: Factors of patient satisfaction investigated

Perceived quality of medical care
- professional competence of physicians
- professional skills of nurses
- human approach of physicians and nurses
- communication skills of physicians and nurses
- information to patients
- privacy during procedures
- admission and discharge procedures

Perceived quality of hotel services
- cleanness and order
- meals for patients
- schedule of day
- patient safety

Perceived quality of social life
- visits, programmes, activities, TV, telephone

Global satisfaction
- direct question
- non-direct question (for example, if the hospital was recommended)

Identification questions: gender, education, age, length of stay, seriousness of the disease, global health status, life satisfaction, returns to hospital, other indicators.

Comparison of hospitals and evaluation of differences

Factors would be classified and the most frequent and important of them would be identified. The data disposable until now show remarkable similarity in factors in various hospitals. The experience and technical skills of physicians seem to show a high correlation to global satisfaction, while "hotel services" are not so important from this point-of-view, even if they are usually evaluated as the worst of all factors. Some differences, according to the type of health institution (central hospital, district hospital, long-term institution) are expected. Differences in global satisfaction between hospitals will be evaluated from the point-of-view of the method used. The hospitals will be compared according to the utilization results.

Construction of the new methodological instrument for patient satisfaction surveys

After finishing the analytical period of the project (1997), we shall use the results for the construction of the new questionnaire and for the standardization of the process. The method should be improved so as to make it possible to use it universally for the comparison of patient satisfaction in various Czech hospitals. The questionnaire will be used and standardized in the second year of this project (1998) through the patient satisfaction survey in three types of health facilities: University hospital, District hospital and a special treatment institution or nursing home.

Because patient satisfaction research was performed in 1994 in the same University hospital, the results of both surveys (1994 and 1998) will be compared. The influence of the transformation process in this hospital regarding patient satisfaction can be evaluated. In addition, the impact of possible changes in the quality of medical care on patient satisfaction will be evaluated.

Conclusion

The presented research project, which has just started in the School of Public Health, wants to contribute to the improvement of patient satisfaction research and its effectiveness in the Czech Republic. The target of the project is to help hospital management to improve the quality of medical care through the tools of patient satisfaction surveys which would be fast, regular, simple, easily applicable and understandable in the presentation of results to hospital top and middle management. It would also provide reasonable interpretations and acceptable recommendations to all personnel, thus allowing for permanent monitoring of the hospital as a living organism. It would give meaningful feedback and play an important role in conflict prevention and other management problems in a hospital. For insurance companies, state administration and other bodies involved in the accreditation process and in contracting health services, it would help to evaluate health care services from the point-of-view of the needs of patients and to assure health care of high quality for the population.

Measuring patient's satisfaction in our hospital

Marta Kovacs

Evolution and history

Our Hospital was built during the years 1926 to 1929. At that time, it had 1000 beds, and was responsible for the county of Vas and the town of Szornbathely.

The remodelling of the hospital began early in the 1960s. The operating theatres and the departmental buildings were renovated in 1966. The new, modern surgical wing and the internal medicine wing were built in 1970. The latest results of the remodelling were the maternity, radiology, laboratory and oncology wards.

At present, the hospital is under the jurisdiction of the commune. It is a university teaching hospital, with 1437 beds and 24 departments, responsible for the county of Vas but also open to patients from other counties.

Our hospital is in an old-fashioned pavilion style and it is difficult to meet modern working conditions.

The measurement of patient satisfaction has been of major concern in medical care research. A general satisfaction measure provides an assessment of physicians and of the medical care delivered, while a specific satisfaction measure assesses past experience with the regular care provider.

Since 1988, patient satisfaction in the hospital has been measured. Data collection is by questionnaire. Since 1994, all data relating to satisfaction have been studied, evaluated and taken into consideration every half year.

Data collection involves the nurse's drawing attention at registration to the following:

- it is possible to express views about satisfaction with all the services provided in the hospital;
- the forms are set out in the sitting room;
- expressing views is voluntary and anonymous;
- the completed questionnaires can be placed in the box in the hospital ward, when leaving the hospital.

The patients receive simple questionnaires. The questionnaires will be processed each semester. The number of questionnaires processed is illustrated in the first diagram. The small quantity in the first semester of 1995 was due to a computer defect.

Every six months, data were assessed by the head of the department. All the data have been studied and evaluated by a control commission, and the departments get feedback on the results.

Dissatisfaction with the accommodation:

- In the older departnents, there are no sitting rooms; the beds are uncomfortable; the telephone service is old.

The necessary steps:

- The renovation of the older departments, although sitting rooms cannot be constructed in all departments because of the unsuitability of the type of building.
- Changing the old beds; but since there are financial problems, this can only be carried out step by step.

Dissatisfaction with the cleanliness of the bathrooms:

- In the old pavilions, there are few bathrooms; there are often repair works, which give a bad impression; and during the repair works they are out of use; patients often smoke in the bathrooms.

The necessary steps:

- Indicating smoking areas; establishing a patients' education programme in the departments; no smoking notices in the hospital.

Dissatisfaction with food:

- Patients do not like the diet food prescribed by physicans; most people in Hungary prefer the traditional food containing fat and spices.

The necessary steps:

- Dieticians should give advice and organise programmes for patients about healthy eating.

Emergency stand-by services and contact with nurses and physicans:

- Patients, mainly in-patients, are dissatisfied with emergency stand-by services, and the restricted number of nurses on nightshift; the number of nursing personnel is too small, and the nurses cannot spend the necessary time with patients.

The necessary steps:

- Instruction and education programmes for the nurses; do not allow the financial situation of the hospital to limit an increase in nursing staff [or 'the financial situation of the hospital prevents an increase in nursing staff'].

At the organisational level

- Most patients complain about the long waiting time for care.

The necessary steps:

- The organisation has been rationalised, and the care days are shorter.

Instructions at registration and discharge

- Old people do not understand the information; at discharge they do not receive advice about risks and lifestyle.

- Physicans fail to spend the necessary time with the patients and also fail to give additional written information.

The necessary steps:

- Instruction for the staff on giving advice to in-patients; organisation of health education programmes on various topics.

Around 15–20 per cent of patients leaving placed completed questionnaires in the box. Explanations of the low completion rate are:

- elderly patients cannot understand the questions;
- the nurses do not draw attention to the existence of the questionnaire;
- fear of people in charge;
- disagreement with the method;
- lack of interest.

Part 4

Health Promotion For Hospital Staff

Introduction

Pauline Fielding

Health promotion for hospital staff and their health is an important focus not only for the staff themselves, but also for managers who have a vested interest in maintaining a healthy and productive workforce.

Session 1 of this chapter considers interventions which might combat organisational stress and includes not just organisational approaches to the management of change but to serious crises which can and do occur from time to time.

Session 2 is concerned with the assessment of health status of hospital staff. The papers in this session range from the assessment of smoking prevalence amongst student nurses, musculo-skeletal disorders amongst nurses and clerical staff and whole workforce health assessment.

In Session 3, some likely interventions are discussed. Interestingly, although from different authors, the interventions (relaxation courses and back school training, policies on smoking, and empowerment of staff) are directly relevant to those issues discussed in Session 2 of this chapter.

A hazard control approach to occupational stress

Margaret Johnston

Introduction

The aim of the presentation is to provide information on an NHS project researching Mental Health At Work. This project was initiated in 1995, within Borders Health Board, South East Scotland (UK). Subsequent years have seen the development and implementation of an action framework appropriate to the findings of the project and to the needs of the rapidly changing health service. Indeed government reforms to Health Promotion in Scotland, re-directed the project itself in 1996. This paper reflects progress made to date and a proposal for the way forward in the development of a model to address organisational stress.

Background

When reviewing the literature, there appears little consensus of opinion on definitions of Mental Health and Mental Health promotion. Similar difficulties arise regarding primary, secondary and tertiary stress prevention. Therefore for the purpose of this paper, working definitions are offered in Appendix 1.

The prevalence of mental health problems in the general population is very high, and even higher levels have been documented in workplace settings. This is particularly the case within the NHS. Furthermore, in a recent survey of 112, UK companies showed that 65% believed stress was the most important health issue within their workplace.

The financial cost to industry has been conservatively estimated at £5.3 billion per annum, equivalent to the loss of 9,000 to 10,000 full time staff for the NHS. More recently, 1996 figures (1) released indicate that 360 million working days are lost annually through sickness at a cost of £8 billion (approximately ECU 9.5 billion). Half of these are, reportedly, related to workplace stress. Overall within the UK the cost of occupational stress is approximately 10% of the Gross National Product (GNP). Compared to other European countries Denmark (1990) 2.5%, Finland (1990) 3.5% and Sweden (1990) 5.1%.

The causes and influences of work-related stress are many and complex, involving intra and inter-personal issues; group and organisational processes. Tangible issues such as isolation, bullying, violence, job insecurity, long/unsociable hours, work under/over load are as important as the 'less tangible' issues such as poor communication, little/no feedback and a non-supportive organisational work culture. It is from within this scenario that the research project has evolved.

This paper outlines the four stage process of the Mental Health at Work initiative. Stage 1 – the pilot project, Stage 2 – implementing the action framework, Stage 3 – The hazard control approach to stress, Stage 4 – The way forward – the development of an organisational model for occupational stress. At the present time (summer 1997) we are implementing stage three and planning stage four.

Stage 1: The Pilot Project 1995

The Framework for Action (1993) reminded Health Boards and Trusts of their responsibility and exemplar role in supporting and encouraging staff to improve their own health, and identified the development of a range health promoting policies in the workplace. They also specified that 'mental health' should be a priority.

Aims and Objectives of the Project:

- To identify levels of stress; stressors; and individual coping strategies
- To provide feedback to the individuals and to the organisation from the questionnaire in the form of a report.
- To develop actions oriented towards individual and organisational change and to improve individuals mental health status.
- To develop a range of actions for Occupational Stress covering promotion, prevention, treatment and rehabilitation.

Funding was provided by Borders Health Board with the contract being awarded to Touche Ross Consultants, an English based company.

Mental Health, Stress and the Workplace Consistency of terminology is the key to any mental health project. Our project focused primarily on stress, because this concept is consistent with a holistic understanding of health as outlined previously. It is increasingly recognised that stress at work is a major cause of mental health problems. This was the rationale behind the project focus.

Process – Assessing Needs:

Needs Assessment is fundamental to health promotion not only to determine size, nature and the pattern of stress, but also the actual consultation process itself encouraged future participation and ownership of the project. The stages of the project were:

- Stage 1 Project preparation
- Stage 2 Data collection, both quantitative and qualitative (OSI)
- Stage 3 Data integration, analysis and project report
- Stage 4 Development of recommendations, interventions and implementation strategy

OSI in Stage 2 refers to the Occupational Stress Indicator, a questionnaire based tool developed by Cooper, Sloan and Williams (1988) and was used as the main instrument to establish the level and nature of participants occupational stress.

Outcome:

Key findings were structured into four main categories

- General mental well being
- Sources of stress
- Effects of stress
- Coping strategies.

Recommendations:

- Dissemination of results – as quickly as possible
- Workshops for managers
- Mental Health policy
- Implementation strategy
- Developing the action framework

Stage 2: The Action Framework 1995/1996

To assist with this process of implementing, identified interventions, an 'action framework' was developed (see appendix 2). This matrix was introduced to help participants focus resolutions from two perspectives:

- At three distinct levels – individual, group (department, ward) and organisational.
- Across a full range of interventions from mental health promotion to rehabilitation.

A monitoring procedure was set up to ensure implementation of the interventions.

Stage 3: A hazard control approach to occupational stress 1996/1997

The rationale behind this approach being adopted is because:

- It has proved effective within the health and safety system.
- It offers a systematic problem solving framework.
- It supports the plethora of information surrounding the management of stress.
- It is based on sound theory.

Yet, there is a dearth of well designed evaluative studies addressing mental health in the (NHS) workplace setting, using this approach.

The first phase in our research is to explore the concept of risk:

- Definition/perceptions of the concept of risk – how much gender, age and occupation affect the perception of risk.
- Identification of 'at risk' groups – who
- 'Risky' behaviours/risk appraisal
- Health consequences
- Role of health education/health promotion.

Thereafter there is a need to:

- Recognise and acknowledge legislation
- The management of the current legislation
- Action control – the cycle
- Implement the process
- Ultimately evaluate the concept

Stage 4: An organisational model for occupational stress 1997

This stage of the research is being planned at present. The research team has been established and funds are being actively pursued. The proposal at this stage is to explore pre-employment screening tools to determine potential employees' mental health status (person – role fit), risk behaviours and organisational behaviour/development. With this stage still in its infancy, any support would be greatly appreciated.

Conclusion

The aim of this presentation was to illustrate how Borders General Hospital NHS Trust is addressing Mental Health at Work. This comprehensive, long-term study evolved from a growing awareness and concern around employees' mental health.

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Appendix 1

For the purposes of this presentation I would like to offer the following definitions:

STRESS is derived from the psycho-social model, and is the product of interaction between individual and their environment. (Cox 1993)

MENTAL HEALTH is viewed as an integral part of overall health or well being and is integral to physical and social health. In this context the term encompasses not only the absence of mental illness, but also positive aspects such as quality of life, high morale and good self esteem. (W.H.O. 1946)

MENTAL HEALTH PROMOTION. Empowerment is central to this concept and is reflected within the definition of Health Promotion – the process of enabling people to increase control over their own lives…' (W. H. O. 1986)

Confusion surrounds the term' Mental Health' not least because it is frequently used in place of the term 'Mental Illness', on the grounds that this is less stigmatising; similar confusion surrounds the term 'Mental Health promotion and Stress'.

In addition I offer these definitions in relation to stress prevention:

Primary: Relates to taking action to reduce or eliminate stressors (sources of stress).

Secondary: Relates to increasing the awareness of stress and providing opportunities for employers to develop the necessary skills to manage their stress more effectively.

Tertiary: Relates to rehabilitation and supporting employees who have or are

Appendix 2

Table 1: ACTION FRAMEWORK

	Mental Health Promotion	Prevention*	Treatment*	Rehabilitation*
Organisational	Constructive feedback on performance	Review/development of a training policy. Staff personal appraisal interviews.	Access to counselling support	Personal policies providing flexibility on taking up employment again (e.g. in terms of responsibility and time)
Group	Team building activities	Training programme surrounding mental health issues	Peer support	Caring and sensitive support structures for individuals returning to work
Individual	Take holidays and lunch breaks	Participate in training e.g. assertiveness	Self referral to Occupational Health Services or counselling services	Develop awareness of stress-inducing situations and coping strategies

Critical incident debriefing of staff involved in the west of Scotland E. Coli 0157 food poisoning outbreak

Mark Kennedy

The food poisoning outbreak involving E-Coli 0157 from 22nd November 1996 to January 1997 is documented, in terms of fatalities, as being the world's second worst incident of its kind. The incident occurred within the Lanarkshire area in the West of Scotland, with the source of the outbreak traced to a local butcher selling contaminated meat. The Infectious Disease Unit (IDU) of Monklands Hospital, situated in Airdrie, near Glasgow was responsible for managing the infected population. On the 22nd of November '96, five confirmed and ten possible cases of E.Coli 0157 were admitted. Normally the IDU receives less than five admissions per year. In the following days the resources within the Unit became increasingly stretched, with over fifty patients admitted during the first week. In total over 160 patients were admitted in a five week period.

Emergency clinics set up at the hospital and within the local community dealt with over 2000 referrals in the first 14 days. The hospital also set up a telephone helpline manned by nurses experienced in counselling skills, in an attempt to provide accurate information and to reduce the prevalence of fear within the local population. Over the outbreak period the helpline received more than 15,000 calls. At the height of the incident 53 beds were occupied by patients infected by the E. Coli 0157 bacterium, requiring the extra services of 24 agency nursing staff. 19 patients, all elderly, died as a result of the outbreak.

The physical and mental consequences of continually working within such demanding conditions for a prolonged period of time are well documented (Kennedy-Ewing 1989, Gilliland 1988, Robinson 1995). In order to address the resultant high levels of stress, perceived by the staff involved in managing the incident, a debriefing

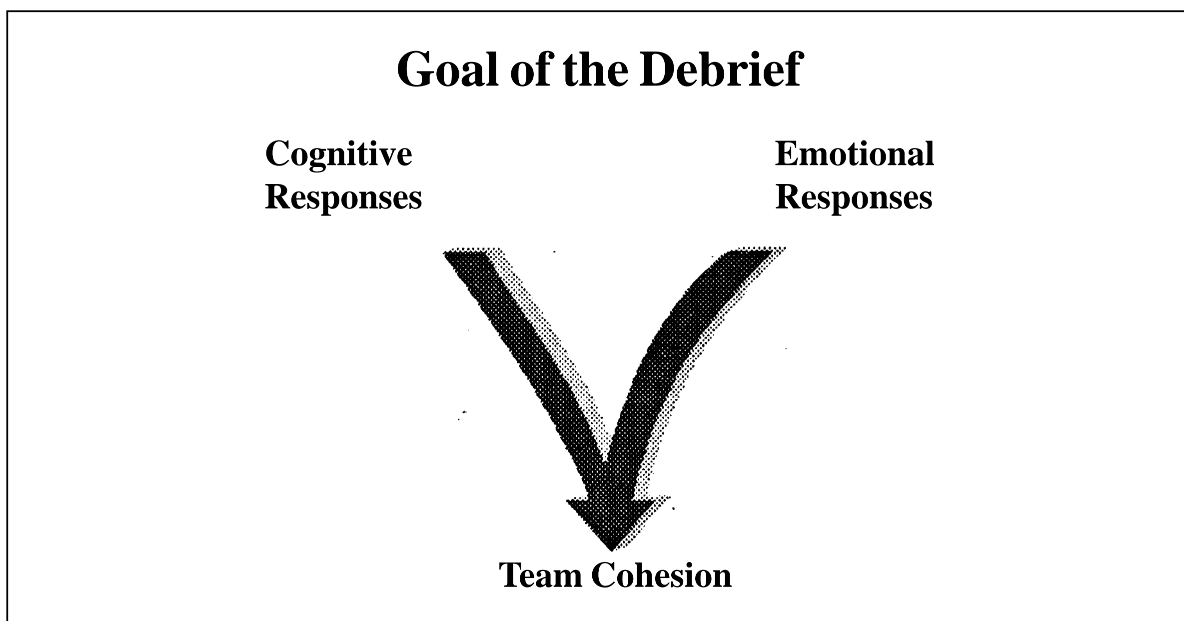

Figure 1: Goal of the Debrief

programme, particularly aimed at nursing staff involved was introduced. The goal of the debriefing programme was relatively simple. **"To explore both the cognitive and emotional issues in a positive manner, resulting in a reduction in stress and an increase in perception of achievement and teambuilding."**

There were many aims involved within the process…

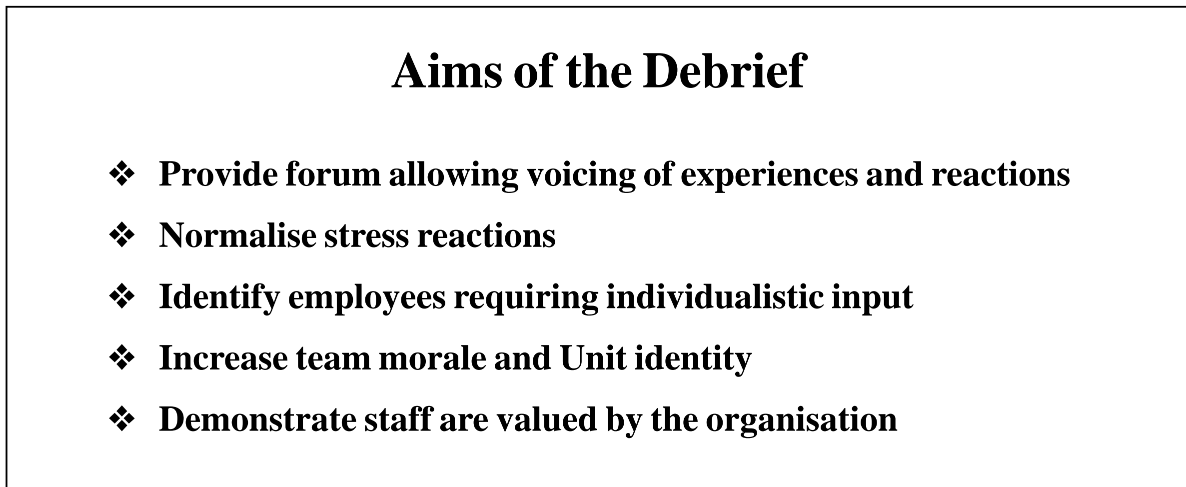

Figure 2: Aims of the Debrief

The debriefing sessions were structured around Jeffrey Mitchell's pioneering model developed regarding emergency services staff (Mitchell 1983), with a slight modification within the final stage of the debrief. The process involved the facilitator guiding the staff group on a journey beginning and ending at the cognitive state via exploration of emotional issues. The process is subdivided into seven stages.

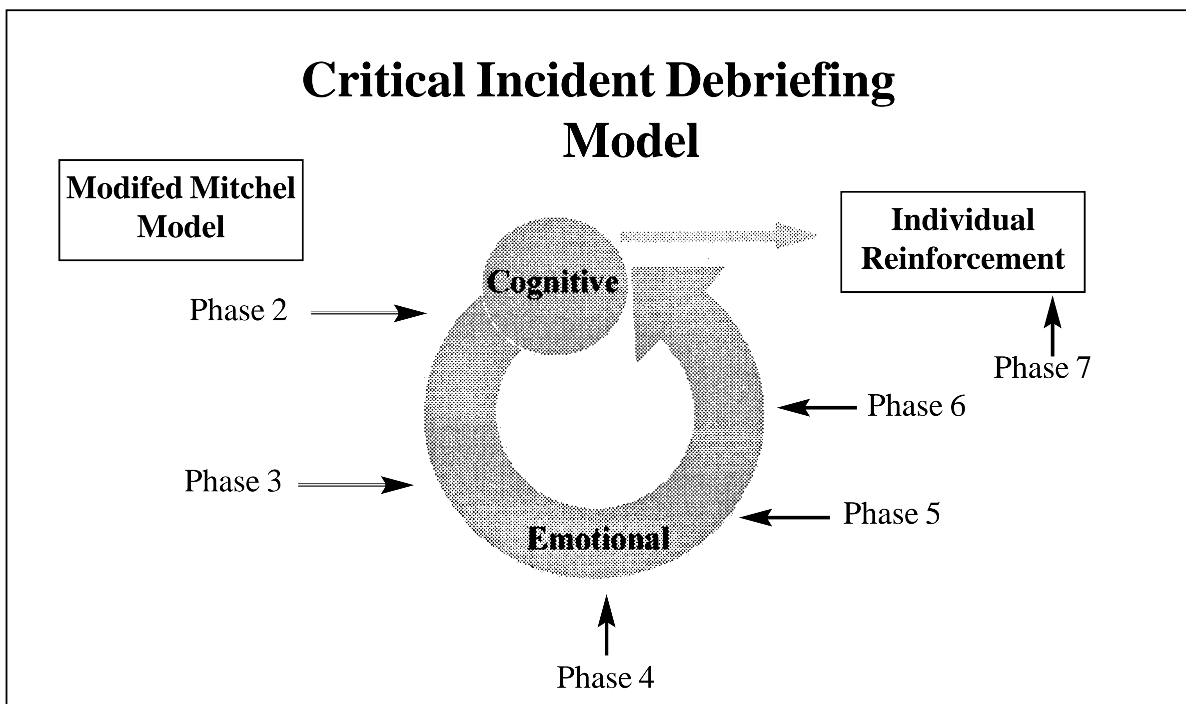

Figure 3: Critical Incident Debriefing Model

The first stage (Phase 1) is fundamental to the success of the programme. Here the ground rules and boundaries were set and agreed by all staff involved. Up to 30 minutes were spent reassuring staff that the facilitator was totally independent and that this process was owned by the staff in the room. Time was spent gaining the trust of the staff as well as creating an environment where individuals were able to contribute freely. This involved agreement around issues such as confidentiality ("What's said in the room, stays in the room."), and all participants being viewed equally regardless of status and grade. Many staff required repeated reassurance that senior management would not be made aware of the results of the debriefing sessions.

Once staff were comfortable with the setting and boundaries, the debrief began by each person in turn explaining their perceptions of events during the incident period (Phase 2). The details and varied perceptions recreated the event for the group as a whole. This gradual piecing together of the facts proved to be the easiest and least threatening method in initiating discussion within the group. Further discussion aimed at what the group were thinking at the time follows (Phase 3), this resulted in more personal aspects becoming involved and began the transition towards an emotional level. The fourth phase, or reaction phase, addressed the worst part of the incident for the participants, with anger, rage, frustration and manifestations of helplessness all clearly displayed.

After exploring all the issues the process returned to encouraging the group to describe their physical, behavioural and cognitive reactions during the outbreak (Phase 5). The facilitator then led the group in explaining the various ramifications of stress and the many ways of naturally coping with extreme conditions, encouraging staff to view these as "Normal reactions by normal people in abnormal circumstances."

The final stage encouraged the participants to reflect upon their main stresses. Two boards were provided, one marked "Personal Issues" the other "Professional Issues" and the participants were instructed to select their 2 main stressors, write them down, and pin them to the relevant board. They were encouraged to do this as if they would now be leaving the issue in the room, and not taking it with them back to the workplace. After the process was completed a short period of time was set aside for general informal discussion prior to returning to duty. This period was usually very animated as individuals realised they had travelled through a difficult process successfully.

The main issue and stressor to most staff involved surrounded inadequate internal communication during the event. This combined with lack of role clarity (self and others) exacerbated an already demanding situation. The findings are given below:

Staff Profile

38 nurses (all grades), 4 Medical Staff, 1 Senior Nurse Manager, 4 Ward Managers, 2 Infection Control Sisters, 6 Ancillary workers.

Findings

No significant problems, other than fatigue with Medical & Ancillary workers. However with nursing staff the following were identified as problematic:

- 81% experienced frequent sleep disturbance
- 52% recall responding inappropriately
- 39% recall frequent loss of concentration (with simple tasks)
- 18% experienced an intense perception of being unable to cope (wave of panic)

Main stressors identified

- 92% unaware of "bigger picture", strategic management
- Work became increasingly reactive in nature
- Ward manager's time increasingly spent co-ordinating other overspill areas, resulting in lack of decision making

Managers Findings

- 70% unclear of role boundaries
- 58% felt unsupported by peers and senior management
- 58% blamed poor communication across disciplines
- 42% had problems devolving responsibility
- 28% were stressed by media demands

Action taken

- Review of Hospital "Major Emergency Plan"
- IDU developed plans to address communication issues
- Training in debriefing techniques offered to ward managers

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Psychiatric, psychosocial and stress assessment in pre-employment screening for nurses and other health care workers

Ulrich Stoessel

Introduction

Pre-employment screening is undoubtfully an important measure in occupational medicine to protect people at risk from entering into a potentially hazardous profession. The interest in pre-employment screening is not alone restricted to the applicants or to the occupational health services. The employer himself has an increased interest in selecting applicants which fit to his special needs. Thus, not only medical reasons are dominating the discussion on pros and cons for selection procedures including medical screening programs but also arguments that follow the track ´how to adapt the worker to the workplace´ and not, as it is postulated, how to adapt work to the worker.

In contrast to pre-employment screening for chemical or physical health hazards the discussion of a potential pre-employment screening for psychiatric, psychosomatic, psychosocial health hazards has to face more and other problems. The measurableness of disorders and diseases is a great methodological problem due to lacks in medical history of the applicants, lack of criterial clarity for psychiatric and psychosocial disorders, lack of valid indicator variables that allow a sensitive prediction of health consequences (besides other consequences, e. g. quality of job performance etc.). There is a need to make a distinction between the different purposes of pre-employment screening and of health surveillance when performing a job. Pre-employment screening can deliver information on the health status of a person but has to express in some kind of probability assessment whether this person will suffer from a diagnosed disorder or disease when performing the job. Health surveillance seems to be a much better measure to control the potential health hazards of a job to a person with pre-existing mental/emotional or psychiatric disorders, impairments or physical handicaps. So conclusions of health surveillance programs can, but must not provide the information needed to decide whether pre-employment screening can be helpful both for the applicant and the employer and if it is reasonable from an ethical point of view.

Another dimension of our problem is the specific character of work in a health care profession compared to other professions e. g. in the construction industry or in administrative or clerk professions. Work analysis of patient centred work in the medical and nursing profession has demonstrated that the role strain of physicians and nurses can be very different but that both have to function within a group of co-workers and in their work with patients. So the purpose of pre-employment screening for health care professions could be a three-fold one:

- to protect the health care worker from self-damaging or aggrieviating his health status;
- to protect colleagues and employer from failure of the employee in his work;
- to protect patients from care- and treatment failure.

In a recently published WHO report of Cox & Cox (1996) on psychosocial and organizational hazards at work, the focus lies not on pre-employment screening but on improving strategies and techniques of controlling and monitoring these hazards. Their list of hazards includes much more organizational factors than personal factors: The function and culture of a organization, degree of workers´ participation, the vision of individuel professional career, role clarity in the organization, content of work, job demand and stress, decision latitude, social gratification of work results, social interaction in work and the compatibility of work and private social life are in the eyes of the authors important sources of psychosocial health resp. health hazards.

Their list of possible mental/emotional reactions (besides a lot of physiological reactions) e. g. on stress in the working life includes drug abuse and addiction, dullness, depressions, nutritional disorders, disturbances of concentration, sleeplessness, susceptibility, low self-esteem, nervous breakdown, hallucinations, phobias, post-traumatic stress syndrom, suicide, fatigue, tremor and stuttering. So when we start to study psychosocial factors in work and work environment in depth, we are confronted with a sophisticated body of knowledge in psychology which could help us do determine the possible areas of pre-employment screening for psychosocial health hazards.

As de Frank & Cooper (1987) could demonstrate, objective stressors of different character meet subjective stressors and lead to the choice of a coping strategy which can have certain outcomes in both positive or negative way. The stressors, the process of coping and the handling of results of coping are modified by personal variables (independent from work related stressors) like age, gender, negative affectivity, optimism, locus of control, hardiness or type A-behaviour. It is not surprising that most of the scientific debate is concentrated on the process of coping or intervening health hazardous structures, procedures and dynamics in the workplace, whereas little is discussed on the possible impact of pre-employment screening on future performance of job and coping with stressors.

Assessment and interventions for occupational mental health as discussed in a lot of publications on stress and well-beeing at work (e.g. Quick et al. 1992) form the body of knowledge we can use to find answers on the question whether planned or already practiced screening procedures are feasible, applicable, helpfull and ethically undoubtful. At the moment only a very few results are reported in scientific literature. Often potential alcohol and drug abuse and its pre-employment screening in health care workers is reported with contradictory results.

Preliminary conclusions

It is difficult to come to conclusions when experiences and scientific results of pre-employment screening are as scarce as described in this short review. General recommendations like the screening guidelines of the U.S. Preventive Services Task Force (2nd edition) e.g. for depression, drug abuse, suicide risk, problem drinking or other chronic mental disorders and handicaps prefer a very cautious position when recommending screening in asymptomatic patients.

Perhaps a guide to professional practice in pre-employment screening published by Lowman already in 1989 represents still the state of development in this field because the questions he rose seem to be valid even nowadays. His catalogue of problems compromises the following, and we should regard them with caution before starting to implement a practice without scientific evidence:

- Is there enough evidence that traditional screening devices which have been tested in other circumstances are applicable without modifying the interpretation procedures?
- What's about false positive and false negative results of screening and what are the consequences for the employee?
- Which kind of psychopathology and mental disorders interferes with job performance?
- Is there a need for using multiple measures rather than basing decisions on results of only one measure?
- What about adjusting the scores within and/or outside the professional group at risk?
- Which kind of further investigations is needed to get more precise information on the predictive value of psychological screenings?

Other questions would have to adress whether infrastructure, compliance, and professional qualification of occupational health services staff is sufficient or wether it would be necessary to train them intensively before starting screening programs.

Psychosocial health hazards and psychopathology in health care workers are embedded in the same way into a context of avoiding unfavorable working conditions as is the case for other industrial work designs.

On the way to interdisciplinary teamwork – A journey full of mishaps

Sonja Novak-Zezula, Ursula Trummer

Interdisciplinary teamwork as precondition for handling the complexity of hospital work

Hospitals as one of the most complex organisations of modern society are characterised by a highly specialised division of labour. Communication and organisation build the linkage between the different professional qualifications and therefore are basic preconditions for the integration of different kinds of knowledge, skills and performances and strongly influence the quality and efficiency of interdisciplinary teamwork. Teamwork is built up by processes of social learning. Realising, reflecting, and analysing the social connections and consequences are most important and necessary. One strategy to realise these ideals is to establish a meta-level of communication where reflection becomes possible. Creating a healthy hospital organisation needs investment in the direction of developing their capacity of self observation and modification through meta-communicative processes.

The design of the study and central results

The presented data are drawn from an empirical research and innovative project on structures of communication and interaction between the staff members of one specific internal hospital ward (comp. Novak-Zezula and Trummer, 1997). Over a period of three months a combination of five qualitative methods was applied: unstructured and structured participant observation, SYMLOG, narrative interviews, and survey-feedback.

The gap between individual ideal conceptions and every-day perception as well as discrepancies in role anticipation, lead to dysfunctional communication between the staff members. Interdisciplinary teamwork is negatively affected by the lack of formally installed opportunities for interdisciplinary communication on a professional as well as on a social level. The disregard of the importance of communicational processes for efficient teamwork hinders the adjustment and balancing of the different role anticipations according to professions. Perceptions, attitudes, values and concepts were measured and visualised with SYMLOG (Bales, 1995). The visualisation of group constellations and individual perceptions was used as an instrument to give feedback to the group and to initiate a process of discussion.

The data show crucial discrepancies between the self-perception of medical and nursing team members and the perception of their colleagues from the other profession and between the ideal role conceptions and the actual experienced „typical" nurse and physician. The frustration, disappointment, and disillusionment about members of the other profession and the non-articulation of these feelings in an appropriate frame and constellation, e.g. in interdisciplinary team sessions, lead to a strategy of defensive co-operation that is characterised by mystification (comp. Laing, 1992), attempts to avoid responsibility and explicit decision making. This defensive co-

operation also contradicts the necessity of involving and integrating the different perspectives and perceptions in decision making processes, which is an essential part of teamwork.

Sociological intervention and support

With the instrument of Survey-Feedback (comp. Rechtien, 1995), we formally installed a level of meta-communication both as an instrument of intervention and as an instrument of collecting data. Inter-professional and inter-hierarchical workshops were utilised to initiate an organisational development process. On the basis of the analytic extraction and visualisation of the specific views, motivations, ascriptions and ways of acting due to profession and status in hierarchy, an intensive discussion was initiated. On the level of social relationships the group-specific and communicational strategies of bargaining, decision-making and conflict-coping were connected with the SYMLOG-results. The group members could at one hand integrate the SYMLOG-findings into their every-day perception, but also had the chance to go beyond and find a more distant and reflecting point of view for problems they normally cannot recognise because of their direct involvement.

This position of self-observation and self-reflection of the group both as a whole and as individual members, built the framework for a more analytical and functional discussion of chosen topics. The central problems were formulated explicitly by the team members at the beginning of the workshops and an agreement was settled concerning the selection and concentration. The workshops were designed as a social process consisting of the following phases:

- *Phase of defining the problems and subjects*

  Two main problems of interdisciplinary teamwork were chosen for discussion, namely (1) difficulties in the co-ordination of admission and discharge of patients and (2) difficulties in information transfer especially concerning new patients.

- *Phase of communication*

  An open discussion was initiated where every member of the team, irrespective of his or her status in hierarchy or membership in the different professions could feel free to articulate their individual perception of problems and existing coping strategies. Both problems were formulated by the nurses who had to deal with the problem that decisions made by doctors that influenced their daily routines were not communicated and discussed in regard to their consequences. The admission and discharge of patients gets committed by doctors and patients. The chosen point of time often is hard to integrate into the routines of the nurses. Secondly, the nurses felt informed to a very marginal degree as far as the disease, its consequences and therapies, and the status of information of the patient was concerned. In this phase it was essential for the mediators to concentrate on the level of relationships, especially on the culture of communication and conflicts. This gains special importance because the group showed a tendency to take over traditional hierarchical patterns. Closely connected was the moderation of the discussion with regard to its contents.

- *Phase of intervention and focusing*

  In this phase we brought in the results of our survey especially when the articulation of critical statements was difficult for the participants. At this point we offered recommendations and suggestions for handling specific problems both on the level of social interaction and organisation of working processes. The central point in connection to the mentioned problems was the lack of a formally installed framework for interdisciplinary discussion and case management.

- *Phase of future perspectives*

  Several arrangements were agreed upon immediately in the workshop. They mainly referred to the division of labour and responsibilities between the professions. Most important was the agreement on weekly interdisciplinary case meetings with two formal subjects: (1) basic information about the patient for all team members and (2) formulation of common aims and related work organisations concerning all professions.

Conclusion

The experience of the workshops shows that interdisciplinary teamwork can hardly be handled in traditional structures. It also shows that interventions can be set with very little effort but can lead to the implementation of ongoing innovation. In this process already existing resources can be utilised. The team members are closely involved in innovation processes when, through mediation and moderation, their contributions are transformed into concepts for new communication strategies. This provides the opportunity to produce enduring reorganisation of team work culture.

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Smoking prevalence among student nurses

Denise Comerford, Veronica O'Neill.

Aim

The overall aim of the study is to document the smoking prevalence and attitude to smoking of student nurses throughout their training.

Objectives

To assess smoking prevalence and attitudes of student nurses entering a new diploma course in nursing studies at St. Vincent's Hospital, to follow up those nurses who continue with their studies at 2nd and 3rd year to assess any change in their smoking status. A smoking education programme will be offered at each year as part of the student's 'health promotion' module of their training.

Methods

The baseline information was obtained by means of a questionnaire. Baseline smoking prevalence and attitudes of 56 student nurses were studied within 3 months of entry to nursing college in October 1996.

Setting

All 56 student nurses accepted into a new diploma nursing course at a large nurse training college of a Health Promoting Hospital (St. Vincent's Hospital).

Baseline results

Number of nurses – 56 (100%).
Average age 18.5 Years.
Numbers of smokers – 25 (44%), of these 6 (10.7%) smoked 'only a few but not every day'.
Average age of starting smoking 15 years.
Average amount smoked 'each work day' – 7.7 cigarettes.
Average amount smoked 'each day off' – 9.2 cigarettes.

The smoking rate among the student nurses is significantly higher than the national average. A study commissioned by the Department of Health in 1993 reported a national smoking level of 38% in 17 year olds.

It is planned to follow up these nurses at 2nd and 3rd year to identify any change in their smoking status. This baseline and annual follow up information of this project will allow for a more focused smoking education programme using information from this study.

Self – rated health of personnel in a Health Promoting Hospital

Margareta Kristenson, Elisabeth Wärnberg Gärdin, Johannes Vang

Introduction

In recent years, studies of health outcome have been given increasing priority in the evaluation of health care services at the policy level. One essential part in health outcome measurement following medical intervention is the relevant, structured and reproducable information on the patient's own perceived health gain. At present attempts are being made to obtain this kind of information using psychometric instruments and computer technique(1).
At the University Hospital in Linköping, we are investigating the possibilities of using the SF – 36 instrument (2–4) as a measure of patients' perceived health. The 36 questions address health related qualities of life. SF-36 is a generic questionnaire and therefore does not ask for specific disease symptoms. Questions asked are such as: „Can you walk up the stairs“? „ Can you do the things you like to do, or are you handicapped by physical (mental) problems? „Do you feel anxiety“? The answers are compiled to scores in the following eight dimensions: Physical function, mental function, role function impaired by physical problems, role function impaired by mental problems, social function, pain, vitality, and perceived health.
The questionnaires are self administrated i.e. patients themselves fill in the questionnaires. Still , the questionnaires need to be introduced to the patients by the personnel. This may sometimes create problems, for instance when nurses find it insensitive and even tactless to ask critically or chronically ill people to fill in questionnaires about their health. In a disease oriented paradigm health and disease are placed against each other as opposites. In traditional disease oriented thinking health is associated with fitness programmes and ideal weight. In a health oriented paradigm this is different. Modern health orientation aims at self-worth, self awareness and coping capacity as the goal of the intervention. The objective is less pain and anxiety, increased autonomy and self-reliance, as good a life as possible even in the face of chronic or fatal illness (5–8).
Obviously it is mandatory to discuss this matter with the personnel in order to deal with their feelings of uneasiness but also with the purpose of introducing them to a modern view of health orientation in health care. This is particularly necessary as they have most often been educated within a disease oriented frame of reference and because most of their patients in fact are chronically ill.
Another perspective is the personnel's own health. Often managers have little knowledge about the personnel's health status. Activities taken to support the health of the staff are most often reactive towards long term sick leave and seldom proactive or preventive. One of the central ideas in „The Health Promoting Hospital“ concept is for hospitals to be models for healthy workplaces. To be able to meet this demand it is important to have a good knowledge of the personnel's own perceived health.

Aims of the study

- to introduce the personnel to the concept of health orientation of health services

and to illustrate that health measurements are possible, and to familiarize them with the SF – 36 instrument.
- to create data on self-reported health amongst personnel, thereby offering valuable information on the health status of personnel in different ages, occupations and over time, in order to improve the hospital as a healthy workplace.

Method

On two geriatric wards and at the Clinic for Pulmonary Diseases, the personnel was asked to fill in the SF – 36. The participation was voluntary and anonymous. Apart from the SF – 36 questionnaire the respondents filled in their working place, age according to 5-year age-groups and their profession, grouped in four: 1) nurses, 2) auxiliary or untrained nurses 3) physicians, psychologists, physiotherapists or occupational therapists and 4) secretaries.

Results

Participation rate was 80 %. 88 persons answered the questionnaire; 33 auxiliary or untrained nurses, 40 nurses, 10 physicians, psychologists, physiotherapists or occupational therapists and four secretaries. In the calculations the age groups were combined into three groups; ages 20–34 (n = 17), 35–49 (n = 59) and 50–64 (n = 12) years old. The variance was within the same range in the three age groups. The personnel's scores on SF-36 was very close to those of the corresponding age groups in the Swedish normal population, and if different, the personnel's total mean were in general higher. This was the case for body pain, general health, physical functioning and emotional role function in the group 20–34 years old and for general health, physical functioning and physical role function in age group 50–64 years old. The age group 35–49 years old differed little compared to the normal population. They had higher scores for social role function and lower for emotional role function. Small differences were found between age groups 35–49 and 50–64 years old. Some differences were found between 35–49 and 20–34 years old (Table 1). These differences

Table 1: Comparisons of SF-36 scale scores between hospital personnel of different age groups; means (SEM). Also the confidence intervals (C-I) for the Swedish normal population of the corresponding age are given (i.e.the lowest and highest confidence limits for the three included age groups). P-values for difference between means.

SF-36 20–34 years	Age group C-I	Population 35–49 years	Age group C-I (pop)	Population p-value	
Body Pain	86 (4)	(75,81)	75 (23)	(70,76)	0.025
General Health	86 (3)	(75,83)	77 (3)	(75,79)	0.056
Mental Health	82 (4)	(77,83)	79 (2)	(78,81)	0.063
Physical Functioning	98 (2)	(90,95)	90 (2)	(86,93)	0.012
Role Emotional	93 (6)	(82-90)	84 (4)	(85-87)	0.259
Role Physical	88 (6)	(83,90)	85 (3)	(84-87)	0.701
Social Function	89 (5)	(86,92)	89 (2)	(86,88)	0.992
Vitality	65 (6)	(63,71)	66 (3)	(64,67)	0.871

were found in the same variables where 20–34 years old were healthier than the normal population i.e. on body pain, general health and physical function. Comparisons between occupations showed only small differences; significant in few cases. Thus auxiliary or untrained nurses compared to the physician group had lower scale scores on role emotional (81 ± 6 versus. 95 ± 3, p = 0.04), and nurses compared to physicians showed a tendency to have lower scale scores on body pain (70 ± 3 versus. 83 ± 6, p = 0.07), with a confidence interval for the difference of -25 – 0.8, indicating a large ß-error risk because of the small sample size. The results from the three wards differed little.

When discussing the questionnaire together with the personnel, the above mentioned fear of asking seriously ill persons about health was changed to the contrary. Having seen and answered the questions and having discussed the concept of health and the goal of health services, there was unanimous agreement about the value of the information obtained through this kind of measurements. It was generally agreed that the information will enhance the understanding of the patients' situation, give a more detailed picture of the therapeutic possibilities and greatly increase the participatory role of the patient both in curative and palliative efforts.

Conclusions

We found it valuable to let personnel fill in SF-36. It gave information on the personnel's perceived health. The study showed that the personnel by and large perceived themselves as being in good health. However, differences between occupations indicated possible important differences, which need larger samples to evaluate properly. Also this work strengthened the understanding of the instrument SF-36 amongst the personnel and created an opportunity to discuss and deepen the understanding of health orientation in the care of the ill. This was important because of the need for the personnel's close involvement in a proper outcome evaluation .

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Health at work

Lorna Woods

This paper describes the Health at Work Project in Preston Acute Hospitals UK. The project is a complex matrix of interventions managed by a multiprofessional team.

Aims

- to establish baseline information on the health of Preston Acute NHS Trust staff
- to develop a range of appropriate health promotion and managerial interventions in order to improve staff health and increase the health promotion role of the hospital
- to evaluate the impact and outcomes of the interventions

Interventions

The main activities of the group initially were to agree the range of interventions which would contribute to achieving outcome targets and their cost effectiveness and which were likely to make the greatest impact on improving health. The strengthening (by improving staff support) or adaptations of existing health promoting policies, such as smoking, healthy eating, alcohol policies were considered important first steps in realising these study objectives.

Over 20 events have been facilitated by the Health at Work Group including stress management workshops, fitness testing and road shows, family fun sports events and health promotion training. Health at Work activities promoted through improved publicity in newsletters, notice boards and the hospital communication system – Team Briefing. Joint staff and management meetings were also used. A brochure was issued individually to each member of staff outlining availability of various staff activities and leisure facilities.

Evaluation Methods

Quota samples, structured interviews, non-participant observation, staff questionnaires, review of documentation, e. g. policies, staff attendance, accidents at work, back injuries.

Results

Some of the interventions have been evaluated in terms of knowledge and/or attitude change, but the majority of interventions have not yet been evaluated in enough detail and in terms of behaviour change.

Conclusions

The aims and objectives were rewritten to ensure they were achievable and measurable. The project team must be representative of all staff groups to achieve credibility and support. Beware of raising staff exceptions too highly. Publicise facilities already available in the hospital and the wider community to maximise their use amon-

The role of staff empowerment in the prevention of patient aggression and staff burnout at psychiatric hospitals

Reinhold Kilian, Rainer Paul, Hartmut Berger

Introduction

Aggressive behaviour of patients is a common phenomenon at psychiatric hospitals. In different studies it was shown that during one year nearly 25 % of all psychiatric staff members were aggressively attacked by patients. In a German study including four psychiatric hospitals with 2.243 beds a one year incidence of 0,019 of aggressive acts of psychiatric in-patients was found, that means during one year 2 % of all admitted patients have been involved in aggressive acts against staff members or other patients (Steinert 1995; Palmstierna & Wilsted 1994; Whittington and Wykes 1992; Steinert et al. 1991; Haller & Deluty 1988). For the hospital staff members, aggressive attacks of patients not seldom result in physical injuries. As it was shown by Berger and Paul (1994) 20 % of the work related accidents of psychiatric hospital staff result from aggressive attacks of patients. Beyond these physical injuries it must be suspected that aggressive attacks also result in emotional disturbances of the staff members. Though there are no systematic data to support this hypothesis, it is known from case reports that staff members who have become victims of aggressive attacks of patients develop feelings of anxiety, shame and disgrace. In some cases these negative feelings develop to serious emotional disturbances such as sleeping disorders and nightmares. One long term effect of such emotional disturbances could be burnout which was established to be a common phenomenon in psychiatric service staff. Systematic studies on the aetiology of aggressive patient behaviour in psychiatric wards are mostly concerned with the individual characteristics of the aggressive patient. Aggression is thus regarded as a symptom of the mental illness, in particular as a consequence of the reduced self control of the patient.

During the last years, some researchers started to analyse not only the characteristics of the aggressive patient but also the characteristics of the environmental context of aggressive behaviour (Whittington and Wykes 1996). As a consequence of the results of these studies, it can be concluded that for the prevention of aggressive patient behaviour in psychiatric wards, the environmental context of the occurred aggression must be taken into consideration. In particular it seems to be necessary to find out which factors will influence whether treatment or caring activities of the staff members will be experienced by patients as aversive stimulation or not. Though it will not be possible to completely avoid aversive stimulation, detecting and controlling these factors could help to reduce aversive stimulation to a minimum.

Description of the study

In a cross sectional study of 234 staff members of a psychiatric hospital conducted in 1994, we found that the more staff members feel that they can use their personal competencies in the working process and the more they participate actively in improving their working conditions, the less they experience their working conditions

as stressful and the more they cope with job stress in an adequate health-promoting way. At a second point of measurement 15 month after time one, staff members were additionally asked whether they had been the victim of an aggressive verbal or physical attack of a patient during the last year. Furthermore in addition to measurement at time one, burnout of staff members was assessed at time two.

The following analysis is based on the assumption that, when empowerment protects staff members from experiencing their working conditions as stressful in general, it could be also a factor which enables them to behave more adequately in situations where the risk of the occurrence of patient aggression is high. Because empowerment was found to be a powerful predictor of active problem-focused coping with job stress, it could be expected that with increasing empowerment the staff members will be more able to cope with the experience of patient aggression in a way that prevents them from harmful emotional consequences, as for instance burnout.

Results

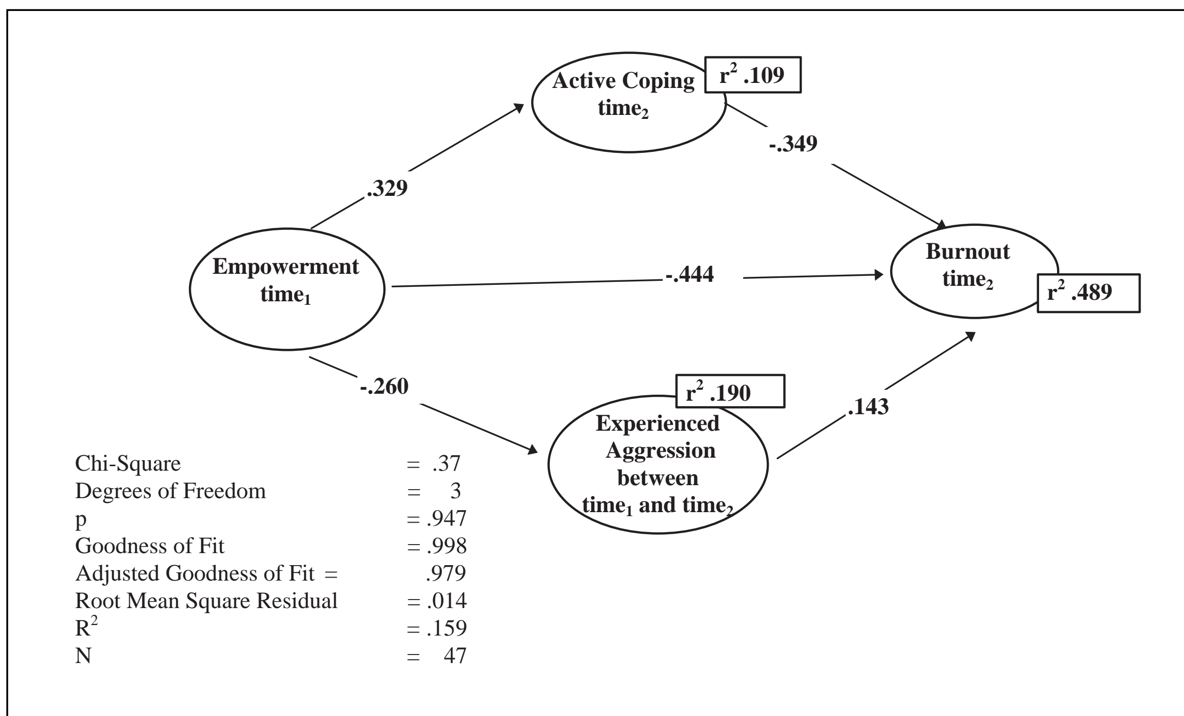

Figure 1: The role of empowerment in the prevention of patient aggression and staff burnout

Figure one shows the results of a path analysis of the relationships between empowerment, the experience of patient aggression, coping style and burnout. As the path coefficients indicate, empowerment measured at time one lowers the risk of experiencing aggressive attacks from patients during the following 15 month. At the same time, empowerment increases the ability of staff members to cope with job stress in a problem-focused way. Furthermore empowerment and problem focused coping are both reducing the degree of staff burnout at time two, whereas the experience of patient aggression between time one and time two increases staff burnout at time two.

As can be seen in Figure 1 one, there is no relationship between coping style and the experience of patient aggression. However it must be suspected that the style of coping influences the relationship between experienced aggression and burnout.

Because it is methodologically difficult to include interaction effects into path models, the effect of coping style on the relationship between experienced aggression and burnout was analyzed by breaking down the zero order correlation between experienced aggression and burnout by coping style.

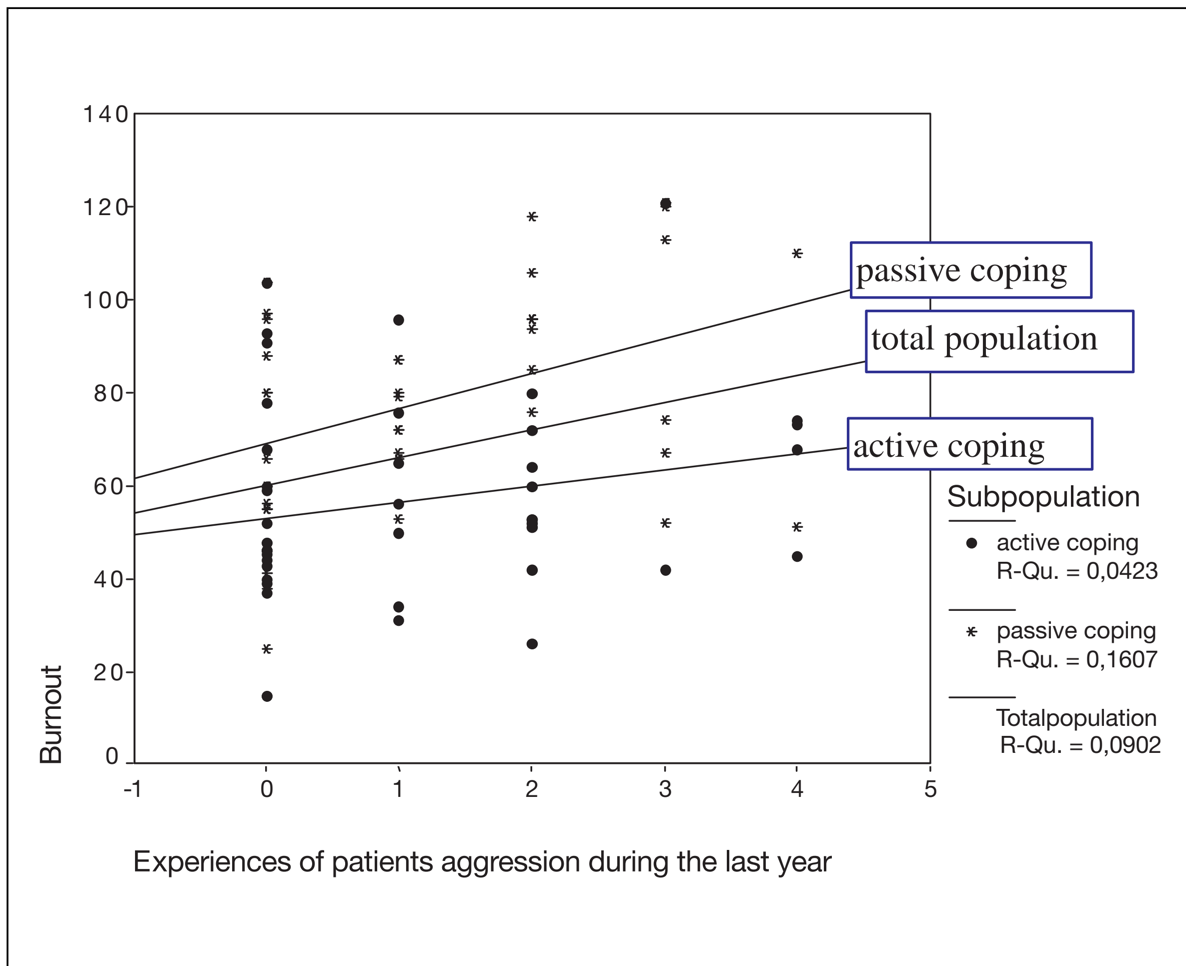

Figure 2: The effect of coping style on the impact

Figure two shows the scatterplot of this analysis. As you can see from the regression line for the total population, the zero order correlation between experienced aggression and staff burnout is .30. For the staff members who tend to cope with job stress in a more active, problem-focused way, the regression line indicates that the correlation between experienced aggression and burnout is only .21. For the staff members which tend to cope with job stress in a more passive emotion-focused manner the regression line indicates that the correlation between experienced aggression and burnout is .40. This is to say, for staff members who cope with job stress in an active, problem-focused manner the correlation between experienced aggression and burnout is nearly half as low as for staff members who cope in a passive emotion-focused manner.

Conclusions

As has been shown by the results of the path analysis and the analysis of interaction effects, empowerment is a crucial factor in preventing staff members from experiencing assaults by patients and also in reducing the negative impact of such experiences on burnout. What we don't know are the mechanisms by which empowerment influences experienced aggression. From our former analysis on the relationships between empowerment and perceived job stress, we know that empowerment influences the perception of the environment: People with a greater sense of empowerment are less afraid of losing control over critical situations. Furthermore, it is well known from studies on the process of decision-making in critical situations that people who fear to lose control tend to take more inadequate decisions than people who don't develop such a fear.

In regard to the prevention of patient aggression the fear of losing control over the situation by staff members could be a significant factor. If the above assumption, that aggression mostly occurs in situations where staff members have to do things which are disagreeable for the patients holds true, it might be that the fear of loosing the control over a patient's behavior leads the staff members to act more compulsive than necessary and therefore increase the risk of aversive stimulation. Testing this hypothesis would require data which include precise information on how people with different degrees of empowerment behave in critical situations and how different forms of behavior are related to the occurrence of patient aggression.

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Part 5

Health Promoting Hospitals In Their Communities

Introduction

Carlo Favaretti

The role of the health promoting hospitals in their communities has been dedicated an important task of the Health Promoting Hospital philosophy: the link with the community and its primary health care services. The 1st session has been focused on Australian experiences. The evaluation of a rural HPH pilot project was presented by Susan Baker of the Gatton Health Services (GHS). The objectives of the pilot project were:

- to strengthen and support existing health promotion practice;
- to identify major health concerns of GHS staff and Gatton Shire community;
- to improve communication within GHS;
- to collaborate with community service providers in the field of alcohol and drug abuse and
- to raise awareness of the GHS HPH project within Gatton Shire and the Region.

The evaluation was carried out by analyzing project design, implementation process and results. Despite some initial methodological uncertainty a change process occurred with the HPH concept providing a systems framework to review and enhance organizational structure and culture. At the end of pilot phase two HPH Project Officers were appointed to develop and disseminate the HPH concept in Queensland.

Judith Dwyer of the Flinders Medical Centre described the experience of reorganization and reorientation of health care services provided by Flinders Medical Centre and four major regional partners. To cope with the challenge of the introduction of managed care in Australia, these institutions signed a voluntary agreement committing them to form a single regional health service and to demonstrate the real potential for health gain for people and the improved access to health care. Using the principle 'methods follow goals', the strategy of regionalization was based on the slogan 'form follows function'. The project has been evaluated as a survival strategy for public health care agencies faced with a policy of managed care and increased competition between public and private sector in health care.

The 2nd session has been dedicated to accident prevention. Kieran Hickey presented the results of a study on 'Accidental Injury in Ireland' Priorities for Prevention, sponsored by the Office for Health Gain. They confirm the potential that hospitals have to influence policies and the education of the community in relation to accident prevention. Sarifa Kabir (Preston Acute Hospitals NHS Trust) described a three years programme, carried out through alliances built in the community by the HPH, to assess and prevent accidents in children aged 0-16. After a very accurate epidemiological analysis of accidents, an information strategy was pointed out within the hospitals and the community. The project is coherent with the HPH concept and the strategy 'Health of the Nation'. Its method will be extended to other targets (i.e. overdoses and alcohol in young teenagers).

The 3rd session has been dedicated to the problems of health promotion and communication in the community. Gunar Baugut presented the experience of Klinikum

Chemnitz on how to visualize what health promotion means. Following the example of Altnagevin Hospital in Derry, the Chemnitz HPH created posters. The main difficulty was to distinguish the concept of health promotion in the hospital from health promoting hospitals also because of the characteristics of the German health care system. A preliminary evaluation about the comprehension by staff and community was carried out and an extended communication strategy is in progress. Stig Erik Westmark (County Councellor and Chairman of the Health Board) and Hans Nilsson (Consultant of Internal Medicine) presented the experience of Bergslagen Hospital in Sweden in building a unifying HPH concept. It is an interesting example of co-operation between politicians and staff, and of a top down/bottom up approach, in building a bridge between cience and policy-making. In other words it is an example of building a public policy for health and reorienting health care services. This pilot experience will be extended to the whole County, to become a day by day activity, following two principles: creation of alliances in the society and cooperation.

Denise Richardson presented the experience of Burnly HPH in creating the hospital without walls, through a complex strategy involving management, staff, patients and their families. The strategy is consistent with the program "Health of the Nation" and WHO HFA 2000. A video was also shown to document results. Hannes Schmidl focused the challenge for HPH in the light of health care reform in Austria. His presentation mainly dealt with the benefits of enlarged and proactive communication. Communication must be understandable, honest, true, correct. This is not a trivial task and needs time, attention and training. He observed a gap, if not a contradiction, between the culture and self-image of the hospital and the needs for communication and cooperation. This last session has been very stimulating, because several crucial topics were discussed:

(a) the cultural, linguistic, political problems as crucial points to communicate a new concept;

(b) the problems of communication in an extremely professionalized setting;

(c) the problems of building an appropriate information system consistent with the HPH concept in a very complex environment.

Evaluation of an Australian rural „Health Promoting Hospital" Pilot Project

Susan Baker

Introduction

Gatton Health Services (GHS) is located within the state of Queensland and is situated 100km West of Brisbane. Health services are provided for residents of the surrounding Gatton Shire which has a population of 16 000. The health service consists of a Dental Clinic, Child Health Clinic, Community Health Service and a 30 bed acute hospital, including accident and emergency, maternity, physiotherapy and optometry services. A mental health team visit on a regular basis. GHS is a component of Queensland Health, a large government organisation providing health services to the Queensland public. During 1995-96, GHS participated in a Queensland Health Promoting Hospital (HPH) pilot project which included two metropolitan hospitals, two rural health services and three remote hospitals.

Project Objectives and Strategies

Objective 1:

To strengthen and support existing health promotion practice.

Strategies:
- A hospital newsletter established
- A new integrated Quality Health Committee (agenda items: Quality improvement, health and safety, staff development, health promotion, the environment.)
- Collaboration with the Quality Coordinator of a nearby regional hospital
- Support to other initiatives (such as the GHS Health Expo)

Objective 2:

To identify the major health concern/s of Gatton Health Services staff and the Gatton Shire community.

Strategies:
- Staff focus groups
- Community service provider questionnaire

Objective 3:

To implement a project to improve communication within Gatton Health Services.

Strategies:
- Hospital newsletter combined with an existing Community Health newsletter
- Communication workshops for staff (topics: Organisational communication, assertion skills, and problem solving and conflict resolution)
- Staff suggestions regarding organisational communication (compilation of GHS communication strengths and suggestions for improvements)

Objective 4:

To collaborate with community service providers to address the community health concern of alcohol and drug abuse.

Strategies:
- Drug and alcohol project briefing session
- Formation of an organising committee to implement the project

Objective 5:

To raise awareness of the Gatton Health Services Health Promoting Hospitals Project within Gatton Shire and the Darling Downs Region.

Strategies:
- Articles in the local paper
- Participation in local health service provider meetings
- Poster presentations
- Conference presentations

Evaluation Objectives

Evaluation of the Gatton Health Services HPH Project was conducted to analyse project design, project implementation, and the success and importance of project objectives.

Evaluation Methods

A questionnaire was sent to all Gatton Health Services staff (53 in total) and seven key informants (health service managers and district managers). Participants were asked to rate the success and importance of project objectives, strategies and implementation. The same seven key informants also participated in taped interviews covering aspects of project implementation. A grounded theory style of qualitative analysis was utilised to analyse the interview data.

Evaluation Results

The Gatton Health Services HPH Project was rated 'moderately successful' and 'very important'. Initial project planning was poor and resulted in insufficient consultation, communication and project funds. Inappropriate timing of implementation and a problematic project management structure also was evident. The Project Officer assumed the role of facilitator, leader and advocate and utilised communication skills based on community development principles to overcome the barriers already listed as well as lack of support from senior management of the health service.

Project strategies valued by staff and managers were the visible action strategies that targeted staff directly or targeted the organisational structure. Strategies important for project success but not valued and/or understood by the majority of staff and managers were the developmental or process strategies (such as planning and needs analysis strategies).

The strength of HPH was found to lie in the area of the organisational mission statement with HPH assisting organisational planning processes, providing a structural framework, facilitating organisational change and functioning as an integrating phi-

losophy for other organisational reform initiatives. Staff empowerment and the ability of staff to impact on workplace decisions and practices was also valued by managers and staff.

Conclusion

Despite poor initial planning, uncertainty regarding the nature of the concept, and early project termination, a change process occurred at the rural health service with the HPH concept providing a systems framework for managers and staff to review and enhance organisational structure and culture. Comments indicate that the benefits of HPH directly impact upon workplace culture and service provision. District managers, local managers and health service staff recommended HPH be adopted by other health services and hospitals, Queensland Health as a whole and even other businesses.

Following project termination and evaluation, support for HPH has resulted in the employment of two HPH Project Officers to develop and disseminate a HPH implementation manual to assist other hospital managers and staff to implement the HPH concept in Queensland.

Assessment and prevention of accidents in children age 0–16

Sarifa Kabir

The annual attendance of children age 0–16 in the Accident and Emergency Department at the Royal Preston Hospital is approximately 15,000.

Aims

- to collect and analyse data relating to accidents occurring within the age group 0–16;
- to use the data gathered within this study to provide an outcome evaluation of interventions aimed at reducing specific accidental injuries within children; and
- compare the findings of this project with those of the 1995 children and accidental injuries project.

Objectives

- To identify what accidents are occurring within this age group.
- To identify causes of such accidents.
- To identify where such accidents are occurring.
- To investigate trends across gender within this age group.
- To take into account all of the findings and make recommendations for specific target areas and target ages for further research and interventions.
- To disseminate relevant findings to various agencies.
- To evaluate the ingestion of harmful products campaign.
- To evaluate the finger injuries campaign.

The project has developed over the last three years, many issues have been highlighted and alliances have been built in the Community, Health Promotion Units and Accident and Emergency Departments. Much interest has been shown on the results evaluated and the method of evaluation. Many Health Promotion Units have formed alliances with their Accident and Emergency Departments. Community Staff, School-Nurses and Health Visitors have shown a great interest, as it has enabled them to work with their local Accident and Emergency Departments and set targets for local campaigns.

Most of the injuries are occurring in the home such as trapped fingers, head injuries and ingestion of harmful products. A percentage of them in the age groups 0–4. Therefore it is not only important to introduce the prevention of accidents to children but also to their carers, such as parents, teachers, baby sitters and older brothers and sisters. In 1996 most of the injuries are still occurring in the home environment, therefore it is important that health education and accident prevention starts from the ante-natal stage.

The following categories were evaluated, they include falls, fractures, burns\scalds, pulled elbows and dog bites, head injuries and sport injuries. 27% of all attenders

were in the 0–5 age group, with the following injuries: falls down stairs, ingestions, trapped fingers, burns\scalds and pulled elbows. A pulled elbow is a dislocation of the elbow joint.

Results:

- In the 0–5 age group, head and facial injuries predominate as a result of falls. Other consistent and preventable presentations in the age group included pulled elbows, scalds, digit injuries, ingestions and falls on stairs.
- In the 6–10 age group, the pattern changes with increasing numbers of extremity injuries including fractures.
- In the 11–16 age group, extremity injuries during sports dominate, overdose cases and assaults become increasingly common.

Medications can be bought from the local shops, pharmacies and super-markets. Most people have a lot of medications in the home that they have acquired over the years. It is important to discard of medications when they are out of date or no longer required. Many unintentional deaths are caused by taking medications, even 12 paracetamol can kill.

In 1995 a study on the ingestion of harmful products was carried out, the attendance for children age 0–16 was 7%. The attendances for 1996 was less 3%. These figures would not have been possible without the assistance of the school nurses and health visitors. A campaign was carried out in the community to bring a general awareness on the importance of storing harmful products such as tablets, cleaning fluids and oils. Ingestion of medications was the highest category taken, majority of the items were taken in the home environment in the age groups 0–5 and 11–16. Paracetamol being the most popular medication taken. The campaign involved the community nurses, schools health centres, G.P. surgeries and public places as part of Child Safety Week. Exhibitions and posters were distributed in the hospitals and in the community. What is important is that the awareness of storing medications and reading the instructions on the medication package has continued to be part of the health education package in the community. The dangers of taking large amounts of paracetamol is also being addressed in the community.

A finger injuries campaign was carried out in late 1995 and early 1996. Trapped fingers appeared to be the highest category in finger injuries. Posters and labels were distributed to 50 schools, there has been a general decrease in the severity of the finger injuries, trapping fingers in car doors still seems to be the most common finger injury.

The link with the community still remains strong, it is important to continue linking information with the community nurses and keeping them updated with information from the Accident and Emergency Department. Frequent meetings have taken place with the community nurses and they are now undergoing their own evaluation on the specific accidents in the schools. A great interest has been shown with sports injuries as these seem to be the most common cause of injury whilst in school. The schools have become heavily involved in health promotion and are keen on health education issues and how they can be directed to their children effectively.

A programme has commenced in Preston since 1995 were posters and comics are sent to all the infant and junior schools at selected times during the year. Local companies have been very generous in donating money towards the campaign, this has enabled us to have a health promotion account in the department. Posters and information on accidents have also been sent to many Accident and Emergency Departments in the country, this has enabled the departments to become interested in the project and form alliances with other Accident and Emergency Departments, the community nurses and their local schools.

Advice is given on how the audit work is carried out and how the information is passed to the children in the schools, the parents and the community workers. Many Womens groups are interested in Health Promotion and are keen to learn First Aid and are keen to respond to activities in Health Education with their children. Local news from their local hospital on accidents seems to have a better respond in reducing the number of accidents and the severity of these accidents. Many local colleges have also become interested in the project as the students have requested to learn about their local community on Heath Promotion Activities.

The outcome of this study has enabled the compilation of a profile regarding accidental injury within the target group of children:

Areas that require interventions are males in need of specific targeting and interventions.

Areas that require specific targeting are:

- Accidents in the home environment
- Accidents during sports
- Burns\Scalds
- Head injuries require specific attention in terms of targeting and interventions.

Local targets aimed at the area of accidents and children need to be established, targets must be achievable, yet challenging, relating to the identified needs of this population and must be open to evaluation.

Conclusion

This piece of research has aimed to put together a community profile of accidents occurring within children in attendance in the Accident and Emergency Department at the Royal Preston Hospital. This research has contributed to what the Health of the Nation describes as a priority task for the NHS, namely the collection and dissemination of data regarding accidents. Such an activity is vital for the overall prevention of accidents at any level, providing the foundation, via the assessment of needs upon which to set local targets, develop a local strategy and plan interventions. This piece of research therefore exists as the first crucial step in the development of a local strategy concerning accidents and children, providing also baseline data by which any planned activity within this area may judge it's success.

The point has been reached whereby we have gained a very clear insight into the local situation regarding children and accidents, and for those areas which are still unclear, the need for further investigation has been highlighted. The next step therefore

is to make practical use of the information in this project, to begin the process of developing a strategy, to tackle the problems and to meet the needs of the children of Preston with regards to Accident Prevention.

This research has also provided evaluation of existing interventions, highlighting the great success which has already been achieved. It is vital that we establish why such interventions have achieved these successes so that future interventions may replicate such success. The results from the evaluation should provide those working in this area with great confidence and a knowledge that we are well on the road to attaining health for all within the population of children in Preston and in the United Kingdom.

Future plans of the project is to continue and build links throughout the United Kingdom and Health of the Nation Projects, evaluate specific injuries and set targets for interventions, such as Head injuries – Burns\ Scalds, Sports injuries, Overdoses and Alcohol in young teenagers.

It is important that we continue this project and make the general public aware of the accidents and how they can be prevented. A well informed child is a safer child. A safe environment makes a healthy and safe future.

How to visualise what health promotion means?

Gunar Baugut, Konrad Schumann

How well is it understood what a Health Promotion Hospital (HPH) means? – Answering this question we cite at first one comment that seems to be typical for those not involved. A German politician expressed with the following provocative remarks what HPH means to him: „… There is evidence that the quality of health care for our citizens is not measured solely in terms of technical equipment, but also by the level of personal attention given. …We are therefore in the fortunate position of being able to view the health promoting hospital as a pleonasm. …“

Asking the lexica to understand this in detail a pleonasm is explained as an accumulation of words meaning identical things. The German language uses as an example „weißer Schimmel“; whereas „Schimmel“ already means „white horse“. The conclusion would be that a hospital is already health promoting by definition.

Next we want to present some findings from our survey at Chemnitz Pilot Hospital, Germany. The project had been started in 1993, the survey was performed in the second quarter of 1996. With a short questionnaire we addressed a panel of the hospital staff and got answers from 494 persons including medical doctors, administrators, nurses, and nursing students. Let us demonstrate some findings related to our question:

- Most of the professionals (79 %) agree with the HPH project and are optimistic that it will have good success.
- A minority (15 %) is against the HPH project and esteems it to be not realistic.
- In the third year of the project still about 2/3 of the doctors and nurses responded not to be informed about the project, although there had been articles in the hospital newspaper, circular letters and oral presentations.
- Lacking understanding, interest and motivation regarding the HPH idea had been mentioned most frequently as reasons that might endanger the project or even let it fail.

From these findings we can conclude that a definition, what an HPH is or wants to be, cannot easily be communicated. That makes the transport of the HPH idea a critical factor for success. From that background it is worthwhile trying new techniques and finding an answer to the question „How about visualization to help communicate what HPH means?“

Altnagelvin Hospital, Derry / Northern Ireland, one of the 20 pilot hospitals involved, had worked out an innovative visualisation approach to communicate the HPH idea. The goal was to intensify the understanding of the HPH project. They intended to run a series of workshops for the staff with the visualisation as an integrated tool. Until now we did not yet get a detailed feedback on the experiences. At the International HPH Conference in Derry there was a demonstration of the visualization tools. The manager of the HPH project at Chemnitz hospital, K. Schumann, became curious about implementing parts of these tools in Germany. In the meantime they have been selected, adapted, and translated.

How can the visualization tools be described? Best thing is to look at the posters. Finding words about them is the second best choice of presentation, but it is needed as a basis for analysis. The posters show the following components:

- Comic-style picture series, e.g. how to deal with children being afraid of hospitals;
- with persons speaking in bubbles;
- with diagrams and a formular showing contexts;
- with coordinates like in a map;
- with references from main posters to interconnected supplementary posters;
- with a smaller text field beyond the comprehensive visualised field.

First reactions from a small survey among the staff at Chemnitz hospital who looked at the posters varied in a wide range from strict rejection to enthusiastic approval. There are the following effects that can be expected from the posters:

- High density of persons, statements, and comments
  → high activity is needed for consideration
- There is no reductive way of formulating the message like in a commercial advertising.
  → No „fast food“ information style is possible
  → Time and patience is needed by those looking at and finding through.
- The persons and their statements are presented in comic style
  → Those who dislike highly sophisticated expressions will rather agree; others feel that seriousness is missing and reject it.
- Some pictures appear like a sketch, with some openness, not fully outlined.
  → Some of those looking at the posters will not look through at first glance and get confused.
  → Some of those will like to discover context on their own and feel the same experience you have with a picture as a piece of art, that needs the eye of those contemplating to get originated.

At present we are preparing the technical prerequisites and work out a communication strategy to implement this new visualization tool at Chemnitz hospital. A brainstorming about the possibilities of utilization led to the following results:

Who could be addressed?

- Hospital staff: nurses, doctors, administrators;
- Patients;
- Pupils and children from the „Kindergarden“;
- maybe even citizens in the community;
- and last not least: the hospital management and the stakeholders.

Where could they be addressed?

- In HPH project groups;
- in professional or interprofessional team discussions;
- within the training of nursing students;

- within an educational laboratory to help children not to be afraid of the hospital;
- within a health campaign at the market place of Chemnitz;
- and not to forget everybody could be addressed by such a poster hanging in the hall.

How could they be addressed?

- Without any additional aid: just let the poster have an effect by its own;
- by a non-directive communication strategy with or without a facilitator;
- by a directive communication strategy, e.g. with a teacher using a slide show looking at the posters in different segments step by step and exploring the elements and their references.

Working with the posters at Chemnitz hospital will be an experiment and we will organize it as a controlled trial.

- The pilot implementation will be within the training of nursing students.
- A suitable communicative strategy is being worked out.
- The experiences from the aspects of the students and the lecturers will be documented.
- The results will be used to improve the application and to prepare a transfer.

And we feel fortunate if the poster-strategy helps making the healthy choice the easier choice.

Part 6

Creating Healthy Hospital Organisations

A health promotion unit within the hospital: difficulties and strategies to legitimize the horizontal role of health promotion in a vertically oriented environment

Isabelle Aujoulat, Francois Martin

The Prevention and Education Unit of the hospital of Dreux: context and difficulties

Located one hundred kilometers from Paris, Dreux is a town known for its difficult economic and social context linked to a high unemployement rate affecting a young population (50% of the inhabitants are under 25). In 1994, an external audit pointed out that the hospital of Dreux, a general hospital with 600 beds, was not able to respond to the needs of patients who are more and more frequently affected by diseases linked to behavioural and environmental factors. As a result of this audit, a health promotion unit, the Prevention and Education Unit (U.P.E.), was set up within the hospital, to organise prevention inside and outside the hospital and, more specifically:

- to build bridges and act as a mediator between the medical and social sectors, care and prevention, the hospital and the city;
- to provide the patients with a comprehensive approach responding to their needs, especially the socially disadvantaged patients or those needing specific education, like patients suffering from chronic diseases.

The first goal of the U.P.E. was achieved through two different kinds of actions:

1. Health education programmes and actions were widely implemented in the city;
2. A special effort was made to create multidisciplinary networks gathering various professionals from the social and medical sectors, from the hospital and private sector.

Although some reluctance was met at the very beginning on the part of some professionals or organisations who felt threatened by the U.P.E. as a potential competitor in their specific field (aids prevention, alcohol or drug abuse), most structures from outside the hospital do feel a need for coordination and it is greatly appreciated to find with the U.P.E. a structure providing methodological support and relevant material to implement health education actions, as well as a mediator facilitating the communication between professionals from different fields.

Concerning the second objective of the U.P.E., i.e. to provide the hospital patients with a comprehensive approach responding to their needs, more difficulties are met, partly due to the very organisation of the hospital structure and to the perception the hospital teams have always had of their professional function.

The hospital can be described as a vertically organised system of professional bodies. Every staff member has a specific role linked to his/her profession and position in the hierarchy, and fully understands his/her role. This well established order has always governed the functioning of the hospital and has enabled its efficacy, notably in cases of emergency. In this context, both the health promotion unit as a structure and the health promoters as professionals not directly involved in care, are considered

as outsiders to the system, and as elements likely to disrupt the established order. One of the most important challenges a health promotion unit faces in the hospital setting is to enter the system to try and bring about changes from the inside, without disrupting the established order.

Strategies to implement health promotion in the hospital setting

In order to improve the quality of health care interventions, a new articulation between the verticality of the hospital setting and the horizontality of health promotion is to be found. Following strategies were adopted so far at the hospital of Dreux:

- creating a structure for health promotion with permanent staff attached to it, and making it a multidisciplinary team from the beginning, was the first step towards formalising the idea of health promotion in the hospital[1];
- regularly participating in the meetings of the medical and senior nursing staff from the different departments helps remain aware of the staff's needs and provides opportunity to inform on the activities and orientations of the U.P.E.;
- seeking (and gaining) institutional support by regularly informing the Board of Directors of the activities of the U.P.E. is an unavoidable step towards internal recognition and legitimisation. Among the factors influencing the type of health care that is given to patients, the organisational and institutional factors are not the least;
- allowing groups of patients to enter the hospital, and enabling them, through the representatives of their associations, to convey their needs and expectations to the hospital Board and medical staff is one of the most important outcomes to be achieved by a health promotion unit in a hospital;
- formalising a network (i.e. creating a patient education committee) of professionals representing the different bodies and departments of the hospital and wanting to work in partnership for a more comprehensive approach responding to the patients' needs, is another step towards building a stronger health promotion policy in the hospital. One of the main difficulties is to get professionals from different bodies to accept to sit together on an equal basis, given the traditional representation of their role (it is sometimes as difficult for a physician to accept to listen to a nursing auxiliary, as it is for a nursing auxiliary to begin to think that she/he has something to say);
- organising training seminars on specific issues within the hospital (patient education, prevention of the burn out syndrom…) and giving various professionals the opportunity to share their experience and learn from each other helps improve the practice by creating a dynamic, based on the promotion of existing team practice and organisation;

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[1] Currently, the U.P.E. counts a physician (a lung specialist who practices part-time clinical activity in the hospital), a coordinator specialised in the management of public health projects, a social worker, a secretary responsible for the library and documentation centre, a nurse and a medical secretary responsible for the early detection of tuberculosis, as well as a few consultants, such as a psychologist and a general practicioner.

- implementing teaching curricula, where possible, helps slowly disseminate the concept of health promotion and a more comprehensive approach towards the patient. Teaching and monitoring the public health course at the nursing school for instance, helps prepare for the future, as the image we have of health and of our function in the health care system forms very early in our mind. Professionals who «grow up» with a broader image of health from the beginning will convey this image when they enter a professional team, and thus participate in the change of practice in the long run;
- establishing links with the appropriate national authorities and different research intitutes is necessary in order to have the practice improved, and to gain visibility.

In all this, a golden rule should be to accept that change takes time. Convinced of the importance and relevance of health promotion and education, we may tend as professionals in this field to want things to change quickly. Yet, we must be aware that organisational changes take time, as they are also the result of a number of individual changes which in turn take time.

**Health promotion in hospital settings –
another way of thinking, another way of acting?**

People who are motivated enough to promote and put into practice a broader image of health often have to struggle against institutional rules and organisational inadequacies, such as lack of time and staff shortages.

When wanting to promote a broader approach of health by implementing, for instance, multidisciplinary patient education programmes in the long run, one must keep in mind that the first aim of the hospital as an institution is to ensure its own survival, based first on economic and financial criteria. Yet, what has been accredited so far by the national health authorities in France, are medical care and technical acts.

If the hospital as a vertical system is to change and open up to a more comprehensive and horizontal practice of health, then directions based on the progress made so far and models of good practice developed by health promoters and/or patient educators from different institutions, must be issued by the appropriate authorities at both the national and international level. Only then can the system change accordingly and adapt to the patients' needs.

Cooperation or Confrontation

Regarding the Relationship between Health Insurance Agencies (Financing Agencies) and Hospitals (Care Providers) in Health Promotion Projects

Elimar Brandt, Wolfgang Niebuhr

Tensions in the Political Arena

The HPH-Project at the Hospital and Polyclinic Rüdersdorf (Limited), entitled „Health Clinic Rüdersdorf 2000“, is supported by two agencies:

- the institution's owner
- a German health insurance agency (AOK in the state of Brandenburg)

Political conditions have changed profoundly since the project began two and a half years ago. We for our part are most concerned about the reform of the welfare state – is the welfare state still affordable? This question strongly affects and determines the relationship between the health insurance agencies (the financial support providers) and the hospitals (the care providers). We would like to share some thoughts in the light of our attempt to jointly realize a hospital project.

The present trend is clearly illustrated by the first and second „Laws for the new regulation of public health insurance“ (NOG). They are part of the third stage of Germany's present health care reform program. In order to slow down price increases, the number of care services has been decreased and the financial burden of the insured person increased. A larger percentage of the costs for services must now be carried by the patient. Such practices will ultimately lead to a two-class system of health care and endanger the principle of solidarity inherent within the traditional Public Health Insurance program. Health promotion measures can no longer be paid for by the financial support providers.

Besides increasing the amount paid directly by the hospitalized patient from 9 to 14 DM per day (which is limited to 14 days per year), all publically insured individuals will be forced to „participate“ in the costs of clinic upkeep by paying an extra 20 DM per year. This begins to undermine the traditional 50:50 division of health costs between employer and employee.

Public health insurance agencies hope not only for increased financial responsibility, they also expect greater public influence. They desire greater possibilities to investigate the necessity of medical services with the goal of limiting in-patient care while increasing partially stationary and out-patient care and strengthening economical structures for in-house care. Health insurance companies hope to make bilateral contracts between themselves and individual health institutions. These political measures will lead to a competitive struggle between hospitals and could result in the closing of hospitals. (One should mention in this context, that 122 hospitals have been closed in Germany since 1990 and that the number of hospital beds in the state of Brandenburg have dropped from 25,376 to 16,922 by the end of 1996.)

Decreased resources will increase insurance agency pressure to limit expenditures and services in the hospital sector. This also means that patients will be referred to the

most inexpensive institution. One current example: It is expected that patients from the state of Brandenburg be treated in Brandenburg because Berlin is significantly more expensive. Hospitals for their part face increasing competition and frequently refuse access to information on their care processes and strategic planning. These developments make tensions between insurance agencies and hospitals inescapable. They are divided by both real and imagined conflicts of interest.

What does this mean for HPH-projects in general and for our project in Rüdersdorf in particular, which has an insurance agency as one of its two supporting bodies?

Does our HPH-project reflect any mutual interests?

The political conditions we have briefly described result in several criteria for rating a modern hospital (see Figure 1):

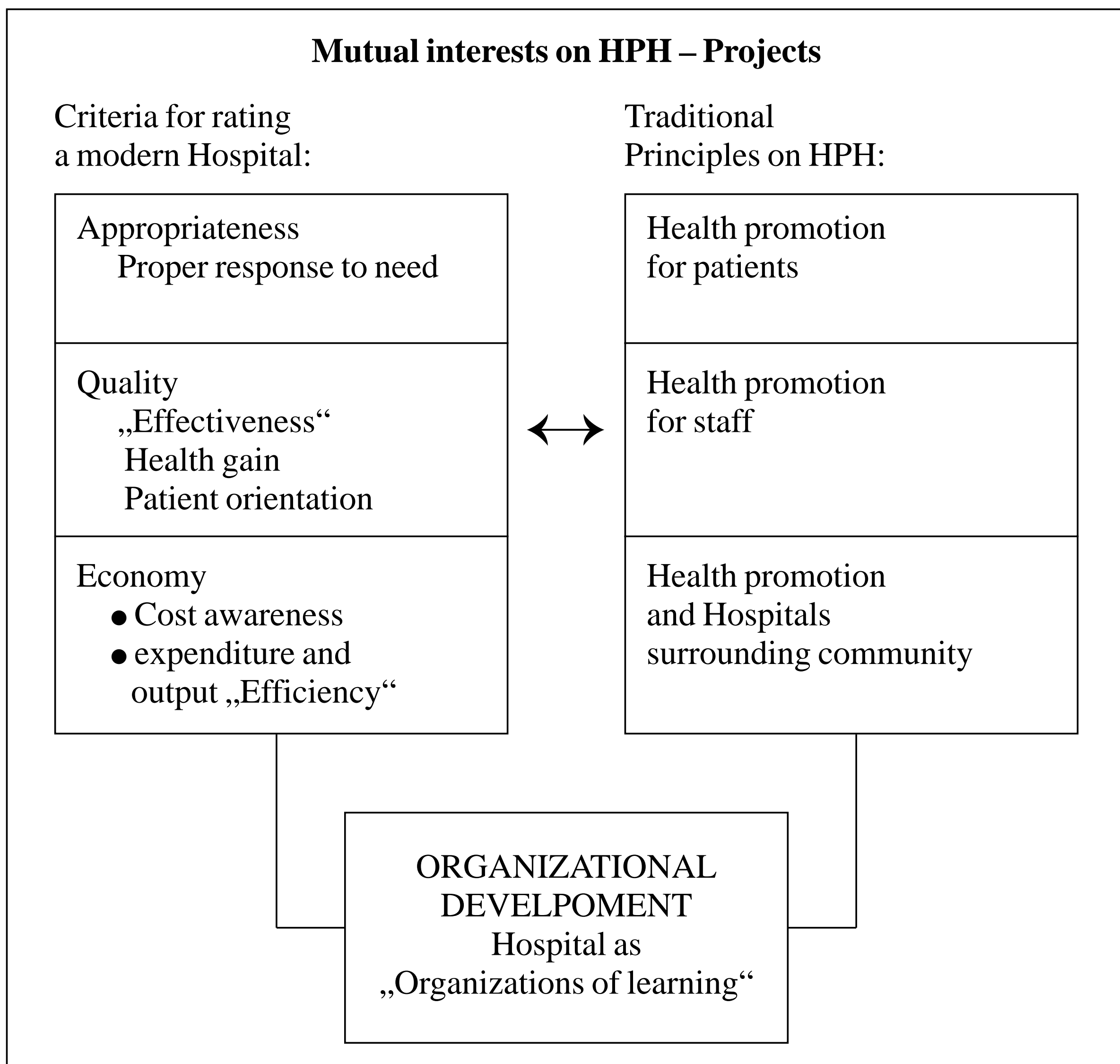


Figure 1: Mutual interests on HPH-Projects.

1. *Appropriateness* (Proper response to need)
   - Through the optimal intermeshing of inpatient, out-patient and post-hospitalization care

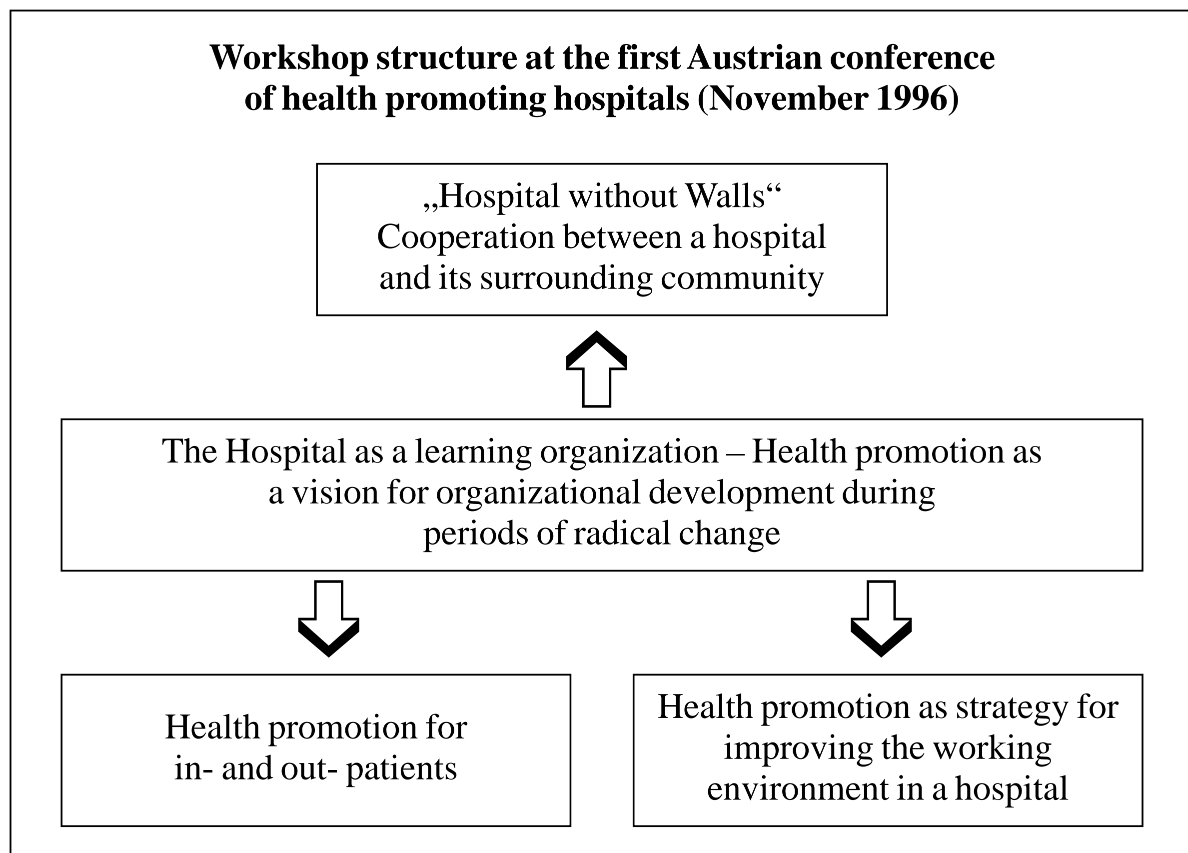
- Through strong cooperation and the cultivation of contacts between hospitals and private practices

2. *Quality*
   The effectiveness, health gain and patient orientation of services provided
3. *Economy*
   Cost awareness as well as the proper relationship of expenditure and output – efficiency

Health insurance agencies and hospitals share a common overarching interest in the realization of these goals. We believe methods of organizational development shaped by these goals (hospitals as „organizations of learning“) obtain increasing significance when combined with the traditional principles of health-promoting hospitals:

- Health promotion for in- and outpatients
- Health promotion as a strategy for improving the working environment in a hospital, and
- Health promotion through cooperation between a hospital and its surrounding community.

The 10 years since Ottawa and the 8 years since initiation of the international network of „Health-Promoting Hospitals“ have proven this concept to be a sound development strategy for hospitals even in the context of radical social and political change. This was demonstrated clearly in November 1996 by the following workshop structure published at the first Austrian conference of health-promoting hospitals:



The following Figure 3 illustrates the structure of the Rüdersdorf project.

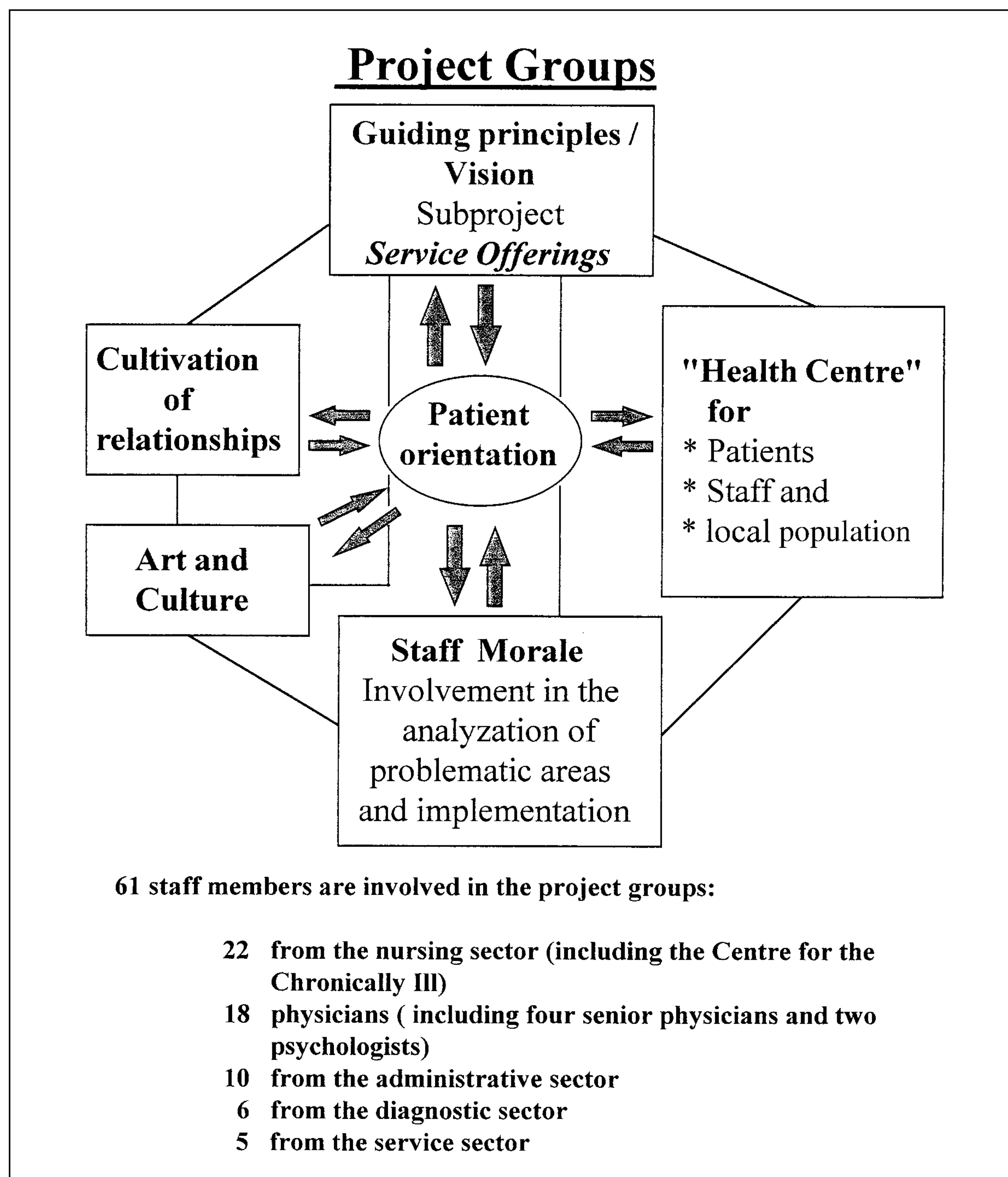


Figure 3: HPH-Project „Health Clinic Rüdersdorf 2000"

In terms of content and strategy, we adhere to the following principles:

1. Health promotion, especially regarding the subjective feeling of patient well-being, is an integral part of all project activities. Hospital projects in formerly East German states need to respect questions emanating from the subjective health experiences made during the social transformation process from a planned to a market economy.

If we comprehend health promotion as a vision for organizational development for hospitals in a period of transition, then we need to take an especially close look at the

social transformation process in the former East Germany. The transformation from a planned to a market economy fundamentally altered living conditions. The abrupt halt to all continuity affected every aspect of one's life and was reflected in the general well-being and health condition of the East German population (see B. Maier, 1997). Although the East German state collapsed seven years ago, it still continues to shape East German thinking. The state's demise not only challenged the entire system of existing values, it also profoundly affected the work and living surroundings while threatening identity and self-confidence. Many whose careers were suddenly halted are now confronted with the task of reinterpreting their biographies, so that they agree with their past and future expectations and identities.

Negative ramifications to well-being and general state of health are noticeable on the following levels:

- On the psychological level: A loss of selfconfidence and identity coupled with greater fear.
- On the social level: New forms of social isolation and relational impediments resulting from the lack of employment or training opportunities (mass unemployment) or from the simple fear of becoming unemployed.
- On the physical level: Bodily symptoms psychosomatic in nature as well as a strong tendency towards addiction.

These traits manifest themselves in many ways within our hospital project. Without going further into these matters, I would like to simply mention the following interrelationships.

Regarding patients:

- Impact on the general well-being of patients (and their families) as well as their association and communication with hospital personnel (medical, nursing, administration).
- An especially strong need for information, consultation (also on social and legal regulations), communication and human attention. Also help and support for the coping strategies of patients and their families.
- Impact on the „morbidity structure“ (psychosomatic illnesses, alcoholism, etc).

Regarding staff:

- Impact on their behavior towards and communication with patients and their families.
- Impact on the amount of motivation for participating actively in the process of organizational development in our hospital.
- Their relationship to the HPH-project (not only negatively, but also as an individual means of coping!)

2. The entire project is becoming more and more aligned with the following goals: the appropriateness, quality and economy of medical and nursing services coupled with the largest possible amount of human attention. Therefore, the development of guiding principles as well as a work and performance profile by maximized com-

munication and cooperation within and without the institution remain of primary importance for the project.

3. Increased utilization of staff competence and its possibility to participate in the transformation process are indicators for the project's development. Step-by-step, the project's findings are being integrated into management decisions, which in turn effect normal, everyday activities. Obviously, this process cannot be free of all conflict, it is a learning process for both the project participants and the hospital management. The hospital is thereby learning to react properly to relevant external demands and to support the development of internal integration.

We conclude that the project's basic principles remain in the general interests of both the hospital and the health insurance agencies. But are they both interested in sharing their project experience and results with other hospital networks?

Is the sharing of project experience problematic?

Experiences within the international HPH network of the WHO have and are demonstrating the great usefulness and value of information- and experience-sharing for the implementation of health promotion in hospitals. Recently formed national and regional networks want to continue these developments on a broad scale.

Combining HPH-projects with quality management and organizational development is giving participating hospitals a competitive edge. But the question regarding the usefulness of such networks on the regional and local level for hospitals which are fighting for their survival remains. Insurance agencies have an unlimited interest in spreading project experience on the local and regional levels. This would help hospitals to economically offer high-quality services producing the greatest possible health gain. But the perspective of the individual „health-promoting hospital" is quite different.

Revealing project results gives other possibly competing local hospitals (and the insurance agencies) access to the situation, problems and strategies of a given institution. The one-sided disclosure of data can lead to a competitive disadvantage, or it can lead to an unduly restrictive disclosure of information. Maintaining a competitive advantage through the certificate „Health Promoting Hospital" and transparency vis a vis competing health institutions look differently in a local and in a national context. We are not fatalistic, but the question is: How can we avoid losing our competitive edge?

The external conditions have – as indicated at the outset – changed dramatically. The „fat" years have passed, hospitals today need to worry about survival and succeeding in the open market. But free market mechanisms are only partially applicable to health care. They lead otherwise to gaps in health care (see for example chronically ill, cost-intensive patients). The HPH-call for the networking of hospitals will only be unencumbered on the local level once every institution has achieved a unique profile or specialty within its geographic area.

Regarding our project: We would like to do what we can to share our findings not only with the institutions we own and with the „Association of Evangelical Hospitals" (VEK), but also with all other interested hospitals in Brandenburg and Berlin.

Managing for clinical effectiveness

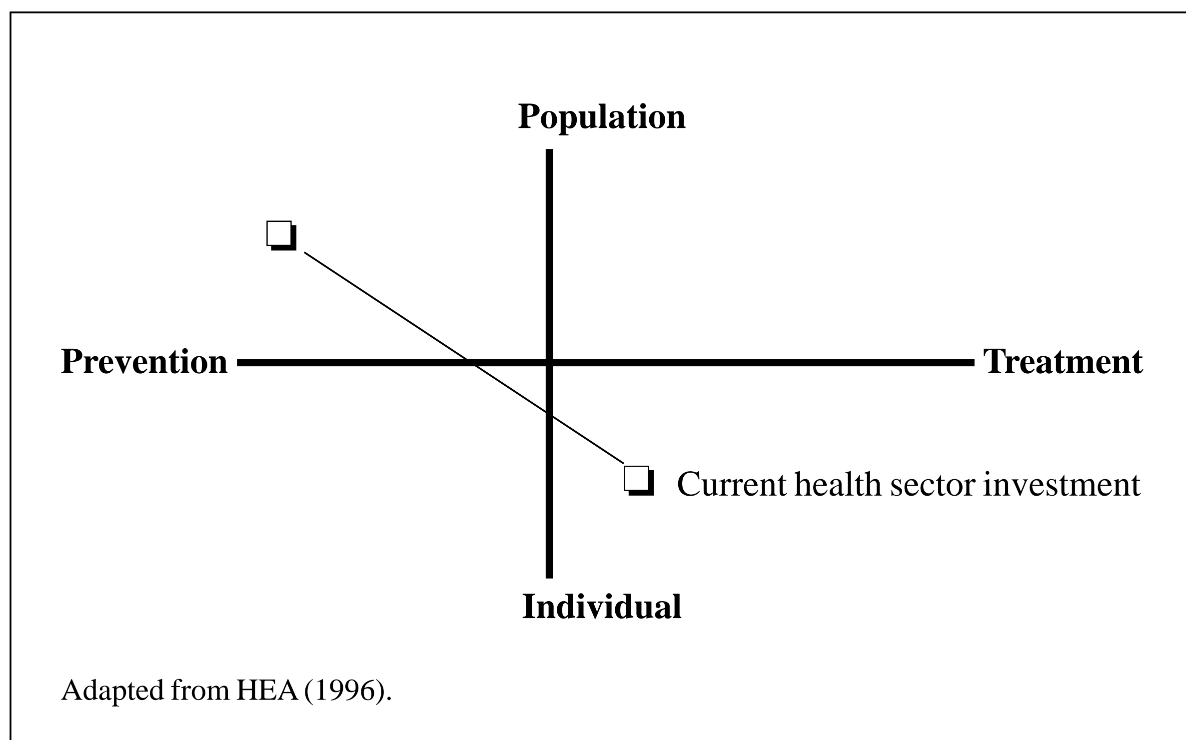
Pauline Fielding, Dominic Harrison

The question addressed in this paper is „What do managers have to do to ensure clinical effectiveness?“ We would like to propose that the most important task for leaders and managers in the secondary sector is to refocus the business of the hospital towards health rather than illness and to encourage health professionals to take responsibility not just for the treatment of ill health but for its causes too. Refocusing on health rather than on illness means taking action in relation to the following topics.

Reviewing the scientific basis of existing resource allocation

At a population level, health sector investment is unrelated to population health status – The World Bank (1993). A principal cause is that the 'cultural framing' of health need in industrial societies has the effect of allowing a potentially preventable incidence of ill health to arise in the whole population as a result of unmet need for preventative interventions. A recent review of health sector investment in the UK (Limb, 1996) concluded that less than 1% of the UK NHS budget is spent on formal health promotion and much of *this* is spent on clinical prevention – aimed at influencing high risk behaviour in individuals.

Allocatively efficient health sector investment would seek to shift investment from individually focused treatment (or prevention) to population focused prevention as demonstrated below.



Adapted from HEA (1996).

Figure 1: Necessary shifts for efficient health sector investments

Reviewing variations

There are large and unexplained variations in health sector investment. These are both unethical and inefficient. Evidence which could usefully be explored in a hospital setting would be unnecessary or inappropriate use of hospital beds – studies in the UK and United States suggest that between 10–40% of days spent in hospital come into this category and we know that length of stay has a major bearing on cost (Smee, 1995).

Smee (1995) also reviewed data showing the variations in nursing staff time in hours per inpatient episode for 25 hospitals. Even excluding the outliers there was approximately a two-fold difference in the distribution of staff time per inpatient episode. This difference held up even when case mix and type of hospital were controlled. Similar differences were demonstrated in relation to consultant and junior medical staff and none of the differences were thought to be related to the quality of care. There was also no evidence in these hospitals that nurses were undertaking work instead of medical staff.

We argue that attention to these issues is increasingly an ethical and financial imperative. The current whole system inefficiencies in health investment are no longer sustainable. Health is not an 'additive' concept, it is an integrative one. The implicit principle of continuously seeking earlier intervention into the disease or illness currently treated in secondary care will inevitably lead health care workers beyond the hospital walls into the places where health is created or destroyed in the first place – where people live, work and play – within the community. The concept of the Health Promoting Hospital has an important contribution to make to the development of good practice in ensuring clinically and cost effective health care. It does this by providing a whole system approach to facilitating sustainable practice based on organisational and clinical interventions that will increase health gain from within existing resources.

The key to this are practitioners who, taking the best research and available evidence, interpret the guidelines and protocols for their particular patients, target the interventions at the earliest appropriate point, and systematically measure the outcome. The challenge for managers is to enable the process to take place. Long and Harrison (1996) offer 5 strategies for success – we offer suggestions for their practical implementation:

- **Establishing a culture –** This should mean giving a high profile to evidence based practice – perhaps building the requirement into local pay and reward strategies – ensuring access to convenient data bases and providing the support to search and interpret the literature and to establish a multidisciplinary forum for dialogue and discussion so that interventions, once agreed, can be implemented speedily.
- **Developing skills –** Critical appraisal or research appreciation are obvious ones here but project management skills are critical and perhaps the single, most important skill needed to ensure that learning is incremental and the treatment intervention sustainable.

- **Applying skills –** Clinical Audit departments have made a useful contribution to date, but many are under utilised and little investment has been made to date on the provision of staff who can search the literature, review practice guidelines and protocols with clinical staff, develop the local guidelines and evaluate the implementation.
- **Measuring outcomes –** It is vitally important that patient outcomes are considered as well as clinical outcomes. If health is to a large degree socially determined, then health gain from the patient's perspective may have little to do with the impact of the intervention on the disease process.
- **Finally –** Long and Harrison suggest we need to be modest about the objectives and aspirations of evidence-based practice. They advise tackling a few areas first to establish 'successes'. This is the approach adopted by the 20 hospitals in the European network of pilot Health Promoting Hospitals. Successful examples can be used to convince others of the value of the approach. We also need to recognise that, with an evidence-based approach, we will never arrive at the destination of perfect health as the knowledge base will always be incomplete.

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Conflicts and the management of change

Karl Purzner

In the last years the Psychiatric Hospital of the City of Vienna – Baumgartner Höhe undertook project oriented action research in the field of organizational conflict. With voluntary teams we did empirical analyses of conflicts, in order to shed light on the background of them. In the course of time some typical causal elements could be worked out, which again and again seemed to underly disturbances of communication on our wards and appeared to be essential in bringing up (unnecessary) conflicts. Almost always the consequence of such social tensions within our wards is, that staff members react with a high level of anxiety. This hinders the organizational development of the respective operational unit. To regard the above mentioned factors early enough and to try to influence them successfully is therefore an important instrument for the promotion of organizational health. To know about these factors and to know, how to modify them could probably facilitate the difficult task of conflict-management within the hospital for executives in the future. Only when there is a sufficient feeling of security, teams seem to be able to use their possibilities of self-development, herein – by the way – not unlike single personalities. In a simple manner it will be shown how organizational and personal causes of conflicts interact, to produce (unnecessary) conflicts. In our investigations we got the impression that the significance of organizational causes for conflicts is generally underestimated (see Fig. 1).

Why is conflict-managment so important for facilitating organizational developement und why at the same time is it so difficult?

On the one hand conflict is a very strong motivator for organization developement. This has to do with the fact, that conflict almost always brings up a lot of anxieties, pain, frustration, shame, guilt etc. within the people involved in the conflict and they suffer and want to get rid of these painful conditions. But not only those employees, who are in the centre of the tensions suffer from the above mentioned feelings, but also those, who find themselves between two conflicting parts of a team. They e.g. often complain about their difficult role of mediating. Finally even more remote parts of an organization are very interested that units are succesful in solving those problems, which led to a conflict, not so much because of emotional reasons, but because they either don't want to be bothered or they fear for their own interests being entangled by the effects of the conflict.

On the other hand once an organization starts to analyse conflicts – by different methods – and tries to learn from them, as we do this in our hospital, it makes a remarkable experience. It finds out, that this is one of the most effective means to enhance, to raise the self-reflective potential within an organization. Its just like with faults, mistakes and errors, from which we learn, if we don't deny them, but deal with them. In fact unnecessary conflicts are only a special form of error or mistake. No wonder then, that dealing with them in a conscious way is a very efficient tool to further facilitate organisation developement (OD).

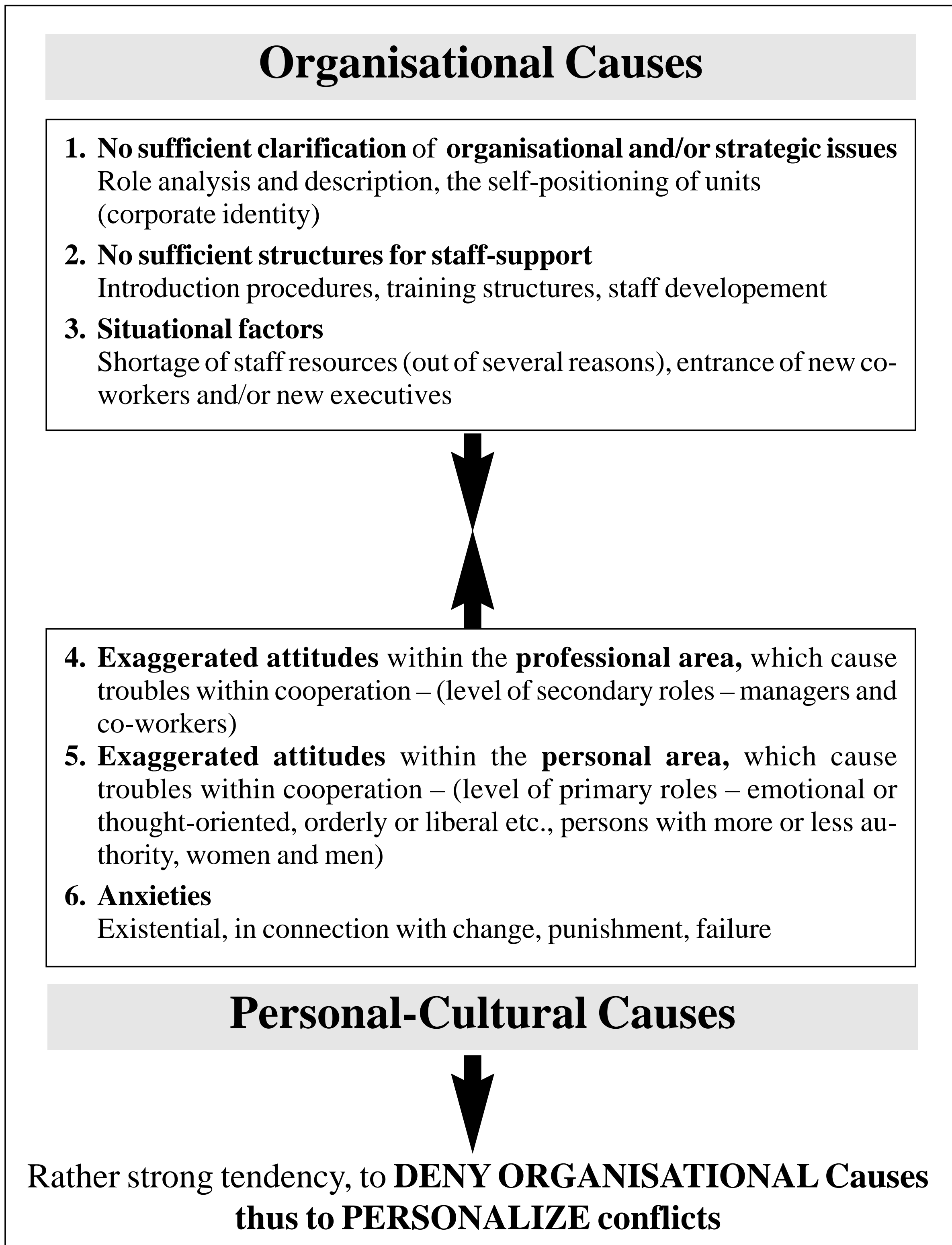

Figure 1: Causes for conflicts

Why then – one could ask – isn't this done more often? We found at least three reasons in our hospital. First of all, conflicts are very often „feared like hell“ and therefore either denied or pushed aside by other means. Another reason is the influence of the local, regional or national culture of dealing with conflicts. In Vienna especially and in Austria in general we observe a rather denying attitude towards important con-

flictuous matters. And this leads to the third reason: since a constructive-creative management of necessary conflicts in order to further developement in our hospitals doesn't happen very often, we are not very experienced in this field. There is not enough know-how for this difficult task, which causes insecurity and this again leads to an avoiding behaviour.

Conflict-management as a developmental strategy in HPH

After several years of working in this field in our hospital, I would go so far as to say, that the art of promoting OD in our hospital towards becoming a Health Promoting Hospital (HPH) depends very much on the skill of our organisation, to use the enormous potential of conflicts for OD by dealing effectively with the enormous ambivalence around the phenomena of conflict. It is for this reason, that two things seem very important to us, when using conflict analysis as a developmental strategy in an organisation – at least in the beginning: first of all, it is essential to make people feel secure, because otherwise they won't be able to approach the difficulties of conflict-management. The second very important point is, to guarantee a successful, helpful experience when dealing with the conflict. Therefore in the first phases of analyzing conflicts within an organization it seems to make sense to use external help (consultants, moderators, supervisors etc.) to give security and guarantee success. Only later on, when there is enough good experience and a feeling of security and know-how, executives and staff memembers can be encouraged to start to try by themselves.

Project- and qualitywork requires capabilities of conflict-management

Not only because of the potential of conflict analysis to motivate the staff and to raise the degree of self-reflection within an organisation we should deal more conciously with conflicts in the future, but also because skills in conflict-management will be of importance in the future more so than before out of several reasons, one of which I want to mention here: it has to do with the increase of process-orientation within management, e. g. by project work and by quality managment. This increase leads to necessary discrepancies with the still existing hierarchy and needs more qualification to deal with them than before.

Traditional forms of "supervision" are not enough

A few remarks towards a possible objection, to what I have said so far: one could say – especially in psychiatry – we have been analyzing conflicts ever since several decades, thinking of the so-called "supervision" (a specific form of external consultation for professionals). Conflicts with patients are dealt within case "supervison", conflicts within teams are worked on by team "supervision". By bringing in this argument, we find ourselves at the core of the topic of this conference: to find out, whether conflict-management by the traditional forms of "supervision" is of sufficient effectiveness and quality today! I believe, taking into account, the situation hospitals are in, within a challenging environment – this is not the case. If creative productive conflict-management is a HPH relevant project and supposedly has been so for many years in psychiatry, then it seems to me, it would make sense, to check the different methods used and compare them as to their effectiveness, quality assurance and sustainability.

An audit and accreditation tool for organisation development in Health Promoting Hospitals in the South & West region of England

Annette Rushmere

The Health Promoting Hospital (HPH) initiative, with its emphasis on health gain through health promotion and disease prevention, provides an opportunity for hospitals to contribute to the success of the Health of the Nation White Paper, and the Primary Health Care led NHS, and is an ideal vehicle for shifting the focus from illness and disease to maintaining good health and promoting health and well being.

Health promotion is not new to hospitals, but being an HPH is more than just the sum of individual health promotion projects. If HPH is to be developed in a sustainable form that has measurable outcomes, it needs to have a total organisational approach. The Wessex Institute for Health Research & Development, together with a management group of purchasers and providers in the South & West region have developed a package that consists of training, a self audit, a peer review and accreditation scheme.

The package has been tested, refined, piloted and evaluated with an independent researcher in 8 hospitals in the South and West region. The size of hospitals ranged from a 20 bedded community hospital with outpatients to a large acute 1500 bedded teaching hospital. The audit tool developed initially consisted of 8 key areas with criteria which have been condensed into six following evaluations. These are:

1 Management Issues
2 Customer Care
3 Health at Work
4 Hotel services and environmental issues
5 Community involvement and health alliances
6 Clinical audit and effectiveness

These six elements include all the quality initiatives currently ongoing in a hospital which contribute to the total organisational approach to HPH. Some of the initiatives referenced in the document are the Patients Charter, Health at Work in the NHS, Junior Doctor Hours and the Code of Practice of Openness, the Disability & Discrimination Act 1997, Clinical Audit & Effectiveness reports and others. Progress in these areas will be unique to every organisation as each one develops key areas appropriate to their needs, to the needs of their population and their purchasers. There will be plenty of opportunity for innovation and creativity as it is not intended that the tool is prescriptive.

Undertaking the audit process demonstrated many benefits which included organisational development and raising the profile of health promotion. The outcome of the action plans developed by the pilots will demonstrate tangible results in terms of Health of the Nation both for the organisations themselves and their purchasers.

Benefits for providers

- *The total organisational approach enabled organisational development to take place.*
- *The audit process triggers and accelerates changes.*

- *It has embedded health promotion into the culture of organisations*
- *Hidden stars were discovered and given recognition for their work. This has given staff a morale boost – and widened horizons of other staff involved with the process.*
- *It raised awareness of health promotion and helped to change attitudes by the recognition of the concept of holistic health. Nurses are now able to understand the part that they are playing with health promotion and now know where to hang the political label to gain recognition for the work that they are doing.*
- *Health promotion reaches the parts of an organisation that it wouldn't otherwise reach (the "Heineken effect").*
- *It puts all the quality initiatives together under one umbrella.*
- *Morale boost for staff from the value they placed on the peer review.*
- *The process has also contributed to the development of the non-executive directors in that it has provided them with a clearer understanding of the working of their own organisations, and an opportunity to visit and learn from another organisation.*
- *Most organisations appreciated the support from their purchasers.*

Benefits for purchasers

- *Provides a detailed picture of qualitative activity within a Trust particularly an acute Trust;*
- *Provides a framework for discussion and gives a focus for negotiating Health of the Nation;*
- *Action plans could be translated into contracts and monitored year on year with purchasers expecting to see evidence that the action plans had been implemented.*

This tool has provided organisations with a baseline audit which can be reassessed on a regular basis to measure progress in the identified areas from the action plans. Outcome measures can be identified through the action plans, and therefore measurable progress can be achieved. The tool could also be used to help streamline contracting and the monitoring process for health authorities. It provides qualitative data and therefore gives a better picture of activity in an acute setting than the quantitative data currently being produced. Further work needs to be done on a national level and locally to obtain more purchaser support (including GPs) both for the tool and the process of Health Promoting Hospitals.

This tool clearly enables organisational development to take place and puts health promotion onto everyone's agenda particularly in the secondary care setting. It has embedded health promotion into the culture of the organisations taking part and will therefore be an ongoing developing process because of the commitment at board level. Action plans demonstrate this continuing commitment. Monitoring of the action planning process over a year should enable tangible outcomes to be measured and hence the effectiveness of this tool as an instrument for change and development.

We have received a great deal of interest in our audit tool from purchasers and providers in England, Scotland, Wales, Ireland and several countries in Europe. This audit tool could be used on a national basis as part of a national scheme for Health Promoting Hospitals.

On the horizon

Magaret Doherty

Altnagelvin Hospital had advocated a smoke free environment since joining the European Health Promoting Hospitals Pilot Scheme some 4 years ago. The Group involved in the promotion of a smoke Free Hospital constantly strives to raise awareness to the harmful effects of both Active and Passive Smoking. The group's 3 Main Objectives were:

- to provide members of the public with information on the harmful effects of active and passive smoking.
- to inform & involve colleagues of actions taken to implement the Smoking Policy.
- to provide Stop Smoking Support.

We achieved two of our objectives by:

- Organising many events such as public awareness campaigns of official „No Smoking Days". Visual displays were erected in Main Foyers, Posters and signs clearly stating No Smoking were erected, leaflets were freely handed out to all attenders at the Hospital, staff were also informed through leaflets attached to their salary slips and many other activities were actioned, providing:
- Stop Smoking Counsellors,
- a data network of Stop Smoking Groups
- Audio tapes for relaxation
- Video tapes for information
- Names of clinics providing alternative treatment
- Advice leaflets.

So now our major concern was the staff's perception of the Smoking and Health Policy. Prior to its introduction, smoking throughout the Hospital was accepted as the norm. Cigarettes were sold by the Hospital shop and were even delivered to immobile patients in Wards. In fact patients often regarded cigarettes as a necessary part of their recovery process! If we were really going to change people's attitudes to one of promoting Health in the Hospital setting then we had to ensure that the policy was introduced to the staff and accepted and implemented by the staff.

On completion of this task we felt a scientific approach to evaluate our success in meeting this objective was required, therefore we commissioned this research project, the aims of which were:

- to assess the level of staff awareness
- to gather information regarding staff attitude, behaviour, compliance to the policy and identify any problems.

The survey was conducted by a postal questionnaire sent to 321 members of staff, approximately 20% of the workforce, with a fair representation of each staff group. The response rate of 58% was excellent given the time scales and nature of the Project. In

summary we found that there is a very high level of awareness of the policy: 98% of staff are aware of its existence of which 56% are quite familiar with the Policy. It was encouraging to note that only 6% were unsure of its meaning.

Staff groups were asked how they were informed of the Policy. lt's interesting to note that although 74% of respondents stated they had worked in Altnagelvin Hospital for over 5 years, only 46% could remember the leaflet we attached to their Salary Forms during the Policy launch in 1993. The majority of respondents feel that the Policy information available ranges from good to excellent, however, information to visitors could be somewhat improved. 90% of staff think the policy is a good idea and has been well received by their colleagues but less well received by patients and visitors who smoke. When asked whose responsibility is it to implement the policy it was very comforting to see that 75% of all staff took ownership.

The majority of respondents also felt that senior management were either very, or fairly determined. However, we obviously have some Senior Managers not doing enough, as 26% of the respondents have clearly identified this. We have other problems, too: There is a high level of awareness amongst staff that smoking does occur in smoke free zones of the Hospital. When approached, some of the offenders can be quite hostile and aggressive. We have also identified a new illness, the "The Blind Eye Syndrome": People turning a blind eye to visitors smoking on back stairs, relatives smoking near Maternity Wards, the list goes on.

What are our conclusions of this project?

There is a high level of awareness of the policy, there is high level of commitment from our staff, staff are aware offenders are in breach of the policy. However their knowledge and commitment is not reflected in their behaviour. Therefore our recommendations are that: Management give active and visible support to staff, regular monitoring and review of the policy be undertaken, clearer sign posting all around the Hospital, and when all else fails a designated smoking room for distressed relatives. These are to name but a few of our recommendations. If we can meet all our recommendations, a healthier future for all is „Just on the Horizon".

Health promotion aspects of storing, collecting, transporting and disposing of domestic and clinical waste

Sian Fisher

Preston Acute Hospitals NHS Trust consists of two hospitals; Royal Preston, providing 700 beds and Sharoe Green with 300 beds. The Trust has an annual income of £85 million and employs 3500 members of staff. The hospitals serve a local population of half a million and provide specialist services for one and a half million. In 1993 the two hospitals were awarded the status of England's pilot Health Promoting Hospital with seven subprojects established across both sites. The main aim of this subproject was to assess and improve the existing waste management system within the Trust, in order to provide a safe and healthy environment for staff, patients and visitors. The Trust owns and operates a clinical waste to energy incinerator, which is based at the Royal Preston site. Approximately 800 tons of clinical waste and 600 tons of domestic waste is produced each year from the two hospitals.

The first aim of the project was to identify and assess existing procedures in waste management. A number of questionnaire surveys were carried out on staff at the Trust, to assess their knowledge of hospital waste management and awareness of associated problems. All the surveys proved that staff had not been properly trained in waste management. Aim two was to indicate areas where waste management practices could be improved. In addition to the questionnaires, observations were carried out to identify these areas. Nursing staff, domestics, porters and incinerator operatives were monitored carrying out their daily routines, involving waste. These observations showed that a number of the procedures, in particular segregation, handling, storage and collection, did not comply with either legislation or the hospital waste disposal policy. It was therefore apparent that inappropriate waste management was occurring mainly due to a lack of staff awareness and knowledge and the absence of facilities to enable employees to correctly and safely deal with waste. To improve waste management at the Trust, a comprehensive staff training programme was required and additional equipment needed.

The third aim was to implement a health promotion and training programme for the improvement of waste management. It was realised that several different groups existed in the waste chain, each with varied training requirements; domestic staff, nursing staff, porters, incinerator operatives, non-clinical staff and patients and visitors. It appeared to be more effective to prepare separate material for stages in the waste management chain and train each group only in those stages relevant to their position. It was decided to appoint key personnel as Waste Management Contacts. A Contact would be nominated for each ward/department and trained by the Waste Minimisation Officer, to act as a trainer for all staff in their area. Information about general hospital waste management and the new system in place at Royal Preston was summarised, simplified and put into a leaflet format, for the patients and visitors.

Aim five was to carry out any practical measures necessary for the improvement of safety in waste management. A consignment of yellow, wheeled bins was purchased for the secure storage and transport of clinical waste only. The use of these bins would

considerably reduce the number of times the waste was handled, minimising the likelihood of infection and accidents. Washing and lifting equipment was also purchased for the wheeled bins, so that they could be kept clean and manual waste handling minimised. The segregation of waste was made easier by attaching colour-coded labels to the bins used at ward level. Concise definitions for the various wastes were devised to assist in the correct segregation of the different waste streams and displayed on posters. Handbooks were also designed and printed for each of the staff groups.

It was intended to introduce the system and training gradually, starting with a pilot ward, so that any major problems could be solved before implementing on a wider scale. A Waste Management Contact was appointed for the ward and trained by the Waste Minimisation Officer, so that she could begin training sessions for her staff. In the meantime a large poster display was produced, providing information on hospital waste management and the new system for staff, patients and visitors on the ward to read. The number, type, size and location of all the waste containers on the ward were recorded. In some cases bins were then swapped around so that they were in the ideal locations for the types of waste likely to be produced in each area. As soon as the yellow wheeled bin was introduced on the pilot ward, staff were asked to monitor the waste produced, so that the figures could be compared to information previously collected, to determine if as a result of training and provision of facilities, waste segregation had improved. The training methods were evaluated by staff, by filling in Evaluation Forms and they were also given the opportunity to list any problems or ideas regarding the system and training, on a Suggestion Form, available on the ward. Alternatively, they could speak to their Waste Management Contact or the Waste Minimisation Officer. Updates are sent to the ward, to keep staff motivated.

The results from the pilot ward have shown that waste segregation has improved, as there is less clinical waste being produced and slightly more domestic waste. This in turn, shows that the staff and even patients and visitors have become more aware of the waste they are generating and are more careful about where and how they dispose it. Waste handling has been minimised, as clinical waste is now safely contained in yellow bins. Although the implementation methods used on the pilot ward were successful, they were quite time consuming. As a result of increasing pressures on the Trust to improve waste management, the remaining wards and departments have now been issued with yellow wheeled bins and the comprehensive training programme will follow. Once all staff in the remaining wards and departments have been trained, it is anticipated that the Trust's clinical waste production may reduce even further, hopefully by as much as 50%. Following the implementation of the training programme hospital wide, further efforts will be made to reduce the waste produced, through minimisation, reuse and recycling initiatives.

Long term benefits to the Trust are expected as a result of this project, which has now become sustainable, these are: increased staff, patient and visitor awareness of waste management, improved health, safety and waste management procedures, improved compliance with hospital policy and relevant legislation, increased environmental benefits, reduced waste disposal costs, external organisation interest in the project, and improved public image. The Trust is not only dedicated to provide excellent healthcare services, but is also keen to promote health by reducing our impact on the environment.

An ethical approach for developing a health promoting culture

Stephen J. Ashcroft

The aim of this paper is to make a contribution to the debate on the role of hospital managers in HPH projects because, after all, it is the job of managers to initiate the debate as to whether a hospital should develop a health promotion policy, take the decision whether to proceed or not, devise strategies to ensure any project is successful – including securing the involvement of staff – and monitoring how effective the policy has been. This, of course, applies to any policy and at the end of the day success or failure depends on the skills of managers. As Mintzberg has pointed out:

"No job is more vital to our society than that of the manager. It is the manager who determines whether our social institutions serve us well or whether they squander our talents and resources."

Too often we pay insufficient attention of the role of managers in creating a HPH even though the key conditions to be met for becoming one of the pilot hospitals in the European network spoke about the need for "managerial commitment to the Ottawa Charter for Health Promotion and the Budapest Declaration on HPH". This 'management commitment' must mean more than simply passing a favourable resolution at a Board meeting and then basking in the warm glow of knowing that your hospital has joined the HPH Club. Yet another tick in box of the extensive list of objectives managers have to achieve. Rightly, in my view, health promotion can be seen as an instrument to change organisation's structure and culture.

As the HPH initiative has developed, increasing attention has been paid to the management processes within hospitals and the way in which managers can stimulate a climate conducive to a successful HP culture. If I knew in 1993, when I first became involved in the HPH network, what I know now, I would have argued that attention to management processes should have been at the forefront of the debate. I want to link the current debate about incorporating the concept of ethics into management and the creation of a climate within a hospital which is conducive to a successful HP project.

My proposition is that managers need to adopt an ethical framework within which they place their decision making processes. I wish to draw upon examples of such frameworks, suggest approaches which may be more effective but also offer words of caution in relation to the potential misuse of an ethical approach by managers in order to achieve their objectives. It has been suggested there are two broad choices when considering how best to motivate employees. (Figure 1)

So if managers are trying to create a culture within a hospital which is more likely to facilitate a successful HP initiative, I think we would all agree that an approach towards the right hand side of the slide is more likely to be relevant. Such a management style, if I can use this term, is rooted in current notions of what kind of society we live in today and assumptions about social order which are vastly different from those of 50 years ago. Some may say organisations adopt a more ethical approach than was previously the case. This is, of course, part of a much wider issue of ethics

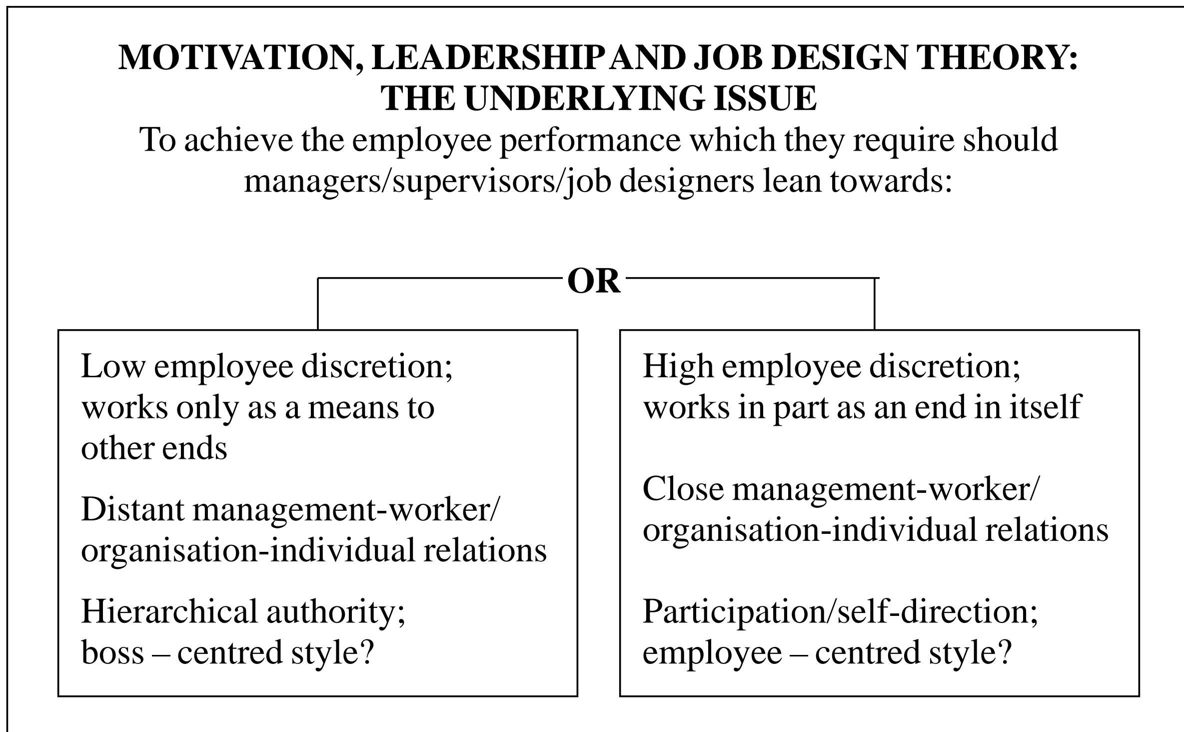

Figure 1: Motivation, leadership and job design theory (From Management Organisation and Employment Strategy: New Ideas in Theory and Practice; Tony J Watson, 1986)

as applied to management. This is a vast subject and I am concentrating here on the motives of managers when stimulating an HP initiative.

As I suggested earlier, do managers wish to pursue the status of being a HPH purely for some kind of commercial or personal advantage? One needs to ask whether the concept fits in with an overall approach to the management of the hospital underpinned by a set of ethical values. As Vernon Henderson has stated:

“Ethical behaviour is always a function of context. It is relative to culture, an era, to the pressures exerted in a given job“ (Quoted in Goddard, 1988).

Organisational hierarchies encourage (in some cases demand) subservience to that organisation’s basic values and objectives rather than ones own leading to what has been called ‘ethical erosion’. A number of models exist to assist in ethical decision making. The International Institute for Quality and Ethics in Service and Tourism Ltd has identified seven tests for ethical decisions:

- Is it legal?
- Does it hurt anyone?
- Is it fair?
- Am I being honest?
- Can I live with myself?
- Would I publish my decision?
- What if everyone did it?

If the question we are attempting to answer is 'Should we become an HPH' then the application of these seven tests would not prevent us from proceeding. Glaser (1) has defined ethics as: "The systematic analysis of our (individual and institutional) behaviour's impact on the dignity of persons. It is the disciplined approach to choosing the better alternatives for respecting human dignity.“ Please note the emphasis on human dignity and 'choosing the better alternative'. I think this goes much deeper that the Institutions seven tests and, again, if applied to a decision regarding an HP initiative, I think we could argue to proceed would be acceptable. It does seem as though ethical considerations are playing an increasing role in organisations. It has been suggested we are seeing an institutionalisation of ethics. The following quotation is from R W Goddard (2). The implication here is that some managers adopt an ethical stance because it is good for the balance sheet: "Companies are moving beyond just writing codes that comply with the law; they are beginning to use them to help achieve corporate objectives. The recognition of the link between ethics and the balance sheet is the driving force behind the trend toward institutionalising ethics in business."

The point here is that health promotion can be used to facilitate a new way of thinking within hospitals, especially where staff have yet to come to terms with the changing role of hospitals. But health promotion could be misused by managers in the same way as management theory and ethics. We should be striving for symmetry between the absolute recognition that HPH is a worthwhile initiative and ethical management processes within the hospital. Each can feed off the other in that I do believe managers should adopt an ethical approach to managing hospitals and if this is clear for all to see, the adoption of HPH principles will be made all the easier.

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Vaugirard Hospital and the district's GPs: An example of a new care organisation

Anne Laurence Le Faou, Anna Ozguler, Nicolas Nathan, Yanka Stahan, Jean Laudet, Dominique Jolly

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of 50 University public hospitals (30.000 beds, 85.000 employees). The board managers of Vaugirard Hospital (VH), the most recent AP-HP geriatric hospital have wanted it to become a reference with the help of the private practitioners of the 15th district of Paris where VH is located. To reach this goal, the VH team created a number of tools and services: a guide listing the health professionals and socially-oriented services (sent to the GPs of the 15th district in January 1994), a geriatric consultation which allows the GPs to seek a geriatrician's advice, a day care hospital whose aim is to allow elderly people to stay at home with the help of the district's health and social professionals and a gerontologic network between VH and the 15th district, whose aim is to encourage a partnership between the VH staff and the GPs of the district. A study was conducted to evaluate the consequences of this new policy on the relationships with the GPs. The objectives of the survey were:

- to measure the GPs' knowledge concerning the Vaugirard Hospital facilities in the 15th district and
- to evaluate the GPs' expectations concerning a geriatric hospital.

Material and methods

Two hundred and twelve GPs are listed in the 15th district. Seventy four of the 95 GPs contacted accepted to answer the questionnaire, which corresponds to 35% of the target population. The survey was carried out by phone from the 15th October 1995 to the 15th January 1996 and it was stipulated that the person in charge of the survey would try to contact the GP a maximum of 3 times. It had 9 questions and an additional open question in order to obtain qualitative information about Vaugirard Hospital services.

The survey describes the GPs recourse to Vaugirard Hospital in the 15th district, the use of the Vaugirard Hospital guide, the referral to the geriatric outpatient service, the knowledge of the day-care hospital, the participation in the gerontologic network by GPs and the GPs expectations from a geriatric hospital. The Statview software was used for this analysis.

Results

The breakdown of the 74 contacts is the following : 95.9% answered by phone, 4.1% answered by mail (after a phone contact). The place of Vaugirard Hospital in the 15th district is assessed. Most of the GPs (82%) have oriented elderly patients to Vaugirard Hospital, half of them (55%) followed up on patients discharged from Vaugirard Hospital of whom : 27 % followed up on fewer than 2 patients, 37% between 2 and 5 patients and 32% more than 5 patients (not specified for 4%).

Concerning the guide, 65% are sure that they received it and 34% suppose they didnot. Among the 48 GPs who received the guide, 23 (48%) use it in their practice. 49% (36/74) of the GPs refer patients to the geriatric outpatient service of Vaugirard Hospital. The day-care hospital is well known (74% reply favorably). Among these doctors, 44% (24/54) have used this center.

Concerning the gerontologic network, 59% of the GPs know about it but only 32% see it as teamwork. Fortynine GPs explain their expectations of a geriatric hospital:

- 26.5% (13/49) regret that their patients cannot be admitted directly to Vaugirard Hospital in an emergency situation and have to first go to an acute care hospital (Boucicaut Hospital in the 15th district which is an AP-HP hospital as well) even if the patient does not require surgery,
- 24% (12/49) mention the lack of beds,
- 10% (5/49) would like more hospitable relationships between staff and patients,
- 10% (5/49) regret the lack of contact with the patient following hospitalisation, especially in the long term care department. They would like to receive a regular update on their patient,
- 26.5% (13/49) of the GPs respond „everything is fine with the Vaugirard Hospital services“.

Conclusion

The results of the survey concerning the GPs' knowledge of Vaugirard Hospital services show that these doctors are aware of the day-care hospital facilities and the geriatric outpatient service. Most of them have referred patients to Vaugirard Hospital. Nevertheless, it must be pointed out that only half of them use the guide regularly, thus showing that social aspects are not often taken into consideration. In addition, the care coordination project between the primary care system and Vaugirard Hospital is not always seen as a gerontologic network. More time will be needed for the staff to become accustomed to this new approach and therefore be able to put into practice what is written in the hospital policy. Taking into consideration the GPs requests, Vaugirard Hospital staff hes recently created an acute care unit. This unit can admit patients directly and facilitates the hospitalisation of elderly people in a specialised environment. The Vaugirard Hospital staff continuously tries to find means to improve the relationships between Vaugirard Hospital and the health and social professionals of the 15th district of Paris, for example, the guide will be revised in 1997.

A psychoanalytic view on health promotion in hospitals – Social constructions to resist anxiety

Rainer Paul

The fact that efforts to instigate changes in the work routine and content in institutions encounter obstacles and lead to conflicts is seldom openly addressed. If a hospital is open to structural changes geared towards establishing it as a health-promoting institution, it is vital to understand the moments of stubbornness and to bring to a close the conflicts that arise. The following addresses this issue, examining as an example the fear prevailing in institutions of expressing individual reasons for resisting change.

The ideas are based on Freud's psychoanalysis and its further development by Klein and Bion, as well as on the application of psychoanalysis to institutions by Jacques and Menzies. Organizational structures are considered from the aspect of their unconscious meaning. The hypothesis is defended that institutional structures possess a defense function with regard to the staff that can undermine the capacity of an institution to meet its obligations. In order to succeed, those who initiate the process of change must be aware of this resistance on the part of existing organizational solutions.

I proceed from the following premises:

- the employees of a hospital – and not just those of a psychiatric hospital! – are confronted by substantial projection of mental anxieties (Menzies, 1984);
- cohesively in institutions the collective resistance takes hold earlier (psychotic anxieties);
- how these projected anxietes are coped with will ultimately decide the functional capacity of the institution with regard to its obligations, decide the health of its patients and staff. I would like to add that particularly executive staff members are at risk, since the manifold projections from within the institution (staff and patients), be they unrefined or in the form of resistance, are bundled in their case (Kernberg 1980, Menzies, 1984).

Psychotic anxieties are all those anxieties which threaten the organization of the psyche itself and question it, that is, attack the adult mental structure. Unlike neurotic anxieties which are more likely to center on specific contents: the fear of examinations or the fear of snakes, etc., the content of psychotic anxieties is limitless. Bion, for example, speaks of „nameless dread". Individuals develop psychotic anxieties with relative ease when they are subject to intense group experiences.

Psychotic anxieties as they present in hospitals are, for example, those related to the integrity of the body. This is manifest, among others, in that anxieties exist with regard to the extent to which an illness spreads or how invasive a treatment itself is, such as operations in which the body is opened. In the anamnesis of the individual this can resemble anxieties such as those experienced by an infant before it has developed the mental capacity necessary to usefully process internal and external stimuli. Thus an unbearable feeling of hunger can absolutely overcome any other sen-

sations and take complete possession of one's percieved existence. This calls to mind that psychotic anxieties always focus on existence.

As Menzies showed in 1984, hospital staff often face the anxieties in their dealings with patients:

- fear of not existing
- fear of loss of the capacity to think and to be aware
- being flooded by diffuse anxiety
- living in a second, private world without any contact to the world of others
- losing the capacity to test reality (reality testing).

Experiencing the full weight of the patient's anxieties and carrying the responsibility for them arouses anxiety among staff members. Otherwise, to take responsibility for these anxieties means functioning as a therapeutic other for the patient. We may ask what is necessary to give the members of an institution the mental strength to function as a therapeutic agent. How can the staff avoid anxiety?

Ways of avoiding anxiety/ defense mechanisms in patient-nurse interactions (Menzies 1984):

- splitting up the nurse-patient relationship
- detachment and denial of feelings
- the attempt to eliminate decisions by means of ritual task performance
- reduce the weight of responsibility in decision-making by means of checks and counter-checks
- collusive social redistribution of responsibility and non-responsibility
- reduction of the impact of responsibility by means of delegation to superiors
- idealization and underestimation of personal development possibilities and perhaps health-promotion activities
- avoidance of change.

Though listed here as being completely separate, these defense mechanisms are not experienced as such in reality, rather as entwined and permeating one another. On the basis of an example from the everyday routine in a psychiatric hospital – similar examples can be described for other clinical situations – I would now like to illustrate the connection between some defense mechanisms (splitting up the nurse-patient relationship, detachment and denial of feelings, the attempt to eliminate decisions by ritual task performance).

Very often patients are found on psychiatric wards who chain-smoke, respectively are addicted to nicotine. These patients receive cigarettes from the staff according to certain rules. One must imagine, for example, that a patient may have two cigarettes each hour and that he or she must ask the staff for the cigarettes each time around. This rule, which is clear enough in itself, disrupts the natural structure of the patient's day, lending his or her interaction with the staff a new focus. For the patient the entire day turns into a waiting period. He must keep an eye on the staff, he must keep an eye on their breaks, which in turn often collide with the rule, etc. On the part of the staff,

the open, perhaps even uncertain manner of dealing with the patient assumes a rigid structure, completely devoid of any anxious psychiatric content. The patient has been successfully turned into someone who makes demands, who must declare him- or herself, who must be controlled, etc. Staff complaints focus on the demanding patient, the circumstance that one is never left alone and that one must always exercise control. While all this may well facilitate the psychiatric dealings with the patient, it also facilitates keeping one's distance to the patient. Once habitualized, however, the individual defense against psychotic anxieties will eventually project itself into institutional processes in the long-term. Upon closer examination of routine organizational processes, this defense information can be isolated. An example:

A student nurse is sent to the housekeeping supply service to fetch towels, sheets and so on. The ward to which she is assigned produces an unusual amount of laundry due to one patient, who becomes incontinent during a psychotic phase and wields this facility accordingly. When the student nurse arrives at the housekeeping service the staff there tells her that the order form she has presented for the bedding has to be signed by the head nurse on the ward, who happens to be off-duty that afternoon, so she cannot get the bedding. „I can't take the responsibility," says the housekeeping staff member, „but I would recommend that you have the form signed by a member of the administrative staff." The student nurse then proceeds to the administration, where she is told that the order form she has presented is not the correct one. But after some discussion and phone calls to the head of administration, the administrative staff member signs it anyway. The student nurse returns with the signed order form to the housekeeping service, only to find it closed in the meantime. She then returns to her ward without the bedding, which leads to a quarrel with the nurse who remained on the ward and, in the absence of the student nurse, has had to do double the work. Their quarrel involves time, order forms, etc., all of which are „safe" subjects to argue about and far removed from the psychotic actions with which their patient has confronted them.

The defense formation described here can be termed a social defense system, in keeping with Jacques (1955). Institutions can be used by individuals to strengthen their own mental defenses. These individual defenses will, as shown, eventually be incorporated into the routine processes of the institution. I would like to add that it is not an individual mental pathology which is being projected but that members of an institution are frequently confronted by the anxious pathologies of their patients and then resonate them, tending for this reason tending towards increased defenses in an effort to protect their own health. At first glance, it is good health-maintenance procedure to resist that which can cause anxiety. The habitualization of such resistance, or defense, however, threatens the capacity of an institution to function and paralyzes staff involvement – thus exercising a pathological effect in the long-term. New staff members are quick to recognize damaging and paralyzing organizational forms. Habitualized defense, which slowly becomes a feature of the routine processes of the institution, is akin to a subculture: extant and determining processes while itself going unrecognized – in the end habitualized defense is the Unconscious, that is the Unknown of the institution in the Freudian sense. In full conformity with Freud, this Unconscious determines to a large extent the manner in which the institution exerci-

ses its duties and whether or not it can even discharge them effectively. As shown in the above example, the staff no longer even needs patients in order to be sufficiently occupied. The defense mechanism has become self-perpetuating. One could term the defense mechanism described: „Ask and wait if you want/feel something“ (the institution must legitimize every expression of life).

The framework of this presentation does not permit description of how to change such habitualized processes. It is evident though that initiatives targeting changes in an organization and which disregard basic anxieties free those anxieties that are bound into organizational solutions. Such initiatives will have to reckon with substantial resistance. Also, idealizing the process of change, for example through membership in an international movement of health-promoting hospitals, will not prevent resistance, but will instead devalue the previously idealized idea.

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Part 7

Twenty Pathways Towards The Health Promoting Hospital

Introduction

Karl Krajic, Margareta Kristenson

The 1st International Conference on Health Promoting Hospitals in Warszaw in May 1993 had marked the beginning of the European Pilot Hospital Project. This has been the central „Model Project" strategy of the International Network, for the first time uniting 20 hospitals. These hospitals had decided to test the concept of Health Promoting Hospitals under their specific national, regional and local circumstances and for their specialisation and size.

The 5th International Conference – 4 years later – marked the end of the main working period of this project. Jürgen Pelikan in his keynote lecture (represented in this book) has already pointed out the main aims and objectives of the project and has provided an overview on the participants and on the structures of co-operation. He has also been giving a first analysis on the successes and strengths, but also on the disappointments of this project on a European level.

The following part of the book now is devoted to short reports on experiences of the Pilot Hospitals´ comprehensive development projects on the local level in each of the participating Pilot Hospitals. To describe a 4 year process, with 5 – 19 subprojects in each of the hospitals, covering all areas of Health Promoting Hospitals (patients, staff, community and organisation), where in some cases several hundred people were involved, is a difficult task – more difficult still if the severe space restrictions of this publication (4 pages per contribution) had to be accepted.

So the pictures that are created about the local Pilot Hospital Projects have to remain sketchy – but nevertheless the reader will get a good first impression about the amount of energy, enthusiasm in these projects and the number of people that have been contributing to this large scale experiment of what a Health Promoting Hospital might look like. The reader will also get a good impression on the wide area of problems chosen and topics selected in the local projects. And finally, the reader will also get a first picture on successes and failures, on factors for success and obstacles in these hospitals. The contributions are regionally grouped – starting in Central Europe, the journey goes to Britain and Ireland, then to Germany and finally to France and the South of Europe.

Perhaps these contributions manage to serve as a good starter – they should create appetite for more information and analysis, which will be available in a publication dedicated to the experiences of the Pilot Hospitals, which is currently in preparation and will be available in spring 1998.

The Vienna WHO-Model Project “Health and Hospital”

Peter Nowak, Robert März

Context and Origin of the Project

The Vienna WHO-Model Project “Health and Hospital” was the first project the WHO Regional Office for Europe initiated to implement the general concept of „Health Promotion“ in the context of the hospital setting. This project was put into practice at the Rudolfstiftung Hospital of the City of Vienna, a general hospital which includes all medical departments except psychiatry and pediatry. The hospital employs approximately 1900 people and has 27 wards and 17 out-patient clinics where about 30 000 in-patients and 100 000 out-patients are treated annually.

After the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBI) had worked out first conceptual drafts on the basis of a pilot study in 1988, a number of hospital administrations were contacted in order to find a suitable hospital in Vienna for carrying out the pilot project . The medical director of the Rudolfstiftung Hospital was interested in this program of reform right from the beginning. The final positive decision about the hospital´s participation was reached during two staff meetings in which all employees had the opportunity to get to know the concept of the project and to vote on whether to participate or not. One reason for the wide acceptance the concept of „Health Promoting Hospital“ found amongst the staff, was due to the fact that beside the patients the staff themselves were to be a target group of health promotion. The hospital management was open to reforms because they expected to improve their future competitive position by taking part in an international model project.

The project at the Rudolfstifung Hospital had the character of a model as a WHO „Health Promoting Hospital“ within the objectives of the Vienna Hospital Reform. For this reason, social-scientific research played an important role as a constant accompaniment of the reforms. The comprehensive documentation and evaluation of the project´s progress were to ensure not only feedback and control of the project’s progress and results, but also to facilitate transfer of these new experiences.

Strategies, project structure and public relations

The aim of the Model Project was to initiate a process of organizational development at the Rudolfstiftung Hospital. The LBI provided organizational counselling based on the principles of „systemic organizational development“ and „project management“ methods. The leading strategy of the Vienna Model Project was to influence the development of the whole organization by carrying out subprojects.

To coordinate the overall project, a Joint Project Committee was set up, consisting of the hospital management, two personnel representatives from the Rudolfstiftung Hospital and three members of the LBI. The Project Committee, acting as client of the project, decided on the subprojects to be carry out, called for participation in special courses and model wards, and appointed project groups to plan and carry out the subprojects. Moreover, it supervised and coordinated the progress of the project by

receiving regular reports from the subproject groups, and providing feedback for the people working on the project. As means for public relations, a bi-monthly Project Newsletter was established and unnual public presentations of the project were organized.

Developing Models

The development, trial and implementation of innovations was carried out according to clearly defined goals, within a given frame of time, work and financial resources, in so called "Sub-projects". To take stock of the problems within the hospital an „information round" was carried out during the initial project phase, including all wards, out-patient clinics and sub-units of the Rudolfstiftung Hospital which had voiced interest in participating in the project. On the basis of this problem analysis, eight Sub-projects were established by the Joint Project Committee. In 1995 three additional projects were established for a two-year running period (1995/1996). In these 11 Sub-projects about 90 action areas were defined and were mostly realized in the course of the 7 years of project work. According to the four main areas of health promotion, Figure 1 gives an idea of the wide spread scope of the measures taken.

PATIENT – AND STAFF – ORIENTED PROGRAMS

Patients	**Staff**
Support for Patients by Volunteer Service	Handling of Dangerous Materials
Hospital Hygiene	(Narcotics, Desinfectants, Cleaning
Training of Diabetics	substances etc.)
Rehabiltation through Physio-	Psychosocial Health and
therapeutical Care	Interprofessional Communication
	Ergonomic Consulting for Workplaces
	Backpain Courses
	Regulation of Working Hours

Patient Oriented Nursing
Cooperation between Wards and Central / Functional Units
Healthy Food in the Hospital
Functional Rebuilding of the Ward Space

COMMUNITY – AND ORGANISATION – ORIENTED PROGRAMS

Community	**Organisation**
Support for Patients by Volunteer Service	Cooperation between Wards and Central
	/Functional Units
	Practical Instruction/Integration of Nurses
	Management Training for Ward Nurses
	Interprofessional Communication

Out-Patient Clinic as Interface Between In- and Out-Patient Care
Mission Statement Rudolfstiftung

Figure 1: Sub-projects and action areas in the Vienna WHO Model Project

Planning and implementing each model was the work of Sub-project Groups, which were composed of members from different professional groups and all levels of the hospital hierarchy. Participation in a Project Group happened on voluntary basis. Hospital staff was allowed to use up to two hours of their weekly working time for project work. Each Sub-project Group could make use of an external organizational consultant from the LBI to support them in solving any task at hand.

Summary of results

The Vienna WHO-Model Project played an important role in helping the Rudolfstiftung Hospital to develop toward a health promoting organization. What proved more difficult however, was the transfer of experiences made in areas of the model project to become permanent features in the daily hospital routine. In some way it seems to be easier to transfer the manyfold experiences of the Rudolfstiftung within a national or international context than within the Rudolfstiftung itself. To sum up the successes of the Vienna WHO-Model Project we can state that it was possible:

- to win the support of the hospital owner, management and staff
- to solve relevant problems of the hospital
- to develop the hospital into a „learning organisation“
- to ensure sustainability of the project results by establishing new professional roles, new communication structures and training of staff
- to work continuonsly on the HPH-projects throughout 7 years (including funding of the last 2 years out of the normal budget of the hospital)
- to involve 250 staff members actively in the subprojects (more nurses than doctors and administrative staff)
- to incorporate the main goals of HPH in the mission statement of the hospital
- to achieve high visibility by newsletters, public presentations, visitors days
- to develop 9 guidance manuals on 9 successful models of HPH-projects
- to start off from this project the European Pilot Hospital Project and the Austrian National Network of HPH

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The Upper – Silesian Rehabilitation Centre „Repty" Annex Ustroñ as Health Promoting Hospital – The end or the beginning?

Zbigniew Eysymontt, Zbigniew Baczek, Alina Marzec, Jerzy Klimczak, Krystyna Zagórska, Ewa Drobik, Barbara Hadaszczak, Barbara Malejka, Barbara Piercha

The Upper-Silesian Rehabilitation Centre „Repty" in Tarnowskie Góry Annex in Ustroñ is a 120-bed rehabilitation hospital which was established in 1989 as the annex of the main centre in Tarnowskie Góry. The initial plans for the implementation of a comprehensive program of health promotion in the hospital appeared midway through 1992. After our application had been accepted, the first phase of the practical implementation of the aims was started. Significant for an effective initiation to the plan was the full support from the hospital authorities.

At the present time we are in the process of implementing 10 sub-projects at varying stages of advancement. The sub-projects which are the most advanced in their state of completion are at present:

1. A health school
2. The hospital as a place for the promotion of culture
3. Healthy food
4. The hospital as a smoke-free place
5. Segregation and utilisation of waste

Major realization problems are:

- Financial shortage which hinders the implementation of the sub-projects
- Lack of support from the local authorities and governmental authorities
- Lack of suitable training and experience in the documentation and assessment
- Cautious reception by the staff of the hospital and even with a certain antipathy at the beginning.

Nevertheless, the time spent on the health promotion project in our hospital has so far undoubtedly been constructive. Many of the newly-established working procedures and organizational changes have been adopted completely within the daily work of the hospital.

A Hungarian pathway towards the Health Promoting Hospital

László Kautzky, Tamás Halmos

The Health Promoting Hospital concept was initiated shortly after the "Budapest Declaration" in 1991. By this time the national Korányi Institute became a full member of the European Pilot Hospital Network.

Life expectancy at birth in Hungary is one of the lowest in Europe. In the past decades the Health Care System has focused mostly on treating diseases, while prevention and health promotion were neglected. A few years ago the Hungarian government declared a new Health Policy named "Health of the Nation". The radical change in political and financial structure gave a good background to the starting "Health Promoting Hospital" movement (HPH). The National Korányi Institute started with five subprojects:

1. Healthy Nutrition
2. Postgraduate training for nurses
3. Hospital Hygiene: methods, which protected staff against infections, toxic damages, etc
4. Efforts, which created a better environment for staff
5. Patient information programs (club activities: diabetes, anti-alcohol, asthma)

For almost two years, we took on the task to build up a National HPH Network. Before describing shortly our efforts on this topic, we have to explain some important conceptional changes, especially in our local Health Policy. Originally, the HPH movement had been created to improve the working conditions within the hospital. First programs focused on achieving better working conditions for staff. While creating a better and healthier environment for staff, this also had beneficial effects for patients. Soon after having joined the movement, we realized that the HPH concept can flourish only by "demolishing the walls" of the Hospital. In achieving a healthier society, it is a **must** to involve the Family Doctors' Network, the communities, and the entire society.

When starting to build up the Hungarian National Network, we therefore encouraged candidate hospitals to focus their programs not only on staff and in-patients, but also on the community. Apart from programs, which remained mainly within the hospital walls, like "Baby friendly birth", hospital hygiene, etc., more and more projects started to deal with programs like prevention of chronic, non-communicable diseases, rehabilitation after cardiovascular and cancer diseases, etc. The role of the hospital became more and more a "model" for healthier life styles.

By this time, some 26 Hungarian Hospitals joined the movement, and their programs presented clearly the change of the original philosophy of HPH, turning to the Primary Health Care System, and the Communities. This change seems to be more pronounced in Hungary because of the very sad parameters in health and diseases. The problem has become even more sharpened, for in the past few months some ten thousands of hospital beds had to be closed in our country. This fact, apart from many

other financial and medical aspects, undermined the prestige of hospitals. It became clear that effective health-protective work cannot be done without involving partners working outside the hospital.

The main problem is still the lack of financial resources. To carry out programs in health prevention and health promotion without extra financial support is extremely difficult. One year ago we created a “Foundation for Health Promotion“, asked International Pharmaceutical Firms for financial help, but with no success. We applied for different grants and got a small amount from the Health Government, and we hope to obtain some more this year.

In summary: The National Korányi Institute is the only Hungarian Hospital participating in the European HPH Pilot Hospital Project. Since two years we started to build up the National HPH Network. In this effort we have realized that the philosophy of the original concept has changed in Hungary. This means that more and more programs are focusing on health prevention and protection, and by doing this, they involve the Primary Health Care System and the Communities, as well. The “walls of the hospital“ started to fall down earlier than in Western Europe, because of the special political and historic background. It is an encouraging fact that in spite of the lack of financial support, some 26 Hungarian Hospitals were willing to accept the HPH concept and joined us.

The University Hospital in Linköping, Sweden

Margareta Kristenson, Gunilla Rainer, Johannes Vang

When the management of the University Hospital in Linköing decided that the hospital should become a Health Promoting Hospital, three factors were determining the decision: the new Community Oriented Curriculum for the Faculty of Health Sciences, the new Health Policy Programme for the County, and the hospital management's need for an orientation towards increased effectiveness and a more visible goal for the service which reflected the mission of the hospital.

Aims and objectives

In 1992, after discussions in several strategic groups, the hospital's mission statement was defined as „Health Gain for Patients, Effectiveness and Client Satisfaction". In 1995, a new Hospital Director revised the mission statement: the cooperation between the University Hospital and the Faculty of Health Sciences was emphasized. This was reflected in the new mission statement „Health Care and Research for Health Gain".

The objective of the HPH concept is to reorient health services towards health, as suggested in the Ottawa Declaration. The „sub-projects" were instruments for this purpose. In Linköping ten sub-projects were identified. All of the identified activities were already ongoing or planned; the criterium used for an activity to be defined as a sub-project was: that it supported development of good practice and was an example of what it means to be health oriented.

Two overarching projects were the development of a decentralized organization with outcome orientation towards health gain and the introduction of Total Quality Management. These overall projects focused on policy and organizational issues. The sub-projects covered the three main areas in a Health Promoting Hospital.

1. Health Gain for Patients:
   - Swedish Health Care and Meeting with Refugees
   - Psychological and Social Support to Patients, Relatives and Staff Suffering from Crisis
   - Caring for Patients with Alcohol Problems Identified at the Emergeny Ward
   - The Smoke free Hospital
2. Health Gain for Personnel
   - Early Active Rehabilitation for University Hospital Personnel
3. Health Gain for the Society Served
   - Hospital Accident Analysis and the Prevention of Accidents
   - Shops for a Better Life
   - Osteoporosis Prevention Project
   - Environmental Protection and Pollution Control

Experiences after 5 years

The University Hospital's budget has during this period been substantially reduced. The personnel force amounted to 6.500 in 1992. It was reduced to 4.500 by 1997. Still, the reorienttaion towards a decentralized health outcome oriented organization with the help of Total Quality Management has continued. This year the Hospital will, besides the ordinary financial balance record, present a „health outcome account" for 3 diagnoses per clinic. In 1997 the balance account will include „health outcome accounts" for half of the diagnoses in every clinic. Several projects for health gain measurement and patient centered outcome measures are ongoing.

The experiences from both the project of early active rehabilitation and from the TQM projects are that empowerment of the personnel by deeper participatory involvement in decision-making has a strong influence on the well-being of the personnel.

Projects oriented toward community have strenghtened the collaboration between local community authorities and the regional health authorities. The hospital is smoke free, a Unit for Tobacco Prevention has started, and a new health related information centre has been opened in the hospital. The Hospital is now a member of the newly established Swedish Network for HPH.

Conclusions

Our experience has been that the concept of Health Promoting Hospitals is relatively easy to accept for personnel, patients and politicians. However, this concept is difficult to pursue if the managerial system is process- and not outcome oriented, or if the economical rewards are productivity-oriented and not outcome focused. We believe that three levels are important.

Health Gain for Patients

This means adjusting the focus of the hospital relevance and outcome of the activities. The TQM method has been very effective in this respect. However, this approach needs to aim at health gains as a goal for the activities and therefore demand regular measuring and reporting of health outcomes. Without this the developmental process is blind. With a routine measurement of outcomes, the personnel can rearrange services accordingly and the management may focus on activities and processes which are efficient.

Health Gain for Personnel

Making the mission of the hospital evident and distinct, setting goals for the activities and making them visible and explicit creates a confident and assured personnel. Empowerment of the personnel is of equal importance in order to create a healthy workplace. This has been shown clearly, both from the experiences of TQM and form the project of Early Active Rehabilitation of Personnel. To this can be added, that as a part of the new „Quality Account Statement", the Department Heads must now report how large a proportion of the personnel was involved in the process of change in the department.

Health Gain for Society

The hospital's knowledge of and information about the state of health in the catchment area, as well a s the concentration of medcial knowledge at the hospital and the prestige of the hospital, makes it possible to initiate preventive programmes in the local community from the hospital. An example in Linköping is the Accident Programme, which now is a joint venture with the local community. The immediate accessability to the 1% of the total population, which works at the hospital, makes the hospital an ecxellent setting for health promotion and life style development, not only within the hospital, but also through its personnel it is possible to reach out into the society.

Important problems in the process of change are the lack of time and the fear of bureaucracy. To minimize this, it is vital that all ongoing developmental projects are clearly inter-linked. Thus, health orientation, health gain measurements, quality assurance and leadership programmes need to be parts of the same process of change, with a shared goal: the mission of the hospital, i.e. the health gain for the people served.

The Child "Health Centre" – Route to the Health Promoting Hospital

Anna Stolarczyk

Information about the health promotion movement came to Poland in the early nineties. The CHC became a Health Promoting Hospital in 1992 and in April 1993 Warsaw was the venue for the First International Conference of The Health Promoting Hospitals Network.

The fact that the first international conference was held in our hospital focused the attention of all the staff members on the work under way at that time and was probably the most important reason for the successful completion of the project and the subsequent sustainability of the concept of the Health Promoting Hospital.

The CHC, as the Health Promoting Hospital, was not the same in 1993 as it is in 1997. At the outset, projects were undertaken at the direction of the hospital management, in addition to normal duties, while now they are considered by hospital staff and by our patients and visitors as a means of improving health.

Health promotion in our practice is not as professionalised as in other hospitals in the pilot hospital network, and it is difficult to compare our results without comparing backgrounds. By this, I mean the health care system in Poland and also the financial resources. The help and experience of other pilot hospitals which are more advanced, has made our success possible.

To give a picture of the scale of our success, I would like to give a few statistics about our hospital. There are 700 beds and nearly 2500 hospital staff; the whole country is the catchment area, and it is a modern, highly specialised, postgraduate centre. Each new, modern initiative has a greater chance of spreading throughout the whole country. Health promotion through the Health Promoting Hospital is one of the best of many examples illustrating what can be achieved.

My colleagues in health promotion and I consider the most important achievement to be the creation of the awareness and understanding of people that health is really their own business. So the first hurdle – 'to know' – appears to have been crossed.

Since 1995, health promotion has been included in the policy manual of the hospital, alongside curing, rehabilitation and science, and there is no doubt that health promotion is therefore a low-risk, low-cost and highly effective way to improve health in the community.

The main areas of our activity are: the patient- and child-friendly hospital; education (about a healthy lifestyle for patients, visitors and staff); and a healthy workplace.

These activities have been carried out through several projects. Some have already been completed to great acclaim, but, at the same time, health promotion is "a never-ending story" – but not a fairy-tale.

Six subprojects, related to patients, their families, and hospital staff were developed. Because of the country-wide catchment area of the hospital the influence on the local community was of less importance.

1. *Nutrition and Health* – An education programme for patients and hospital staff, concerning adequate nutrition and a healthy life style. „Healthy food" presentations, lectures, meetings with nutritionists and a dietetic education programme were carried out on the basis of regular meetings. Creative methods to teach nutrition concepts made learning fun for the child as well as encouraged a positive attitude about rational nutrition throughout life. Ward dieticians educated staff about healthy eating. Informal contacts with experts from The National Food and Nutrition Institute were arranged for the project leaders and dieticians involved in the HP program, to discuss how to encourage staff to eat a more healthy diet. Co-operation with the Physiotherapy Department was undertaken to promote fitness and physical activity.
2. *Smoke-free Hospital* – Smoking is not allowed on the hospital premises, and cigarettes are not available for sale at the hospital. 'Stop Smoking' courses, counselling and a support programme are available for smokers who want to give up. An exhibition of patients' anti-smoking posters is presented every year during international 'No Smoking' day. An area has been reserved for smokers outside the hospital. New health workers are informed of the hospital policy in their contracts. Unfortunately, the number of smokers is still unsatisfactorily high, but their knowledge and motivation to stop smoking is satisfactory.
3. *Prevention of Type B Hepatitis in children and hospital staff* – The purpose of this programme was to eliminate cases of type B hepatitis among high-risk hospitalised children, and hospital staff most vulnerable to this infection. A significant decrease in HBV incidence among hospital staff was achieved by: regular training; meetings concerning hygiene rules in the workplace; the distribution of educational films for medical staff; the routine sterilisation of multiple-use equipment and the introduction of disposable equipment; and the biological and chemical sterilisation control of supplies. In 1988, a vaccination program against infection among the high risk group was started with „Engerix B" vaccine. In 1989, 32 persons suffered from HBV and were recognised as cases of occupational illness at the CHC. In 1989–94, the HBV infection incidence decreased rapidly each year and since 1994 we have not recorded any new cases of HBV infections among hospital staff. A Hospital Infection Control Team was created to examine all cases of hospital infection, and to provide constant education for employees and visitors about hospital hygiene rules.
4. *Promotion of the Psycho-Social Well-Being of Hospitalised Children* – To fulfil the psycho-social needs of hospitalised children and their parents and to reduce the psychological stress due to hospitalisation, this project aims to create an atmosphere of warmth, trust and security for patients, continue an open-door policy, provide printed information to families about the hospital, the way its various services work, and about patients' rights. Patient satisfaction is assessed through questionnaires. In the light of the results we have reason to be pleased.
5. *The Hospital – one of the Sources of Health Education* – This programme is being implemented by the Department of Education at the Child Health Centre and is addressed to our patients and their families, as well as to teachers and pedagogical staff. A healthy life-style is popularised through games, play, contests, skills

training, occupational therapy and fine art sessions. Verbal, visual and active participation methods are used. Close co-operation with dieticians, nurses and physiotherapists has resulted in the possibility of bringing professional influence to bear on patients, their families and staff through a process of education.

6. *Involvement of the Parodontic Department in the Health Promoting Programme* – The objective of this project is to extend prophylactic and therapeutic oral cavity care to all CHC patients and also to carry out consultations for children in other hospitals and institutions country-wide.

   Among chronically ill or handicapped children we often find very poor oral health conditions due to the fact that those who take care of these children do not see the problem as very important, compared to serious disease or impairment. Health promoting activities are also often not available to these people. During hospitalisation the children's knowledge of their own health, as well as the interest of their parents in health care, are significantly improved. The HPH could support their behavioural re-orientation.

To be effective, the strategy of health promotion is based on the individual needs of children. The following areas of focus-groups carrying out evaluations for adequate standards: physical impairment only, mental disease only, congenital heart failure, cerebral palsy, haemopathies, endocrinopathies, metabolic diseases, expected organ transplantation or chemotherapy, and other bed-ridden states.

Conclusion

Due to organizational and structural changes health promotion will continue within the CHC as an integral element of all medical, educational and other activities. Health promotion exists in the everyday activity of the hospital.

The health promoting hospital programme stimulates new activities and co-operation among different departments. Physiotherapists, dieticians, psychologists, doctors and nurses work together to improve quality of hospital care and patient satisfaction through activities offered to patients, staff members, the environment and the wider community, as a part of a modern approach to the targets of a health service system.

The overall success rate of all health promoting activities undertaken by the CHC is 67% and, at 75%, is even higher among patients.

The CHC is an active member of the Polish Health Promoting Hospitals Network, which is developing at highly satisfying rate.

Attempts to assess the cost-effectiveness of health promotion is planned as the next step.

Preston as a Pilot Health Promoting Hospital

Stephen J. Ashcroft

Royal Preston Hospital and Sharoe Green Hospital provide a complementary range of services to a local population of 230,000 and Royal Preston Hospital is a tertiary referral centre for Neurosciences, Burns and Plastic Surgery, Renal Medicine and Cancer, serving a population of 1.6million. These two hospitals employ 4,000 staff and have an annual budget of £ 94 million.

Dominic Harrison and Pauline Fielding (1996 – unpublished internal paper) have taken Prochaska's and DiClemente's Stages of Change Model (Prochaska, JO and DiClemente CC (1984) The Transtheroretical Approach:Crossing Traditional Boundaries of Therapy. Harnewood, Illinos) and adapted it to allow the identification of strategies for change across the organisation or different parts of it. This has been applied to the hospitals as a setting for health promotion.

The following stages have been identified:

1. Precontemplative

Prior to the 1990s the hospitals were probably at the precontemplative stage. We focused on the traditional function of the hospital, i. e. to treat, care and diagnose. Health gain had not been identified as a concept – we merely focused on our existing contractual work load.

2. Change Stimulus

In Preston, there were two elements to this. Firstly, in the early 1990s with the reforms of the National Health Service we clarified our corporate objectives and became aware of wider issues stimulated by Government Health Policy, in particular the Health of the Nation document (1992). This report stated that "hospitals exist to provide treatment and care, but they also offer wider opportunities for the promotion of health".

Secondly, we have spent time debating the various factors which were impacting on the role of hospitals, such as:

- Changing technology
- Increased expectations from patients and the public in general
- The drive to reduce costs
- Increasing emphasis on clinical effectiveness
- A move towards Day Case Surgery

The discussions led key people within the hospitals to recognise the need to change the way we had previously viewed the role of the hospital.

3. Management Commitment to Change

By 1993, with the importation of health promotion advice and consultancy, senior

hospital managers understood the principles of the Ottawa Charter and the Budapest Declaration. It was recognised that becoming a Health Promoting Hospital was a long term investment in the health of the population and that it would require particular leadership ability to create ownership amongst staff and the community. Because of the previous work on the need for change, key staff recognised that becoming a pilot hospital was a logical step to take.

4. Organisational Commitment

Once the management commitment was established, it was relatively easy to define our local health promotion aims and these included:

- Developing a more effective organisation in terms of health gain
- Reducing costs and improving outcomes
- Developing alliances with the community
- Contracting for health gain
- Delivering high quality care

Translating and communicating the hospitals' new health promoting role to staff at the sharp end was problematic. Initially these staff on the whole did not really understand how their day to day work could have any bearing on health promotion. New roles were established in order to facilitate links between "grass roots" health promotion activity and redefined corporate objectives. For example, funding was established for the HPH Project Co-ordinator and a Waste Minimisation Officer.

5. Project Management

Other roles were adapted in order for individual key staff to incorporate management of the five nominated sub projects into their existing work. This was the first important shift from health promotion being seen as an "add-on" activity to actually becoming incorporated into every day work.

Preston's pilot project required a clear and systematic planning and co-ordination. Milestones were set and progress monitored. Project management training was identified early as a development need but this was not effectively addressed until 1996. As the sub project managers gain confidence and new knowledge, original sub project objectives were rewritten to reflect life.

Much of the change could not have been achieved without the support of our project partners – the University of Central Lancashire and the North West Lancashire Health Promotion Unit. The University has funded (from within its own resources) a Post Doctoral Research Fellow to assist with evaluation and a Senior Lecturer in Health Studies is manager of one of the sub projects. The North West Lancashire Health Promotion Unit provided administrative support to assist with meeting external enquiries and requests for training, education and resources from other UK and European hospitals. The manager of the unit has played a key role in establishing an English Network of Health Promoting Hospitals and the co-ordinating centre in Preston as well as publicising aspects of the local project.

6. Integrating and Sustaining Change

As we started to get positive results from the sub project work, it became part of the accepted way of delivering the service. For example, accident prevention has become legitimate work of doctors and nurses in the Accident and Emergency department and this reflects the difference between health promoting in hospital and a Health Promoting Hospital. Two other projects were added to the initial list of five sub projects, plus a total of 38 other initiatives were identified, recognised and monitored.

Practitioners recognised that they were not equipped with health education skills and this is being addressed by appropriate in house training led by health promotion specialists. Changing the hospital culture has been about individuals being energised and feeling in a position to make a positive difference to what the hospital actually does. For example, after reading an article on safe cycling to work in our staff newsletter, a medical secretary has decided that she wants to lead the work of encouraging her colleagues to cycle to work. In terms of the future work to be undertaken, we intend to:

- Continue to investigate appropriate health promotion outcome measures
- Recognise, support and refine effective health promotion interventions
- Consider developing a health strategy for the hospital encouraging other hospitals to develop their health promoting role as part of our pilot hospital status

Key recommendations from our experience which may be of benefit to other hospitals would be as follows:

- Firstly, develop an understanding of the cultural, health, behavioural and demographic characteristics of those who work, visit or receive treatment in the hospital.
- Secondly, be aware of the external relations of the hospital as a positive force for health.
- Thirdly, identify and use a model of change that fits with the culture of the organisation.

The Altnagelvin pathway to the Health Promoting Hospital

Annie Courtney

Health and social characteristics of the Altnagelvin Hospital

Altnagelvin Hospital opened in 1960 and was the first hospital completed in the U.K. since the Second World War. It is situated in the North West of Ireland within the Western Health & Social Services Board. The W.H.S.S.B. is one of four Boards serving the entire population of Northern Ireland. Health and social characteristics of the Western Board indicate a

- High level of material deprivation
- Poor health status
- High mortality rate.

The standardized death rate for males and females in the Western Board is the highest in Northern Ireland. The main causes are:

- Ischaemic Heart Disease
- Cancer
- Respiratory Disease

For some time there has been evidence of a link between deprivation, unemployment and ill-health. e. g. the area whose population Altnagelvin H&SS Trust serves has 29% – male unemployment, 16% – female unemployment and statistics show that the unemployment in the Western area is approximately 10 times higher than the U.K. average. On closer scrutiny the following issues have emerged:

- There is a considerable gap between what people know about healthy living and what they do.
- Young people tend to have a less healthy lifestyle than the older age groups.
- Women lead a healthier lifestyle than men.
- There is a link between social – economic group and health and lifestyle.
- Drugs – cigarettes and alcohol play a role in the majority of peoples lives.

It is against this background highlighted by 27 years of troubles that Altnagelvin Hospital is ensuring that the health needs of the population are addressed. It was in 1993 – Altnagelvin Hospital applied and was accepted as a Pilot Hospital within the European Health Promoting Hospital Project.

Aims of the project and sub-projects

(a) „To develop the hospital into a healthier organisation by incorporating health promotion criteria into all decision making processes and into the culture of the hospital.“

(b) „To offer additional health promoting services for patients and adopt the role of model within the community and the health care system.“

After consideration it was decided to use the Health Promoting Hospital Project as a launch pad for hospital policies – they therefore became the sub-projects of the E.H.P.H Project. The following sub-projects were selected:

- CPR (Cardio-Pulmanory Resuscitation)
- Nutrition
- Children's Education Programme
- Accidents at Work
- Breast-Feeding Promotion
- Workplace Alcohol
- Smoking and Health Policy

Each sub-group appointed a team leader and co-ordinator and agreed on aims, objectives and evaluations. £ 1000 was given to each group to spend on necessary equipment to bring the project forward. The aims of the sub-groups can be summarized as follows:

CPR

- To improve standards of resuscitation by providing appropriate training in Basic Life Support for all disciplines within the hospital.
- Ultimate aim – to have full time Resuscitation Training Officer appointed.

Nutrition

- To create a greater awareness of the link between food and health among patients and staff in Altnagelvin Hospital.
- To extend awareness into the community.

Child Education

- To introduce children to the hospital in a non-threatening way
- and relieve anxieties.

Accident at Work

- To identify the extent which work related accidents contribute to the accident & emergency workload.
- To educate employers and employees to reduce the incidents.

Breast Feeding Promotion

- To stimulate active concern for Breastfeeding issues and provide sound understanding of the physiology of Breast-Feeding.
- Increase incidence of breast-feeding to 35% within 5 years.

Workplace Alcohol Policy

- Promote an understanding of sensible drinking.
- Ensure that the community receives a safe and efficient service.
- Provide training for managers to recognise alcohol related problems.

Smoking and Health Policy

- To implement the policy in acceptable stages to staff, patients and visitors.
- Increase awareness of passive smoking.
- Provide support to those trying to quit.

Project activities

Following the establishing of the project a public launch of the European Project took place. This was a high profile event and was carried on T.V., Radio and in all Newspapers.

In order to keep the project visible and motivate staff various avenues were pursued. In October 1994 – a Conference entitled „Care, Cure, Prevention – The European Model" was held. This was well attended and created a lot of interest. Art had been used successfully in other hospitals and a series of posters were designed around the sub-projects.

In 1996 a meeting to establish a Northern Ireland Health Promoting Network was held. This has still to be further actioned. In April 1996 the 4th International Health Promoting Conference took place. It was attended by over 300 delegates and proved successful. In addition a display highlighting the sub-projects was visible in the hospital foyer and signs were evident of the project within departments.

Project outcomes

The success or failure of a project is how it is perceived and after 4 years we can look at positive changes which have emerged. In 1993 Altnagelvin was a smoking hospital and staff, visitors and patients treated it as such. Much has been achieved in the four years and smoking is no longer considered the norm. Alcohol is only allowed on premises with permission of the Chief Executive. Healthy eating is encouraged and partnership with supermarkets have been initiated. A full time Resuscitation Training Officer for CPR is in post. Breast-feeding is promoted and each year we have seen a percentage increase. The Accidents At Work team have formed relationships with all major employers in the area and joint surveys of attitudes to safety are carried out. The Child Education project continues and is popular with schools.

In summary the European Pilot Model has been important for Altnagelvin Trust. It has:

- Encouraged us to look at the Hospital from a Health Promoting point of view and develop relevant policies.
- Encouraged exchange of ideas and good practice.
- Increased communication between the hospital and community.
- Cemented relationships with other hospitals.
- Given an International focus to the hospital, and most importantly opened up various avenues to diverse cultures which would not have been possible in the normal hospital philosophy.

Creating and encouraging organisational change – The JCM Hospital story

Ann O'Riordan

JCM Hospital, a large general hospital, servicing the north/western region of Dublin city, has a staff of over 800 and a bed complement of 380. During the last four years the hospital has worked hard to bring about the desired organisational change through the implementation of the requirements of the European Pilot Project, based on the Ottawa Charter (1986) and the Budapest Declaration (1991). The hospital's aim, through participation in the European HPH Pilot Project, was to broaden the range of its hospital services, by developing an organisational focus that would go beyond the provision of high quality curative services.

Broad Project Structure

To realise our aim, it was acknowledged that a number of factors needed to be addressed and new strategies devised and implemented. The concept necessitated the adoption of an approach that actively sought participation and ownership of the HPH Project, both at an organisational and a local level. Furthermore, in order to move the project forward, from awareness to conviction and action, the concept needed to be made real. In order to attain this aim the hospital set about achieve the following objectives:

- Raise general awareness of the importance of the hospital's health promotional role.
- Motivate staff to identify, develop and evaluate the effectiveness of their health promotional activities.
- Develop a cultural change within the organisation
- Improve communication and collaboration with existing social and health services within the local community.
- Encourage the exchange of information and the development of the health promoting hospital concept in other Irish hospital's.

The hospital was assisted in this process through the implementation of the structures specified for participation in the European Pilot Project.

- Attainment of general staff approval for participation
- Establishment of a Joint Project Committee/Steering Committee
- Nomination of a Project Manager/Coordinator
- Involvement of an evaluation expert through linkage with an External Organisation
- Development of an internal newsletter
- Active promotion of links with congruent local health promotion programmes
- Selection of at least five innovative health promoting sub-projects

Figure 1: European HPH Pilot structures

The initial five sub-projects identified were chosen from submissions made by staff. Selection was made on the basis of relevance to the organisation, ability to succeed within a limited time frame, availability of essential expertise and resource implications. The initial sub-projects were as follows:

- Smoke Awareness
- Cardio-Pulmonary Resuscitation
- Stress Management
- Waste Management
- Backcare

The development of the sub-projects gave considerable impetus to the realisation of the overall HPH Project by creating visibility and status for the project among staff within the hospital. The successful outcomes of the sub-projects were viewed as the pebbles that would create the ripples of change, essential for the achievement of the ultimate aim – that of organisational change. Later on, development and motivation was gained through the hospital's obligation, under the European Pilot Project contract, to facilitate the establishment of a National Health Promoting Hospitals Network. This gave recognition to the work already achieved, while stimulating new areas for expansion and development, thereby increasing the visibility and prestige of the hospital not only in the local community but throughout the health service.

Organisational achievements

So, what has been achieved? What changes have resulted from the hospital's participation in the 20 European HPH Pilot Project? Quantifying the results in itself is a difficult task and we realise that we still have some way to go to achieve this. Notwithstanding this, we have separated our achievements into two different categories; tangible aspects and intangible aspects.

Tangible Aspects	Intangible Aspects
• Sub-projects	• Staff/Management Awareness
• Staff Participation and Development	• Heightened Public Profile
• Patient Empowerment	• Multidisciplinary Approach
• Community Education	• Staff Empowerment

Figure 2: Categories of achievements

The actual sub-projects were found to be highly visible and identifiable within the hospital. Most of them being absorbed into the routine of the hospital service by the end of the project. The key results of the sub-projects contributed greatly to the growth the HPH Project, in that a wide range of staff became directly involved and gave substantial personal commitment to the development of the project. Through their efforts very positive results have been achieved in the quality improvement of our services. Patient empowerment has occurred, particularly in the areas of Cardiac Rehabilitation, Stress Management, Smoking Cessation and others, were better patient

facilitation actively encourages definite action towards a healthier lifestyle. Community education programmes have been developed whereby the knowledge and expertise of hospital specialists is being disseminated to the community.

The more difficult areas to quantify are those relating to the intangible aspects of the HPH project, these being staff/management awareness, heightened public profile, multidisciplinary involvement and staff empowerment. However, in reviewing our services and facilities, a more conscious awareness and consideration of the qualitative elements of health promotion and the need for their inclusion in new initiatives can be detected. Health promotion is now firmly on the hospital's agenda. In addition, through extended community involvement the public profile of the hospital has increased.

- The establishment of a multi-disciplinary HPH Steering Committee.
- On-going commitment for the position of a full-time Health Promotion Coordinator within the hospital.
- Regular publication of the "Pro-Health" Newsletter.
- Introduction and continued support for the development of services with a health promotional focus.
- A general move within the organisation towards decision-making that is based on health gain orientated outcomes.
- Improved image and prestige within the local community health service generally.

Figure 3: Achievements of the project

Key factor

Evaluation was a viewed as a critical factor for success. In this respect, the involvement, commitment and input of the external consultant into the development of the project was considered vital. The role of the external consultant covered the following areas:

- Input during the planning phase of all sub-projects
- Expert advise on methodology and project design
- Assistance with sub-project data analysis
- Full involvement in areas of overall project evaluation
  (i.e. questionnaires, surveys, data analysis, evaluation reports etc.)
- Assistance with documentation.

Summary

In many respects, JCM Hospital has been successful in attaining the objectives set by the European Pilot Project. However, it must be acknowledged that more time is required, before the level of ownership essential for the maintenance and development

of the HPH concept, can truly be realised. Many difficulties and problems have been encountered during the period of the European Pilot Project, many of which have been resolved successfully, while some still require on-going attention.

Difficulties and problems encountered were:

- Communicating an intangible concept.
- Establishing individual and collective staff ownership of the HPH Project.
- Generating active multi-disciplinary involvement
- Budget and resource deficiencies
- Development of an on-going effective communication strategies.

Future Plans

Despite these difficulties, enthusiasm remains high and greater effort is now being placed on the development of new sub-projects, the encouragement of wider multi-disciplinary co-operation and the provision of adequate feedback to all grades of staff on the development of change. Future plans include greater emphasis being placed on the following points:

- Increasing multi-disciplinary involvement.
- Provision of adequate and frequent feedback to staff on developmental progress
- Motivation and support for new and existing sub-project developments
- Introduction of models of best practice gained from other HPH hospitals.
- Foster and encourage community links
- Continue to be a key participant in the development of the Irish National HPH Network.

In conclusion, our future focus plans to improve not only hospital-community participation but also community involvement in the development of hospital services and the creation of a healthier community environment.

The Health Promoting Hospital Project at Prince Philipp Hospital, Llanelli, Wales

John Price

Introduction

The fundamental purpose of The European Pilot Hospital Project was to demonstrate if, and how, health promotion can become an integral part of our hospital. In order to substantiate evidence of change in our organisation`s structure and culture, an in depth analysis was required.

The paper presented at the Vienna Conference outlined this analysis and the process that we undertook in attempting to move forward and develop Prince Philip Hospital as a health promoting organisation. It also provided a brief account of the local responses to this process and their effects on developing an intrinsic health promotion culture. Specifically, the paper focused on six crucial elements detailing the way in which our hospital had:

- generated shared ownership of the overall project;
- generated a shared vision at the outset of the project;
- maximised consultation and participation during the formulation and implementation of the overall project/subprojects;
- identified potential resistance and barriers to developing a health promoting culture;
- selected appropriate change strategies and
- identified the political approaches necessary to influence the decision making process in the organisation.

Generating a shared ownership at the outset

In order to move the concept of a health promoting hospital toward a reality it was necessary for us to determine, in some detail, where we wanted to go and how we aimed to get there. This part of the process was assisted by the objectives of the European Pilot Project.

Our project team viewed the Health Promoting Hospital Project as `a product`. If the objectives of the European Pilot Project were to be achieved then:

- the "product" had to satisfy the needs of our target audience, i.e. staff, patients and wider community;
- the "product" must be integrated within the organisations objectives.

So, from the very beginning there was a need for a marketing approach; one where new and innovative ways to address health problems could be used. By working with and influencing the target audience i.e. hospital management board, senior managers, staff, patients and the wider community, we hoped to generate a shared ownership of the overall project.

Generating a shared vision

This part of the process required good communication and diffusion throughout the organisation. The main aims of our marketing plan were therefore:

- to create an understanding of the “product“ (or vision);
- to identify the characteristics of specific target audiences which make up the larger audience;
- to carry out some formative research prior to the implementation of the overall project to determine any strengths, weaknesses, opportunities and even any threats there may be.

Initially, the “product“ was not easily recognisable by the target audiences, after all, “What hospital isn`t health promoting?”, was the usual reply. From this typical response the project team set about generating a shared vision of actively promoting positive health and disregarding, to some extent, the old philosophy that hospitals purely exist for treatment and curative purposes.

Maximising consultation and participation

In marketing terms, maximising consultation and participation required careful analysis to :

- identify and understand the `media` habits of the target groups in the hospital;
- make sure the philosophy reached a significantly large proportion of the hospital population in order to meet the European Project objectives;
- determine the variety of communication channels available;
- determine the complexity, reach and frequency of these channels.

In order to maximise the consultation and participation process it was eventually deemed necessary (and obvious) to create a network of teams with thematic terms of reference.

Identifying potential resistance and barriers to developing a health promoting culture/selecting appropriate change strategies

Consideration had to be given to the ways and means of facilitating a change of culture in a health promoting direction, both at an individual and at an organisational level. Conducting a ‘Forcefield Analysis‘ that identified the driving and restraining forces to the change was considered an essential element in the management of the overall project.

Using the results of this analysis appropriate change strategies were selected in terms of speed of the effort of implementation, the amount of pre planning and the involvement of others in the change process.

At an individual level, the tools of education, communication, participation and support were used to bring about the desired effect. Central to this approach was the “change agent“ role of each member of the overall project team. They aimed to influence individual decisions about the philosophy of the Health Promoting Hospital

in the desired direction. In this way it was possible to influence change in the covert aspects of the organisation, over a moderately short period of time.

However, bringing about change at an organisational level was a far slower process and required determination, good leadership and involvement of key stakeholders within the hospital.

Political approaches necessary to influence the decision making process in the organisation

This was considered to be the final implementation barrier to developing a health promoting culture in our hospital.To these ends an ‘Administrative Diagnosis‘ was carried out at regular intervals to identify where the power of decision making lay and what approaches were necessary to influence the decision making process in our hospital.

The ‘gatekeepers‘ were those officials within our hospital who had powerful interests and could potentially have an obstructive or ‘watering down‘ effect on the project. It was essential that these individuals became early adopters of the philosophy of the Health Promoting Hospital concept.

Concluding remarks

By providing an outline of the six key issues which have guided Prince Philip Hospital toward achieving the objectives of the European Project, the paper presented to the Vienna Conference attempted to demonstrate some sound reasons for adopting a rational planning approach to implementing the project. Understanding power structures and utilising existing management skills were other success criteria.

The Hospital St. Irmingard in Prien/Chiemsee, Germany

Klaus-Diethart Hüllemann

The hospital has joined the HPH-initiative at the first business meeting in Budapest 1991. It was the first German Pilot Hospital and acted as a midwife for other Pilot Hospitals in Germany and the Ustron Pilot Hospital in Poland. The Hospital St.Irmingard has 3 major departments:

- the medical department
- the department of psychosomatic medicine
- the department of early rehabilitation
  - cardiac rehabilitation (myocardial infarction, artificial heart valves, heart transplantations)
  - cancer (all forms, patients with metastasies)

How many days do the patients stay in the hospital?

- Medical department 9 days
- Psychosomatic department 6 weeks
- Early rehabilitation department 3 weeks

The hospital has a close contact to the University of Munich. The teaching activity for medical students covers the whole field of internal medicine, sport medicine, and psychosomatic medicine. The hospital offers postgraduate training for medical doctors, for psychotherapists, and for social workers.

HPH subprojects at St. Irmingard Hospital

Table 1: Agreed upon selection of 11 subprojects

	Cancelled	Finished	Ongoing
1. Energy and pollution commission			x
2. Self-measurement of blood-clotting-time			x
3. Total Quality Management (TQM) Internal and external evaluation			x
4. Doctor-patient-seminars weekend and one-week seminars			x
5. Improvement of health food and prudent diet for patients and staff-members		x	
6. Initiative to improve public acceptance of patients with psychosomatic disorders			x
7. More colours and flowers in the hospital		x	
8a Pre-Project: outpatient heartgroups			
8b Seminars to specialize physical educators for outpatient heartgroups			x
9. Self-management training for patients with hypertensive or metabolic disorders			x
10. Early integration of cancer patients			x
11. Effective communication strategies between doctor and patient	x		

Five of the subprojects can be briefly described as follows:

Patients evaluate their blood clotting time

Training group:	15–20 patients
Location:	Irmingard Seminar-House
Duration:	2 days
Subject:	handling of a new self-test-systems of anticoagulation
Teaching team:	doctor laboratory assistant secretary nutritionist experienced patient
Schedule:	Theoretical lessons about: – physiology of blood-cl. – dangers and complications of anticoagulation – influence of nutrition and drugs on blood clotting – dosage of anticoag. pills – practice in self-evaluation
Evaluation of knowledge:	by questionnaires
Certificate:	Prerequisite for test equipment

Evaluation

External evaluation:
Regular evaluation within the TQM

Internal evaluation:

- questionnaires given to the patients in the seminars (to test for instance whether the doctors language is understandable by the layman, the patient)
- questionnaires given by our administration covering a variety of themes
  - personal well-being
  - diets
  - nurses and doctors aids
  - hospital athmosphere
- questionnaires given to the staff members about the most important issues of our projects „Top Ten“

Reducing prejudice against psychosomatic patients

Aims and objectives	effective medical treatment of
Methods	– continuous qualification ongoing activity of staff members – good team work additional external quality management with other clinics in Bavaria
Responsible persons involved:	5 physicians, 1 psychologist, 4 nurses, 1 physiotherapist 4 non-verbal psychotherapists, 1 social worker
Starting point:	1995 Ongoing activity.

Outpatient Heartgroups

Aims:
- Continuation of physical exercise after early rehabilitation
- On a regular basis (1-2 x per week)
- Under medical supervision
- Guided by specialized physical educators

Objectives:
- Motivation to „do it yourself" health care
- Amelioration of cardial and circulatory capacities
- Train self control (HR) and perception of individual strain limits
- Individual guidance of training process and goals
- Inform about:
  - „Do's and Dont's" of exercise
  - atherogenic risk factors
  - nutrition
  - relaxation techniques
  - drug treatment

Participants:

Patients with various is heart diseases
- Coronary heart disease
  - without / after MI
  - bypass surgery, PTCA
- PM-Pts., after cardiac valve replacement
- Hypertension, after heart surgery (others)

Methods:

Division of patients into 2 groups

„Practice Group"	„Training Group"
low impact (~ 50-70 Watt)	higher impact (> 75 Watt)
physical rating (1 Watt/kg bodywt.)	physical rating > 1 Watt/kg bodywt.
→ Pts. in convalescence phase	→ Pts. in post-convalescence phase
→ Pts. with low LV-Function	→ Pts. with good LY-Function
→ Multi morbid Pts.	

Organization:
- Collaboration with VHS (Community Education Centre)
- 2 Doctors, 3 Coaches of St.Irmingard's Hospital
- Costs paid by insurances and patients.

Seminars to specialize physical educators for outpatient heart groups

Aims:

– to train qualified physical educators
– to create a widespreading net of outpatient heart groups all over Germany
– to promote outpatient cardiac rehabilitation and prevention

Methods:

Two courses, the first course (taking seven days) has the following contents:
– medical and physiological basic elements
– methods and organisational concepts
– practical lessons for exercise- and training-groups
– basic elements of
  → relaxation techniques
  → stress management
  → nutrition
– basics in conversation
– organisational structures
– distribution of demonstration lessons for students

the second course (taking four days) has the following contents:
– exams
– test demonstration of lessons

Evaluation:

At the end of the second course the members get a certificate which allows them to lead an outpatient heart group (or build up a new one)

Responsible persons:

– 3–4 physicians of the hospital of St. Irmingard
– 1–2 psychologists
– physical educators

in cooperation with the association for outpatient cardiac rehabilitation and prevention

Time schedule:

Since 1995 regular training and further education once a year

Early integration of cancer patient

Problem

Cancer as a disease is nearly as dangerous as coronary heart disease. In society cancer patients are often stigmatized and feel stigmatized themselves. „Heart“ – patients do not. It's the hospital's challenge to help the patients: to cope with the physical, psychological and social burden of their illnesses.

Many patients are thrown into a deep crisis of identity and depression. They have lost orientation, are helpless, hopeless without prospects of life. Their working places are in danger and they have difficulties to reintegrate themselves into their families.

Participants: two seniors, one registrar, one psychologist, one social worker, one nurse, two physiotherapists

Methods

I. *Information groups or classes (*to give security and to diminish fear)
- once a week, four different themes
  - Cancer etiology
  - Cancer treatment
  - Physical fitness and well-being
  - Social support or counselling

II. *Skills*
- self-examination-classes for the female breast
- special callisthenics

III. *Personal councelling and information in a therapeutic* session (thirty minutes for each patient, done by a senior physican)
- to help or to support patients with individual and special problems (depression, anxiety, relationship-, workplace-disturbances)
- to demonstrate breast-protheses and discuss breast-reconstruction
- for individual examination and individual medical treatment – counselling
- for individual nutritional advice (e.g. patients with cancer of the intestinal)

IV. *Individual psychological counselling* by a psychologist in an individual session

V. *Individual social support* by a social worker

VI. *Special relaxation techniques*

VII. *Information and training* (medical-, psychological training, personal stress-management) in a daily morning session and in special classes for staff members.

Results

The project is an ongoing activity and part of the routine offer of our hospital. The project gets permanent feed-back with the consequence of development and improvement. Staff members and non cancer patients have less fear to communicate with cancer patients. All got some spiritual gain that life and hope is the „Here and Now“, that creates sometimes a feeling of happiness. The cancer patient's problems (physical, psychological, social) can be solved step by step!

Conclusions

Most activities which were started as a subproject are now part of the routine program of our hospital. One could not say, that the HPH-initiative started a change process in our hospital, but most of our activities got more structured. All activities are run by the regular budget and regular staff members. We can compare this activity with our major Research Project: the Multicenter German Carciovascular Preventive Study, which lasted from 1978 to 1992. This study was sponsered by the German Ministry of Research and Technology. The budget for the field project of St.Irmingard Hospital was 10 Million D-Mark. Up to 15 researchers worked in this project.

When we compare the final results of this research study and our HPH pilot project, we can summarize: extra money and extra staff in the Research Project did not guarantee excellent results and ongoing effects. No extra money and no extra staff in the Pilot HPH-Project had visible ongoing effects for patients, staff members, and the catchment area, and most of all: The Pilot Project was highly motivating.

Becoming healthy –
Lessons from the 230-bed hospital "Alten Eichen"

Wolfgang Mursa, Helmut Hildebrandt

The hospital's way into the project

The first impetus to take part in the pilot project was given to the hospital by the project convocation in the „Messages of the Hamburger Krankenhausgesellschaft" (Hamburg Hospital Association) in autumn 1991. Further information about the aim and contents of the WHO project was given by the Hildebrandt GesundheitsConsult GmbH, an external consulting company. For the directors, a special motivation to take part in the project resulted from the changing situation of the Public Health Service in the Federal Republic of Germany.

- The Diakonie Krankenhaus Alten Eichen was touched more and more by the general negative discussion about the German hospital sector.
- The corporate identity of the hospital is characterised by the classical image of nursing as an expression of active Christian brotherly love. Changes within the company and in the structure of the employees (rising number of non-deaconal personnel) made an examination necessary.

The company investigated the problems in individual talks or group discussions with the managers, the employees' representatives or with employees from all different departments, wards or professional groups. These discussions had three aims: Presentation of the WHO project; questioning of the participants concerning their ideas about the necessity of health promotion; examples for the style of the project and the participation of employees and management in the planning. The employees and managers participating in these talks were also questioned about their ideas and the strong and weak points of Alten Eichen. Most of the problems concerned two related complexes: The quality of one's own work in relation to the health condition of patients and the working atmosphere and the *condition of the employees,* but also with the management quality, the decision-making process, the hectic work, the loss of meetings with colleagues, etc.

In the discussion we noticed that the condition of the employees is directly connected with the improvement of the patients' health. Measures to improve only the health condition of the patients would put even more stress on the employees and are, therfore, bound to fail from the beginning. The main incentives to take part in the project were:

Above all the promotion of health and well-being of the patients by:

- psychological and social support of the recovery process
- quality improvement and control (medical effectiveness)
- arranging of health promotion facilities for the time after the hospital stay

Promotion of the employees' health and well-being by:

- a reduction of the sickness leave numbers and fluctuation
- support of well-being and motivation
- avoiding work – related illness

Health promotion as a part of the corporate identitiy of the hospital by:

- development of a corporate image, definition of goals of the work in the hospital
- it's special deaconal task and improvement of organizational procedures, communication, management and team structures

Phases of the project process

Within the WHO project, an approach had to be found to start programs regarding patients and employees on a parallel basis and, furthermore, to try to solve the structural problems which have so far hindered organizational changes. To make the planned effects measurable and check the measures, from the beginning of the project a large scale accompanying scientific research was initiated, the basis of which was a research to check the starting situation in the selected departements.

The *initial phase* (Nov. 92 to Dec. 93) included the project groups „G – Gesundheitsförderung für Mitarbeiter" (health promotion for employees), „P – Pflegemodell" (care) and „U – Umwelt- und Gesundheitsschutz" (Health & Environment protection).

During the *second phase* (Dec. 93 to Dec. 94), the project groups „A – Arbeitsbedingungen" (working conditions) and „P – Pflegemodell (care) – have taken up results from the initial phase but also worked on the problems raised by other project groups.

The *third phase* started with the establishment of the project groups „E – Ernährung" (nutrition), „K – Gesundheitsförderung für Patienten" (Health promotion for patients).

During these project phases, the WHO project and the structural framework were established and the first positive results of the project work were achieved. The project group participants learned and applied the instruments and methods of organzational development. The WHO project will give new impetus for the further development of the hospital. A new corporate image is the basis of the further success to survive in a growing competetive social market in Germany.

Recommendations to other hospitals

After the pilot phase, we have been looking for key factors to assure the success of the project to recommend them to other hospitals. The philosophy of the „Health promoting hospitals" aims at changes in the organizational process to make the hospital more appropriate for the needs of its customers. Regarding the process of organizational development, the operational goals of the „Health Promoting Hospital" can be compared to those of the Total Quality Management (TQM):

- Quality improvement by enlarging the performance spectrum and promotion of the recovery process
- reduction of the sickness leave numbers, increase of the motivation and reduction of personnel expenses
- organizational development and improvement of the internal communication and
- health promotion as a part of the corporate identity.

To realise these goals, certain key factors have to be observed.

Commitment of the managing directors

In case of a positive decision to apply this model of organizational development, the

whole management must support the philosophy of the „Health Promoting Hospital". Although, the concept of the „Health Promoting Hospital" should not be seen as a project but as a strategy implemented on the highest level. This means that the responsibility and competence for the project cannot be delegated to lower organizational levels, but the hospital managers have to be active promoters of the concept themselves.

Long-term process

The introduction of the philosophy of the „Health Promoting Hospital" has to be understood and accepted as a long-term process. If the opinion is no longer focused on the changing process, the employees tend to get frustrated. On the one hand, the hospital needs a long-term vision and on the other hand the single results and developmental steps have to presented again and again to the employees.

Communication system

The hospital needs an effective management-information system reaching all employees.

Motivation and incentives

In the health service company, financial incentives are not possible as the hospital follows the zero-mistakes-system. The employees have to be motivated differently. An incentive could be through empowerment, i.e. by delegating decisions to the employees and let them participate in the development process.

Satisfied customers

The satisfaction of patients becomes more and more the central competition factor. The hospitals have to start questioning their patients continuously, not only looking for single problems.

Perspectives for the future

Apart from its original goals, the WHO project must respond more and more to the economic situation ot the hospital. The motto is: „ to combine rentability, quality and health promotion!" New project groups or „expert commissions" will follow the motto: lower budgets, shorter time, clearer task structure and more effective application. For 1996 and 1997, we have been planning the following project themes: „Work process and organization", „Cooperation with general practitioners", „Diagnostics & Therapy & Standards". The project group „patients-charta" will be the first to work within this frame.

The possibility for the statutory health insurances to finance such projects has been considerably restricted. The "Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege (BGW)" has in the past actively taken part in the financing of projects for the health promotion for employees and their scientific evaluation.

The WHO pilot project itself will be officially finished by a large meeting and transferred into the next phase. The hospital "Alten Eichen" will continue its activities within the above mentioned framework as a member of the „German network of Health Promoting Hospitals" and try to keep up the positive results and changes reached so far.

Everybody is involved in promoting health

Konrad Schumann, Gunar Baugut

The title defines the vision of the HPH project at the Chemnitz Clinic. In order to make this vision become reality – or better, to approach this vision – it had been a long way and still there will be a lot more of energy needed for the future.

Starting the project under difficult conditions

Chemnitz Clinic in Saxony, Germany, has several specific features. When compared with the German scenery of hospitals, it can be characterized by the following items: 6 locations spread all over the town; 50.000 inhouse-patients; 23 departments, differentiated by specialities and subspecialites; 310 physicians, 1.200 nurses; 3.000 employees and 1.993 hospital beds. This large scale capacities give an impression of the conditions under which the HPH project started.

More important than these problems from the magnitude of scales had been the deep changes since the German unification in 1989: The hospital bed capacity of Chemnitz Clinic had been reduced by 36% within three years (1991–1993). Most of the beds and wards closed had been utilized before as well, causing a lot of internal problems. There were a severe reductions of staff, fundamental changes of functional processes and responsibilities, organizational restructuring of departments and new methods of diagnostic and treatment. In addition, a comprehensive documentation for the nursing process had to be implemented, the nursing process from the former solution divided by functions towards an integrated patient orientation to be restructured, and last not least replacement of the existing medical technology. The last item mentioned had been needed to fulfill the new mandatory legal safety requirements and lots of time and money had to be spent for this purpose in the field of medical technology, and similar in the nonmedical capacities including the buildings and their installation.

You may think that in a time with so many changes it should be easier to implement the innovative HPH-idea. On the contrary, hardly anybody liked to promote additional changes. The political system-change in former Eastern Germany has not at all been supportive to implement the idea of health promotion. At the very beginning there was only a very small group around a hospital manager of nursing, who was willing to think about a future development of the hospital beside and in addition to the normal hospital care.

Using the methods of organisational development, a minority of project supporters started with an analysis of the situation. From there, several activities were defined to be necessary and formulated as tasks for 5 subprojects. The following time had been used to win additional supporters for the HPH project. In the further discussions the tasks and objectives from the beginning proved to be highly ambitious but not realistic enough for the first steps. The following activities were concentrated to redefine the objectives and to derive temporarily attainable targets. Otherwise placing too extensive demands would have tended to discourage rather then encourage further participants.

Lessons learned

One of our successful subproject groups worked in the field of quality assurance concerning nursing. They worked out a set of nursing standards as models of good practice, tested these instruments and implemented it in the hospital. More than 100 nurses had been engaged in elaborating and optimizing a set of nursing standards with 54 elements at the moment. Already the process to generate the standards and, more than this, the way to implement the standards into daily nursing care are steps towards high quality nursing care for the benefit and safety of the patients and for the safety and motivation of the nurses. In another subproject we do not want to conceal the fact that we made quite severe mistakes. Within the subproject on patient information, those who had been active at the beginning did not want to cooperate any longer. The mistake made was simple but severe. The head of the medical department responsible for the information and instruction of patients in the important field of chronic diseases did not feel to take a leading role in this development. He got the impression that his work would be transferred out of his former central responsibility. He communicated his feelings very strong and a gap separated this opinion leader from the other members of the project group. The gap could not be overcome, though there had been several attempts. The very important issue of instructions for patients, so that they can develop a positive lifestyle even with a chronic illness, will need an innovative second project approach to find a successful strategy.

High recognition and visibility could be reached with a project that optimizes the interrelations between the Chemnitz Clinic and the children in the community. The aim of this project is that the hospital does not want to be looked at as a „frightening ominous something“, but wants to be looked at as an integrative part of the community. The best approach seemed to be the concentration on the children in the region, following the strategy of health education to start to influence behaviour and lifestyles as early as possible. We try to address the interest of the children, satisfy their curiosity and build up an relationship of confidence. The success within this project would not have been possible without the engagement of the hospital staff and particularly the teachers at school as co-operative partners in this HPH project.

Another project is on quality management and tries to improve environmental protection. It is very impressive to learn from the figures about the reduction of the overuse of desinfectants about the success in this field. The tasks performed within this project group convinced the management and the stakeholders of the Chemnitz Clinic to contribute to these efforts. An environmental commission had been established in 1995 and a department for hospital hygiene and environmental medicine had been set up in 1997. These organizational efforts will help stabilizing the success of the former HPH project group. It seems to us a good example for transferring the HPH project work into the everyday work of the hospital, developing towards a Health Promoting Hospital together with the partners in the surrounding community.

From our experiences at the Chemnitz Clinic we leamed that it is not worthwhile to wait until the prerequisites in the environment of costs and politics are favourable. Even in a period, where discussions in the health sector in germany are dominated by costs instead of impacts on health, our project activities helped our patients and staff to reorientate hospital activities towards health promotion.

The Areteion Health Promoting Hospital Project (AHPH) – Overview of a four year experience

Nick Arkadopoulos, Kiki Tsamandouraki, Yannis Tountas

Areteion is a 100 year old, inner city University Hospital, which has always functioned as a tertiary care institution with a highly academic tradition. Areteion is owned and managed by the University of Athens. The Hospital provides services mainly to the population of the greater Athens area (approx. 4,000,000). However, because of its reputation, the Hospital is a referral center for the whole southern part of Greece. In the last decade, there has been a steady increase in the number of both inpatients and outpatients each year. In 1995 alone, 4,247 inpatients and 10,301 outpatients were treated in Areteion, resulting in an average utilization of beds of 68%. Total number of staff is 494 (medical, 120; nursing, 142; administrative and technical 232). There are only five clinical departments in Areteion: general surgery (105 beds), obstetrics & gynecology (95 beds), neonatal unit (30 beds), nephrology unit (10 beds) and radiology-radiotherapy unit (10 beds). These departments are supported by a variety of laboratories and technical services. Main functions of Areteion also include teaching (medical students, postgraduate medical education, nursing education) and research (basic and clinical). Before joining the European Network of Health Promoting Hospitals in 1993, Areteion had a very weak background in health promotion. Apart from the organized implementation of two outpatient programs for the secondary prevention of breast and cervical cancer, health promotion was otherwise left to the empirical approaches of physicians and nurses.

Initiation of the AHPH project was due to the efforts of a group of health promotion specialists and members of the Hospital administration who envisioned the modernization of the Hospital's profile through incorporation of the health promotion philosophy. In addition, joining a prestigious European project was seen as a means of improving the international relations of the Hospital and gaining access to the valuable experience of other countries on issues of both health promotion and hospital management in general. In May 1993, an eight-member steering committee was formed and a project coordinator was appointed. Five initial subprojects on health promotion were successfully launched:

- Hygiene and safety in the Hospital,
- Control of nosocomial infections,
- Training of young mothers on issues of perinatal care and breast feeding,
- Study of patient satisfaction and
- Development of a quality control program in the surgical department.

Later on four more subprojects were initiated:

- Early diagnosis of neonatal hearing loss and prevention of mutism
- Rational use of antibiotics through the link to a national database
- Total quality management in the nephrology department and
- Study of health level in the hospital community.

All subprojects shared a common structure which included a benchmark – questionnaire based study for evaluation of pre-existing conditions in a specific area of health promotion, an implementation phase and a transition phase aiming at the incorporation of the subproject in the daily Hospital routines. All subprojects included standardized documentation and evaluation procedures. The whole AHPH project was carried out in close collaboration with the Institute of Social and Preventive Medicine (ISPM), an external non-profit organization with expertise on health promotion. ISPM provided consultation in every step of the AHPH project and organized the initial phase of the Greek health promoting hospitals' network development.

Seven of the subprojects are currently in various stages of realization and/or evaluation whereas two subprojects were canceled after an unsuccessful pilot period. The two principal difficulties encountered during realization of the AHPH project were: (a) lack of previous health promotion experience and training and, (b) staff shortage and financial problems. Absence of health promotion background proved to be a limiting factor during the initial stages of the project development, when the innovative concept of health promotion had to be introduced to the Hospital community. Staff motivation was achieved through three strategies: (a) development of subprojects that aimed at promoting safety in the workplace and staff wellbeing (b) development of internal communication of the project (e. g. meetings, newsletters, etc) and (c) combination of the project implementation with research opportunities for Hospital physicians.

Nine percent of the Hospital staff actively participated in project groups, while another 30% got involved at some point of the subprojects' evolution. Despite occasional contributions from private sponsors, underfinancing persisted through the project duration and caused serious delays and deviations from the initial planning. Financial problems were partially relieved through the offer of a significant amount of voluntary work by the Hospital staff and medical students (average = 3777 hours/year).

Although the impact of the AHPH can not be fully appreciated before data from evaluation studies are analyzed, there are several preliminary observations on the success of the project:

(a) Important organizational experiences were gained through the development of the AHPH project. The concept of teamwork was strengthened and staff motivation strategies were tested. In addition, the small size of Areteion enhanced flexibility and fast decision making and facilitated the testing of new ideas during the project development.

(b) Specific changes, related to the successful implementation of the various subprojects, were made. For example, improvements in the safety of the workplace and new measures for the control of nosocomial infections were the direct result of two AHPH subprojects.

(c) Most important, awareness on health promotion issues increased among the Hospital community and a health promotion culture started to develop in people previously not concerned about health promotion.

Buzzi Hospital Experiences – Towards a Health Promoting Hospital

Francesco Ceratti

The reform of the health system in Italy: main innovations

In January 1995, a reform of the Italian National Health System was set in place, with the overall objective of making certain that expenditure commitments at the various institutional levels were respected, while ensuring equity of assistance to the population. To this effect, the law provides for the decentralisation of tasks and responsibilities to those more directly involved in the processes of expenditure and services management. Responsibility for health expenditure control and social and health planning has thus been devolved to the Regions, while the Local Health Units and the hospitals are responsible for the efficiency of the management of services. We may speak of the 'regionalization' of the health system, since the reform gives greater responsibilities as well as new tasks to the Regions: they are accountable, at a political level, for the carrying out of the services for their own population, and have to provide from their own resources for expenditure actually incurred.

The second outcome of the law is that the Local Health Units and hospitals, previously accountable to the Regions and operating on behalf of the Municipalities, now have legal status and are self-governing concerns within the Region. They are independent in organisation, administration, finance, accounting, assets, operation and technical aspects.

It must be pointed out that the law draws attention to the 'accounting equation' or 'economical and efficient management'. In short, the law emphasises efficiency and respect for the limits of resources, as well as the great importance of a sound investment planning and resource monitoring by Regions, Local Health Units and hospitals.

Buzzi hospital functions

In this context, and in the light of the process still in progress, of the fundamental changes in laws and organisation concerning the National Health System, in 1992 the Buzzi Hospital in Milan began its involvement in the Health Promoting Hospital Project. This was a consequence of the collaboration between the Buzzi Hospital and the Healthy Cities Project of Milan, based on the firm belief that the Buzzi Hospital, because of its traditional paediatric vocation, could represent a focal point in experimental initiatives in health promotion.

The Buzzi Hospital had been established towards the end of last century as a Children's Hospital. The Hospital building was enlarged at the beginning of the current century and the Hospital's competence in the field of child care continued to increase.

In 1972, a new large building, with wards for obstetrics, the new-born and neonatological pathology was opened. Later, provision was made for general surgery and general medicine for adult patients.

Since July 1992, the Hospital has been within Milan Local Health 75/VI, and integrated with other local regional services such as the services of GPs and paediatrici-

ans, family and paediatric consultant centres, and the like. It has been possible to develop integrated projects to implement a network of health care services.

From the point of view of the functions performed in the Hospital, we may divide activity into three main fields:

1. Obstetrics and neonatology with a relevant activity in obstetric prophylaxis, neonatological intensive care and rooming-in for healthy new-born;
2. Paediatric services for emergency, outpatients and surgery;
3. A sector concerned with adult care, general surgery and general medicine departments which have significant outpatient activity.

The subprojects

Following discussion with the management staff about the opportunity of joining the HPH project, the Third Business Meeting of Health Promoting Hospitals in Milan was organised in April 1992. Subsequently, the following six subprojects were developed:

a. *Survey of relationships in the hospital*
   This project has the aim of humanising care in the Hospital by improving communication relationships among the care providers of the various departments, and between them and their patients and patients' families.
b. *The psychological impact of hospitalization on children*
   This project has the aim of limiting the psychological impact of hospitalisation on children and their families.
c. *The early discharge from hospital of puerpera and newborn*
   This project has the aim of improving the relationship between and psycho-affective development of the mother and the new-born, while ensuring protected labour, delivery and childbirth.
d. *The family risk of premature atherosclerosis*
   This project has the aim of reducing the level of risk factors in teenagers and young adults at high risk of coronary artery disease.
e. *Postmenopausal osteoporosis*
   This project has the aim of promoting awareness and knowledge of osteoporosis, of its related complications, of prevention and therapy with a view to reducing the incidence of fractures among elderly women.
f. *The surveillance of operating theatre staff*
   This project has the aim of improving the hygiene environment and working conditions in the various operating theatres of the Hospital.

The expectations

In addition to the specific aims and objectives set for each subproject, the overall expectations arising from the participation in the HPH Project included the introduction of a behavioural and cultural change in the care providers of the Buzzi Hospital, so that health promotion should become the central element in all professional decisions and activities.

Such an attitude was expected also to be reflected in the management of the clinical issues faced daily in the hospital, as well as in the handling of the specific professional risks faced by all care providers within the hospital.

From 1992 to date, Buzzi Hospital has undergone three institutional changes as a result of modifications of regional and national legislation. Each of the three changes has involved the replacement of the general director and of some of the functions of the other directors. The development of the project has thus been hampered, since on every occasion the project had to be discussed anew in order to obtain political approval and the financial support.

In addition, each new director made some changes in the overall objectives of the project, giving more or less emphasis to the visibility of the overall project as compared with the development of individual subprojects, and, consequently, changing budget allocations.

Overall project and subproject development

Following the guidance of the Budapest Declaration, an overall organisational structure of the project was established, including the identification of a Project Co-ordination Committee, a Project Manager and an External Institution for evaluation and organisational consultation.

This organisational structure could not operate without interruption, because of the institutional changes already mentioned. In fact, the Project Manager remained in charge, as well as the External Institution, represented by a private company; but the Project Co-ordination Committee, including the Director General of the Hospital and representatives from the Municipality of Milan, could, owing to the institutional changes, be convened only a few times.

Each subproject identified its Project Leader and Vice Project Leader as well as its aims and objectives. Positive results were obtained by those subprojects which had precise objectives and firm funding. On the other hand, subprojects with no such prerequisites had difficulty with continuity of action and in obtaining positive results.

Funding

Despite changes in its management staff, the Hospital Administration continued to grant direct funding of the overall structure of the HPH project for the following:

- the working time of the care providers involved in the overall project and in the subprojects;
- all expenses incurred for organising the Third Business Meeting in Milan and another international meeting on health promotion in the Hospital;
- all expenses incurred for participation in Business Meetings and International Conferences;
- payment of the external company for consultation and evaluation.

Funding for each single subproject was reimbursed through different sectors:

- regional funds providing specifically for innovative research projects;

- funds assigned for work contracts and by the Region for training of personnel;
- through funds made available from pharmaceutical industries for those subprojects having objectives and impacts of a clinical character.

Results

The results that have emerged after five years of experience in Buzzi Hospital, as a Pilot Hospital in health promotion, are the following:

1. There has been a reported increase in cultural awareness related to health promotion issues and in the approach to clinical problems. This increase, however, relates only to the individual professionals (the Project Leaders) or groups of professionals involved in the development of the various subprojects. The expected overall involvement of all the care providers in the Hospital, with the consequent changes in all the structures and the teams operating in the Hospital, was not reported.
2. The experience of the HPH has compelled the management staff of the overall project and the project leaders to acquire the capacity to plan initiatives, unusual in the Hospital environment, and to evaluate them without reference to clinical criteria. Within this planning capability, an effort has been made to find funding for the single subprojects.
3. It has been important to understand the necessity for collaboration between members of various health care structures, especially among health care providers in the hospitals, who often carry out their functions autonomously, forgetting the need for continuity in the care of temporarily hospitalised patients.
4. Subprojects which had well defined objectives and assured funding have brought about operational changes that have become behavioural routine in the Hospital's activities. Such a result was obtained in the subprojects 'The early discharge from hospital of puerpera and new-born' and of 'The surveillance of operating theatre staff'.
5. Some results, such as those obtained in the above-mentioned subprojects, have been transferred as operational methods to other hospitals in the city of Milan, being adopted as standardised behaviour in these organisations also.
6. Building on the links with those hospitals which incorporated the results of the subprojects, and on the basis of this initial networking experience, it was decided to promote, in 1997, an initiative for the involvement of other public and private hospitals in the Lombardia Region, in order to establish a Regional Network.

The overall project of Vaugirard Hospital

Anne Laurence Le Faou, Lucile Mercier, Dominique Jolly

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of 50 public hospitals which provides care to the metropolitan area of Paris with 30,000 beds and 85,000 employees. The health care services of AP-HP tend to emphasize high technology rather than preventive care. Vaugirard, a geriatric hospital, located in the 15th district of Paris, is a pilot hospital in the WHO-Health Promoting Hospital programme because the board managers have wanted to become a model of good practice in geriatric care.

The first five starting projects

To reach this goal, five sub-projects were conducted between 1993 and 1997:

- a gerontologic network between the health professionals of the 15th district and the hospital staff;
- an information system between the professionals of the district and the hospital staff;
- a programme to improve staff working conditions;
- a partnership between the volunteer associations and Vaugirard Hospital;
- a new concept of the life of elderly people in the hospital.

The Vaugirard hospital was one of the geriatric pilot hospitals responsible for improving the geriatric care in the federation of AP-HP hospitals. The Division of International Affairs of AP-HP decided to encourage Vaugirard Hospital to participate in the programme in order to benefit from health promotion experiments of foreign countries. In addition, this agreement gave the opportunity to the Vaugirard board managers to promote their activities in the network. It appears that due to the Health Promoting Hospital programme, the Vaugirard Hospital team was encouraged to manage projects and conduct evaluations to justify medical activities, thus qualifying for additional budget. Although obtaining funds was a real incentive in the health expenditures control context, the results of the projects' evaluations were of great interest for the medical team. In fact, these results gave the opportunity to hospital organisation reforms, particularly in order to improve the relationships between Vaugirard Hospital and the health and social professionals of the 15th disctrict of Paris.

Implementation of six new follow-up projects

Prescription guidelines for the elderly

This quality of care programme was implemented by the Vaugirard Hospital pharmacist. Each new group of residents is tested when they join the staff in order to evaluate their prescription capabilities. Then, training sessions are organised by the pharmacist for all of the residents regardless of the results of the examination. The main topics concern antibiotics, pain relievers, antidepressants, hypnotic drugs, anti-inflammatory drugs and especially the interaction between medications.

Promotion of nursing for elderly people

In France, there is no nurse specialty in geriatrics. In addition, geriatric courses in nursing schools are not well developed. The Vaugirard Hospital team has decided to

become involved in a geriatric training programme in the AP-HP nursing school of the 15th district of Paris. Furthermore, in 1997, the Vaugirard Hospital medical team published a book dealing with nursing care in geriatrics.

Prevention of hospital-acquired infections

Vaugirard Hospital is participating in an AP-HP programme to reduce the number of hospital infections. A hospital committee is in charge of defining the rules to prevent these diseases.

Staff exchange programme

After years of trying to implement a gerontologic network, the bord managers have gone a step further by setting up a staff exchange programme for the nurses. The nurses of the 15th district involved in home health care work in Vaugirard Hospital while their counterparts visit patients at home. This programme makes it possible for the staff and the nurses of the district to become aware of the working conditions of each other while re-enforcing the coordination between the Vaugirard Hospital staff and the health care professionals of the district.

Vaugirard Hospital beyond its walls

Vaugirard Hospital was a new experiment of a geriatric hospital inside Paris. In fact, most of the geriatric hospitals are in the country, thus limiting family visits and participation in the everyday life of the surrounding area. As a result, AP-HP is converting acute care hospitals located within the city of Paris into long term care hospitals. Some of these hospitals will be renovated and redesigned with elderly people in mind whereas one hospital, Bretonneau Hospital has been torn down to be rebuilt using foreign experiments and the Vaugirard pilot program as models. Taking into consideration the increasing needs, Vaugirard Hospital board managers have decided to provide services outside the hospital. A ground floor appartment will be leased to accomodate a group of dependent elderly persons in order to allow them to stay in their district while being followed up by the hospital team.

Quality assurance programmes

A quality assurance manager was hired in Vaugirard Hospital to set up, implement and evaluate quality programmes. These programmes concern for example the flextime organisation while enforcing actual work time, the quality services of the catering team and the efficiency of managers. These new subprojects illustrate the fact that a health promotion culture is being developed in Vaugirard Hospital.

Conclusions

Without the active participation of the staff at every level, the objectives of the WHO programme could never have been reached and Vaugirard Hospital would not be the model hospital as it is today. The external institution (the Institute for Health Policy Studies of the Broussais Hôtel-Dieu school of Medicine) helped Vaugirard Hospital to organise the surveys, draft and prepare for the conferences. This work was very effective to check up on the different stages of the projects. This cooperation between Vaugirard Hospital and a university team was quite new for a geriatric hospital, thus demonstrating that health promotion projects are making headway in France. The next step is the implementation of a French HPH network.

Experiences of Padova Hospital Trust as a Health Promoting Pilot Hospital

Giorgia Marcato, Massimo Castoro, Roberto Gnesotto, Adriano Marcolongo, Margherita Boschetto

Provision of hospital care, basic and continuing education and research constitute the institution's mission. Padua's Hospital and University Medical Centre has 2454 beds, 60 wards of which 24 of surgery, 28 of medicine and 8 of maternal and child health. There are also 118 ambulatory services and 5 Emercency Care units, of which 1 medical and surgical and 4 specialties (OB-GYN, paediatrics, ENT and ophtalmology). The infrastructure is made up of 16 buildings, distributed on a surface of 180,000 square metres. The organization delivers complex services such as organ transplantation, PTCA, intensive care and radiotherapy. Also several complex procedures are provided including MRI (2 equipments), CT scan (4) and SPECT. During 1996 admissions were about 90,961 and days of stay were 655,638. At present there are 11 Day Hospital services; 40 more will be established by the end of 1997. Staff includes 918 MD's, of whom 546 are hospital employees and 372 are university physicians, 2384 nurses, 448 ancillary personnel and 352 technicians.

Padova's Hospital joined the project as European Pilot Hospital for two basic reasons. First, because the City of Padova participates in the Healthy Cities Programme which represents the first applied effort towards a new public health model. Secondly, since 1987 the Hospital of Padova is a member of the Network of Hospitals that co-operates with the WHO Hospital Program. Since May 1992 the Project Committee has planned and implemented the following 5 sub-projects:

- A Smoke Free Hospital
- Occupational Risk for Health Workers
- Changing Demand of an Aging Population
- Birth's Quality Improvement
- Nutrition and Health

A Smoke Free Hospital

This project is also an important step towards an action, in which the hospital and field health services, the "Healthy City" project of the city of Padova, schools and others collaborate to impact Community Health.

Patient oriented activities

Counseling activities will begin in three services (Cardiology, Pneumology, Pneumotisiology) after training of nurses. The activity will be organized on the basis of the approach formulated in a manual called 'How to help patients to quit smoking". Hospital's strategic apex (made up of General Director, Medical Director and Administrative Director) has adopted a new strategy following the approval of the new national contract of nurses. Such strategy is called "project-objectives". Its main tenets is the introduction of management by objectives strictly linked to individual assess-

ment and financial incentives. This approach has helped creating a positive attitude towards projects, objectives negotiation and achievement of measurable results.

Staff-oriented activities

Counseling will begin for all hospital workers. To this end a short course will be organized involving Preventive Medicine Service's MD's and nurses designed on the basis of a manual specifically produced for them.

Community oriented activities

A new anti-smoking bill has been passed in December 1995. It establishes that smoking is forbidden in all public buildings and therefore in all hospitals. All signs must include the sentence "No smoking" and the name of the person responsible for the implementation of the norm. Consequently, signs concerning smoking have been updated. Following the new law, a hospital's regulation has been approved. Smoking is prohibited in all areas, including means of transportation and no space is available for smokers. Heads of wards are responsible for the implementation of the norm. Soon after the new signs will be exibited, an assessment of the impact on patients, visitors and personnel will be carried out.

Occupational Risk for Health Workers

Monitoring of accidental exposures among personnel has become a routine activity during the last ten years. Data show a substantial reduction in the frequency of exposures followed by a steady incidence during the last three years.

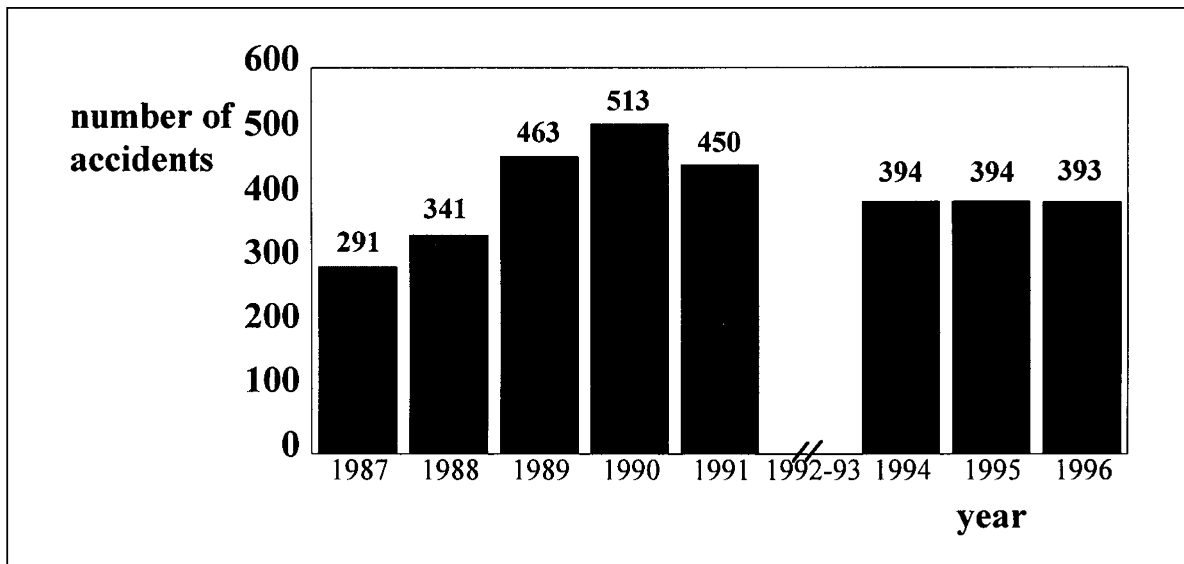

Figure 1: Accidents by year in Padova Teaching Hospital (1987–1996)

Preventive measures have been applied especially regarding needle-sticks which represented the most important type of accidents. A device allowing blood collection under vacuum directly into test tubes, therefore avoiding the use of syringes, has been adopted by all services in 1994. A mid-term evaluation has shown a decrease of this kind of accidents by 11.5% in 1995 and 16% in 1996, relatively to 1994. During the last three years, such reduction has occurred particularly in patients' rooms, but in-

creased in operating theaters. The latter might be explained by a better reporting of accidents following the increased awareness among personnel. Training courses are about to be completed. An evaluation will be conducted soon after looking at personnel compliance. The form used to collect data on accidents is under review and will include the time of exposure.

Towards the end of 1994 a new law was passed concerning workers safety. The bill accepts the principles of the Ottawa Charter which aims to enable workers to promote their health status offering a healthy physical and social environment and providing the means to exploit these opportunities. At present, this project focuses its attention on control of risk infections and will soon deal with other professional risks such as anaesthetic gases, antiblastic drugs, heavy use of computers and carrying of heavy weights.

Changing Demand of an Aging Population

Unfortunately, after the health reform of 1995, the Geriatric Hospital has been separated from the Teaching Hospital and, consequentely, the project concerning elderly patients in the latter structure has started from scratch. Our hospital has no geriatric ward, with the exception of a surgical unit, nevertheless a high proportion of patients is aged.

Objectives of the project "Bed sores"

- To measure size and caracteristics of pressure sores by a survey of prevalence and approaches to prevention and care
- To formulate and implement guidelines about pressure sores' prevention and treatment through multidisciplinary working groups
- To rise awareness about the importance of the problem among health personnel
- To assess adherence to established guidelines.

By now we have completed a prevalence survey among 49 wards and guidelines for the prevention and treatment have been introduced in some wards. Main data showed that general prevalence rate was 3.5% (51/1459) and among risk patients (defined on the basis of Norton classification) was 21.2% (51/241). These percentages are substantially similar to those reported by the literature. Only 6.1% of wards had designed and applied guidelines, whereas 45% of wards had not developed any guidelines. At present we are setting up working groups to prepare common guidelines.

Falls during hospital stay

Our hospital has conducted a retrospective survey concerning falls occurred during 1995 and 1996. During the latter year 366 falls have been reported out of 91.000 admissions, of which 216 among patients over 65 years (59%). Falls occur mainly at night: 34% between 1.00 a.m. and 7.00 a.m. and 24% between 7.00 p.m. and 1.00 a. m. Our investigation will also study other circumstances correlated with the fall, i. e. diseases suffered by the patient, drug therapy and change of posture. Finally we are creating a group with the task of increasing awareness and understanding among personnel regarding their roles about surveillance and careful application of safety measures especially for elderly patients during night shifts.

Nutrition and Health

This project has been slowed down by the National Health Service's reform, given that key people have left their positions and those who remained have committed themselves insufficiently because of their limited ownership in the project. Nevertheless a new team has developed through a new collaboration with the Nutrition and Diet Service and Hygiene Institute both belonging to the University. The general objectives are to improve quality of food service for in-patients, to assure a quantitatively and qualitatively balanced diet to patients, to improve patients' satisfaction and to modify food habits related to chronic diseases among patients and personnel.

The target population includes all patients in particular in-patients affected by chronic diseases or exposed to risk factors and age groups such as newborns, children and elderly; hospital personnel and family members of patients. Actions carried out are:

- to assure the possibility to choose from a menu adapted to specific diseases
- to set up a food surveillance system
- to assure the appropriate preparation and conservation of food (system HACCP)
- to perform a survey among patients
- to develop a food counseling service for patients, personnel and family members
- to design and distribute leaflets concerning diet

Birth's Quality Improvement

Among the five ongoing projects, this is the one which has suffered most from delays, being still at the first phase of the three planned:

- Detailed knowledge of the quality of care at childbirth in the Hospital and University Medical Centre, including technical and psychological aspects.
- Comparison of results with WHO recommendations and international literature
- Organization and implementation of health promoting actions

A survey has been conducted through a questionnaire given to mothers of newborns before discharge with the aim to assess quality of care as perceived by them. We are now conducting a study on clinical documentation, i.e. medical records and birth care certificates. Diverse professionals (MDs, psycologists and nurses) conducting the training of pregnant mothers have been involved with the aim to better inform this group about necessary investigations during a normal pregnancy, indications to delivery induction and anaesthesia during delivery and Cesarean section.

In order to complete these five subprojects, we asked to renew for another two years our contract as a HPH Pilot Hospital. Finally our hospital has been introduced in Internet giving general information about the hospital, our service Chart, description of Padova's Hospital experience as a HPH pilot hospital and news about the recently established HPH Veneto Region network (http: //www.padovanet.it).

Part 8

Methodological and Technical Aspects of Health Promoting Hospitals

Introduction

Dominique Jolly

Methodological and technical aspects of Health Promoting Hospitals have interested a lot of participants. I would like to stress that it is very hard to convince hospital managers, physicians and politicians that hospitals have to be not only a place dedicated to curative care, but also to promoting health care, education and hygiene. We will only succeed if we can show the efficiency and effectiveness of our projects, as well as the evaluation of the results of our work (done with scientific methodology). Otherwise, physicians, managers and politicians will keep on believing that HPH is a very good idea but not a serious one.

The various sessions on this topic showed that more and more projects are evaluated, with indicators chosen at the beginning of the project, as was demonstrated in projects from Germany, the United Kingdom, Austria, Lithuania and Italy. Quality assurance and patient satisfaction, though they are indeed part of Health Promotion in hospitals, cannot summarize the HPH's idea. It is obvious that the major target for the Western European countries (for politicians, administrators and managers) is to succeed in reducing health expenditures.

If we manage to show the efficiency of Health Promotion initiatives in hospitals, HPH could become one of the corner stones of managed care in Europe. This was the major idea that emerged, as costs have to be reduced and quality of care increased at the same time.

Health promotion and the rise of "Managed Care" in Europe

Helmut Hildebrandt

A great variety of healthcare organization forms are to be found in Europe but common pressures exist onto the health sector towards cost cutting in every European country. What are the problems? Global competition leads countries and industry to minimize the side-costs of labour and the ageing of the population is overlapping with a chronification of many diseases, which is up to now not sufficiently treated. New technology and innovation in health care most often result in higher costs and people get informed about the possibilities of better health care and do not accept substandard care.

Health Care is still organized in a manufacture style work and lacks an integrated approach = health process reengineering. Focusing on the organization of health care, sectorisation of health care is ineffective and inefficient but total integration as well (e. g. UK NHS). The challenge is a new balance of integrated organization of health care that is dynamic and uses the market forces to drive down costs and work efficiently.

Focusing on the financial organization of health care, sickness funds (in countries with social insurance systems) and health authorities (in countries with national health systems) have often served as passive payers for services. New health care reforms in this respect are heading towards:

(a) Purchaser-provider split being undertaken in several countries (UK, Sweden, France, Denmark, NL, Spain)

(b) Budget-allocation on macro and sometimes micro level leading to capitation systems (Germany, Switzerland, UK, NL)

These developments can be seen as first steps towards an European form of the American Managed Care. That means managing healthcare delivery through the purchasers of healthcare by direct contractual agreements with providers and thorough assessment of the appropiateness of care prior to its provision. Mainly in conjunction with a payment system based on capitation and new forms of integration of health care delivery linking the different sectors (clinical and outpatient services, home nursing, rehabilitation). Translated into business words the process towards managed care could be seen as 'health care process reengineering'.

Differing from the American perspective, a European kind of managed care rises within the debates on health care reforms on national and international level. Cooper&Lybrand defined this European view on managed care as: „A process to maximize the health gain of a community within limited resources, by monitoring on a case-by-case basis to ensure that they are continuously improved to meet national targets for health and individual health needs". They argued that this definition differs from the US perspective in:

- community health gain as the starting point for the management of healthcare delivery

- the integration of the three levels of national health policy, community based management and individual patient care management
- disease management across all sectors of healthcare provision

What relevance has managed care in the European and/or American perspective to health promotion? Or let us put the question first the other way around: What are the barriers to more health promotion today – focusing on our issue of health promotion by and in hospitals? First we have to define health promotion. Our definition is: „Health promotion by and in hospitals means substitution of high-cost and hi-tech 'end-of-the-pipe' treatment by early intervention into the disease development process based mainly on a positive resource oriented strategy that supports the salutogenic potentials of the patient and his/her social, physical and working environment.

The same idea is being applied to the workers within the hospital as well as to the patients, so the hospital develops a health promoting setting." Certainly this definition is more a vision then a precise description of the standard of todays Health Promoting Hospital work. The beginning of health promotion often resembles more the adding of new services instead the substitution of high-cost and hi-tech services. But in the long run new services will not stay alive if they are not able to prove their substitutive potentials. The new health care reform in Germany just proved this by cutting additional health promotion services back.

What are the barriers to more health promotion today? One is complexity: Thinking in terms of early intervention instead of intervention after the problem occured is always a lot more difficult and challenging than the other way around. Another one is knowhow: Health Promotion and Salutogenesis are concepts that are being developed within the last fifteen years. Thorough evaluation still lacks quite often. A lot of knowhow is still to be developed. Finally the payment system: Who pays for more health gain and for better quality of services? What are the reimbursements hospital get if they have successful intervened? Or don't hospitals even lose money if they successfully implement health promotion? What are the financial incentives? What is the best arena for early intervention, so that patients don't develop a condition where they need high-cost and hi-tech services? In a fragmented health system where all kind of care is delivered by other institutions, from general practitioner to rehabilitation and chronic care hospital, health promotion tends to fall into the gaps between these institutions.

What are the advantages for Health Promotion through Managed Care?

(a) A capitation system that pays per capita for those insured and inscribed allows and even enforces that the providers look where and by which intervention they are getting the most health gain for there invested money. Effective substitutive health promotion in this sense will be strengthened and developed.

(b) Managed Care can be translated with health process reengineering as mentioned above. One of the core activities will be a better understanding and linkage of the disease process. Many authors argue for a disease management as a central part of managed care. The fragmented organisation of healthcare today will be history within the next twenty years. Health promotion then will be fostered by the providers of integrated health care delivery services. It is in their own financial interest to invest at the point where they get the best value for the least cost.

(c) Managed Care leads to standards and guidelines for therapeutical interventions. It will be a challenge to health promotion how the development of guidelines can be used to include health promoting aspects (e.g. raising health and coping competencies) into the standard care.

What are the problems for Health Promotion through Managed Care?

(a) Health Promotion today often has a friendly image of caring and missionising (the latter is sometimes less liked, what is understandable). Health Promotion in the times of Managed Care has to prove its effectiveness and effiency. If certain methodologies cannot prove their value they will be abandoned.

(b) In the time of transition from the actual health care system to a system including elements of managed care some turmoil will occur that makes it difficult to set a clear direction and to develop on a step-to-step base the knowhow of health promotion.

(c) Managed Care goes together with an economisation of healthcare. Many doctors, nurses and owners of hospitals fear that this process will lead to a medicalisation of health care and will throw people out of healthcare access that cannot pay and will jeopardize the quality of health services. It is of vital interest to all europeans that qualified certification policies, specific consumers information and good epidemiological and health economical instruments will be developed by national and international authorities that this process will not happen.

Our result: The rising of an European kind of managed care is a chance and a challenge to health promotion. It won't be an easy way but it is promising enough that we should carefully examine how we could relate to these developments in a professionally manner. Some concepts and steps forward we share at the moment with hospitals in Germany and Switzerland, building upon the experiences in the US and in the health promotion and hospital consulting work we have conducted during the last fifteen years.

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Evaluation: Labonte Style

Eunice Taylor

Ronald Labonte is a leading Canadian expert in 'state of the art' approaches to the development of health promotion practice and the bench marking of its effectiveness. This paper describes the collaborative piloting of his **story dialogue method** as a means of evaluating the Health Promoting Hospital Pilot Project at the Royal Preston Hospital, England.

Table 1: The Story Dialogue Process

1. Story telling
2. Structured dialogue
3. Identification of insights
4. Process repeated with other stories
5. Development of general themes

The method is essentially a qualitative technique built around the age old practice of story telling. It is , however, highly structured and uses the stories as 'triggers' to raise probing questions about what had been done, why it was done, what it accomplished and what lessons could be learned. A small group of practitioners are brought together to examine a general theme. The reflective practitioner tells the story and through structured dialogue, with each member having a defined role, the story is rigorously analysed. A written record of 'insights' into practice is developed. By repeating this process with other group members it is possible to tease out general themes. Labonte suggests that the methodology has the rigour and validity to match traditional quantitative techniques.

In January 1997, after the evaluator attended a 2 day workshop ran by Labonte in the UK, the sub-project managers prepared their project stories and the group arranged a series of afternoon workshops. On each occasion one story was told briefly followed by a series of structured questions from the other members of the group. Each member of the group took responsibility for asking one of four categories of questions: what; why; so what; now what. This formed the basis of an interactive brainstorming session aimed at uncovering the hidden complexity of the project. Participants reported that this detailed 'examination' by group members uncovered many issues and detail that had not been formally recorded or sometimes not even considered in the past. Table 1 illustrates examples of typical questions.

The next stage in the method required the group to develop a record of lessons which had been learned from the sub-project. Short statements or 'insights ' were written onto separate sheets of paper (insight cards). Further workshops were conducted until all the sub-project stories were told. The 'insight cards' were then displayed together and sorted into general themes. At a glance it was seen that there was genera-

Table 2: Question Categories

What questions: *to create a full description of the story*
e. g. What were the initial aims?
What were the problems and successes?
How were decisions made?

Why questions: *to explain all aspects of the story*
e. g. Why did you choose the project?
Why did you think it would promote health?
Why did it take so long?

So What questions: *to synthesise the information*
e. g. What have we learnt about practice?
How has the organisation changed through the process?
What were the unexpected spin-offs?

Now What questions: *to plan for the future*
e. g. What will we do differently next time?
What will be our next set of actions
How can our power to act more effectively be increased?

lisability amongst the sub-projects despite their widely differing contexts. Thus, a series of recommendations for other hospitals emerged which were (1) firmly grounded in practice and (2) widely applicable. Some of the key issues are briefly illustrated below.

- **Needs assessment** was identified as a crucial stage in the project planning process but one which could be neglected in the haste to ' get started'. Participants reflected that the greater the time spent at this stage (varying from a few weeks to two years) the more focused the project – with the subsequent route to success easier to find.
- The **project management team**, which managed the project through its 5 year life, emerged as a major factor in the success of the project. Ideally it should represent the 'breath' and 'depth' of the organisation and should be led by someone able to initiate change from within. The requirement for **written records** of all team meetings was considered important to aid continuity over the life of the project. It also provides the rationale of decision making which is crucial for external evaluation.
- The complexity of the HPH project dictates an equally wide **range of skills** required. With hindsight, the importance of tapping into existing resources and identifying any training/support implications at an early stage is recommended. General training requirements, identified across all sub-projects, involved project management, health promotion, research and evaluation, documentation and report writing.

- The formation of **aims and objectives** were seen as an academic exercise performed by managers or consultants, often in response to a national rather than local agenda. Long discussions at the workshops led to the general consensus that it is essential to 'operationalise' aims into practical and manageable objectives. In an effort to engender realism, commitment and ownership this should be done in consultation with the people who ultimately have to carry them out. Given the long term nature of the HPH project it is necessary to periodically review the aims and objectives and modify them if necessary. It is important for participants to feel they are operating in a flexible system and that the need to change direction is not seen as a failure.
- In common with many projects the important resource implication for the HPH pilot was considered to be **time**. Participants spoke of the many out-of-work hours they put into the sub-projects. The group made a clear recommendation that at sub-project level additional time must be allocated at the onset of the project – despite the long term aim for the health promoting activities to be incorporated into the normal workload of the staff involved.
- At the end of the five year project much had been learnt about how the project should have been evaluated! **Evaluation** of health promoting initiatives is a developing 'science' , in the quest for evidence based health care, will continue to play a vital role in project management. Whilst it was considered that it was never too late to do 'something', evaluation strategies should be built into the project from the beginning. Recommendations focused on the need for (1) accurate base line data (2) realistic objectives (3) pre-determined indicators of success (4) periodic review.

The information presented in this paper gives a brief insight into both the methodology and its outcome in the context of the English Pilot Hospital. However, perhaps the most important lesson gained from using the Labonte technique is its power to overcome the well documented problems associated with 'external evaluation'. This can be described in terms of three key benefits:

1. The external evaluator is merely the facilitator and the project workers themselves take **ownership.**
2. This is a group exercise ran by the practitioners themselves, they formulate the evaluation by **consensus.**
3. The practitioners are actively involved in the research process and this generates great enthusiasm and **commitment**.

Evaluation of the Health Promoting Hospital “Alten Eichen“ in Hamburg from the patients’ point of view

Alf Trojan, Stefan Nickel

Background and setting

Our study was situated in one of the WHO Pilot Hospitals, the Diakonie Krankenhaus Alten Eichen, a 230 bed hospital in Hamburg with mainly surgical and internal wards. Two quantitative patient surveys (T1 = June/ July 1994, N = 157; T2 = April/ May 1996, N = 265) were carried out by the Institute for Medical Sociology in Hamburg.

As a reaction to the first survey the project group „K = Health Promotion for patients“ was established. The group consisted of 9 staff members of the Hospital with a variety of professional backgrounds. The 11 meetings of the group resulted in several recommendations for quality improvement. Not all of them had been implemented at the time of the second patient survey, and most of them were not specific enough to attribute changes directly to them. Changes can rather be conceived of as the result of more general changes in the hospital through various working groups and their impact on processes, structures and the whole „new spirit“ of the hospital.

We did participant observation in project group „K“. This part of our research, however, will not be dealt with in this report. Instead we will focus on the results of the two patient surveys, through which we aimed at measuring hospital quality from the patients’ view and at evaluating effectiveness of quality improvement endeavors of the hospital.

Methods

It was a postal survey 2 to 4 weeks after discharge from the hospital. Table 1 shows the most relevant differences between survey design and respondents in both studies. Our questionaire included 8 core dimensions of quality and 3 „success measures“ which were derived from both social system approach and social support research: facilities and services („material support“), emotional support, professional performance, organisation and waiting time, transparency of hospital procedures, opportunities for patient participation, informational support (instructions/ communication) increase in coping competence, affect balance, health gains, attractivity of the hospital.

Because of the differences in the samples (see Table 1) the simple means of the dimensions are not directly comparable. Therefore further statistical analysis will be carried out. By covariance analysis we will produce „adapted means“ which are adjusted for the most relevant parameters of the two samples. First results of these statistical procedures (though not completed yet) have demonstrated that the differences between simple means and adapted means will not change our results substantially.

Table 1: Comparing survey-design and respondents

	T 1-Study	T 2-Study*
time	June/ July 1994	April/ May 1996
N	157	265
response rate:	58.1%	55.6%
answering of questionnaire within 2 weeks after discharge:	22%	63%
meantime for filling out:	38 min.	20 min.
main differences between patients in terms of clinical data:		
patients from internal medicine:	35%	51%
patients from surgical wards:	65%	49%
stay of 3–14 days:	80%	64%
stay of 15 days or more:	20%	36%
main differences of patients in terms of demographic data:		
age of ≥ 60:	32%	49%
income ≥ 4000 DM:	51%	29%
retired:	32%	47%
* In the T2-study there was an additional short questionnaire for staff before results of the T2-study were known, asking about expected changes from T1 to T2 (N=19)		

Results

The main results are shown in Table 2. About equal mean scores (difference less than ± 0.1) were reached for the dimensions: facilities and services, emotional support, professional performance, organisation and waiting time, opportunities for patient participation. Considerable improvements were yielded on the scales: transpareny of hospital organisation (+ 0.7)), increase in coping competence (+ 0.6), informational support (+ 0.2). There was on the other hand one change for the worse: „affect balance“ (- 0.4) was less good than in the T1-study. At present we can not give a convincing explanation for this somewhat contradictory result. The resulting „health gain“ (+ 0.2) will not be discussed because it might have been reached by a slightly different phrasing of question and formate of answers in the T2-study. The considerable improvements on the 3 scales mentioned before were obviously not strong enough to generate a measurable increase in the „attractivity“ of the hospital.
In general staff estimations of changes (see last column in table 2) did not differ very much. „Professional performance“ and „affect balance“ of patients were overestimated by staff whereas „transparency of hospital procedures“ and „increase in coping competence“ were underestimated.

Discussion

Looking at the changes on comunication-based dimensions we find increases in 3 dimensions where the mean score in T1 was below 4. In fact the lower the T1-mean

Table 2: Summary of results: Mean scores on 11 scales and comparisons of expected changes (by staff) and real differences between T1 and T2

scales	mean scores *		standard deviation		mean differences 1996	
	1994	1996	1994	1996	patients	staff**
1. facilities and services („material support“)	3,8	3,9	0,7	0,7	+ 0,1	– 0,1
2. emotional support	4,5	4,4	0,6	0,6	– 0,1	+ 0,1
3. professional performance	4,4	4,3	0,5	0,8	– 0,1	+ 0,3
4. organization and waiting time	4,3	4,4	0,7	0,7	+ 0,1	+ 0,1
5. transparency of hospital procedures	2,6	3,3	1,2	1,2	+ 0,7	+ 0,2
6. opportunities for patient participation	4,3	4,3	0,8	0,8	0,0	+ 0,2
7. informational support (in-structions/communication)	3,9	4,1	1,1	0,9	+ 0,2	+ 0,3
8. increase in coping competence	2,8	3,4	1,4	1,5	+ 0,6	+ 0,3
9. affect balance	4,3	3,9	0,9	1,0	– 0,4	0,0
10. health gains	3,4	3,6	0,5	0,9	+ 0,2	+ 0,1
11. attractivity of the hospital	4,3	4,3	0,7	0,9	0,0	+ 0,2

* High scores indicate high satisfaction on a scale from 1 to 5;
** based on staff questionnaire asking about expected changes (N=19)

score the higher was the increase (cf. tab. 1). „Opportunities for patient participation“ (T1 score: 4.3) and „emotional support“ (T1 score: 4.5) did not change substantially. Our interpretation is that the quality improvement effects were only on those dimensions measurable where quality was relatively low in the T1-study. This pattern seems to prevail in all dimensions. We checked whether structural differences between the two survey periods (less patients? more staff?) could explain the improvement in communication but did not find any indication of that. Therefore we believe that the impact of the hospital´s more general improvement activities as well as some specific interventions, such as presentation of T1 results two times in the hospital (emphasizing low scores on communication based quality dimensions), proposals of working group „K“ and the newly introduced scheme for in-hospital training, have led to the better results in the T2-study. The presentation of further results and their discussion is being prepared by our research team.

Our overall conclusions are that patient surveys can serve as an important tool in measuring effectiveness of HPH interventions, that such surveys are feasible even under high pressure working conditions in the hospital, and that they can provide valuable information about the hospital's performance. There are, however, some methodological problems which limit the interpretation of changes over time.

Principles and methods of implementing the Network of Health Promoting Hospitals in the Veneto Region – Italy

Carlo Favaretti[1], Paolo De Pieri[2]

Since 1990 several health education programs were funded and implemented across the Veneto region. These programs dealt with smoking prevention, reduction of paediatric and occupational accidents, improvement of dietary habits, control of sexually transmitted diseases, etc. From 1994 however an effort has been made to

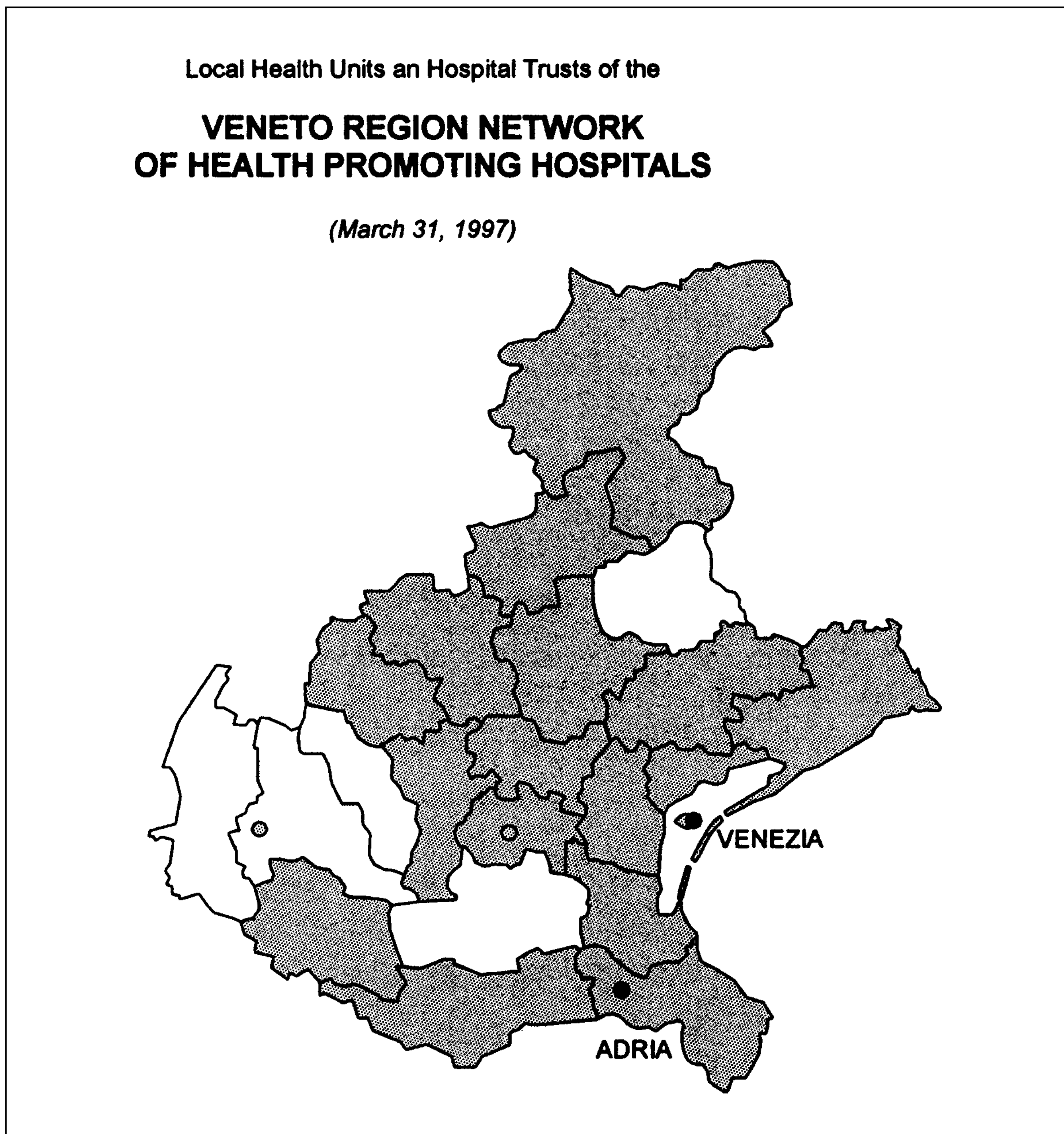

Figure 1: Veneto Region Network of Health Promoting Hospials

[1] General Director of Local Health Unit No. 19 – Adria and Coordinator of the Veneto Region Network of Health Promoting Hospitals
[2] Veneto Region Network of Health Promoting Hospitals

give a definite health promotion approach aiming to modify the settings and the organizations where people live and work, thus creating a total environment to support a health gain orientation of the different programs.

In 1995 the Veneto Regional Government decided to fund a programme to establish a regional network of Health Promoting Hospitals. The timing of the initiative was extremely appropriate as far as in 1995 the National Health Service underwent a major reform, with emphasis on regionalization and introduction of several mechanisms of internal and external competition, mainly in the hospital sector. The Coordinating Centre of the Regional Network of Health Promoting Hospitals was established at the Local Health Unit No. 19 of Adria.

The Coordinating Centre organized several promotional activities for implementing the Network. In the summer of 1995, to convince the General Directors of the Local Health Units (LHUs) and the Hospital Trusts, a folder was prepared with the essential documentation dealing with philosophy, principles and aims of the initiative. The folder also including the draft of the decree to be adopted in order to join the network. In addition, a workshop on principles and methods of health promotion, and on the Health Promoting Hospitals programme, was organized in October 1995. A settings-based approach was followed: this approach starts from a target population and plans interventions for a population in different settings relevant to that population. Professionals working in hospitals, schools and workplaces participated, corresponding to a total of 89 people, 28 of whom working in hospitals.

From Novembre 1995 to March 1997, 16 out of 21 LHUs of the Region and the two Hospital Trusts officially joined the Regional Network with a decree of the General Director: the Agreement between EURO/WHO and the Network was signed.

The Veneto Network of Health Promoting Hospitals aims to act as a focal point in population based health promotion interventions, because hospitals in the regional health care system: a) are owned by the Regional Government; b) have sensible human and financial resources; c) have contact with a large part of the population; d) represent the most important challenge in the reorientation of the system; e) have strong links with the primary health care system.

Following the experience of the HPH Pilot Hospitals Program, in 1996 several informal meetings, two business meetings and two training workshops were held for the members of the Veneto Region Network of HPH in order to organize the Network's activities. The first training workshop has been intended for the medical hospital managers and the second for the professionals which are involved in clinical activities.

To facilitate the work of member hospitals, a task force set up guidelines to plan, implement and evaluate specific subprojects within the hospitals following the Ottawa Charter principles and the Budapest Declaration. Consistently with the theoretical bases of HPH movement, the specific objectives of a plan must be addressed to patients, staff and community ; the planned actions must be consistent with the essential activities of the Ottawa Charter (to enable, to adovocate, to mediate); and the indicators must allow the assessment of the used resources, the developed processes and the gained outcomes (Figure 2).

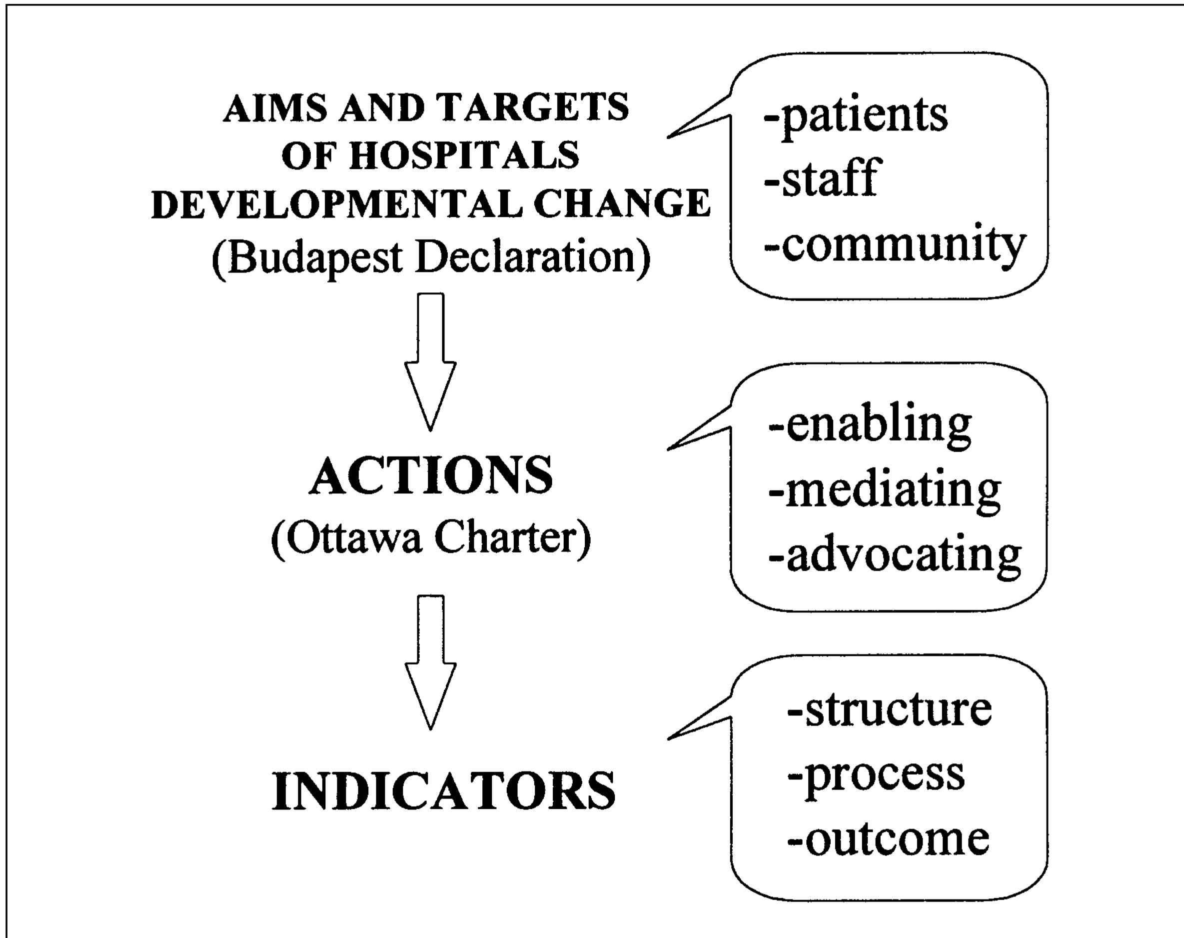

Figure 2: Development process and the gained outcomes

In each hospital a Technical Committee for coordinating the Health Promoting Hospitals project was constituted; for the implementation of selected subprojects several working groups were formed, using project management techniques. The Local Health Units and the Hospital Trusts of the Network engaged themselves to implement 52 projects. In every hospital a common regional project ("Smoke free hospitals and health care services") will be implemented: to facilitate the common planning and the implementation of this project a working group was established and a manual was prepared. The other projects which will be locally implemented deal with some clinical aspects (i. e.: prevention of hospitals infections); health promotion in the workplace; evaluation and improvement of patient satisfaction; continuity of care from hospital to primary health care services; diet and health; quality of life for the elderly; improvement of birth care.

Three regional working groups on "health in workplaces" were established and deal with the assessment of biologic risk, the antineoplastic drug preparation and the prevention of low back problems. Other working groups between two or more hospitals were also established in the field of nutrition and patient satisfaction. The first and the second issues of the Regional Network newsletter were prepared and distributed among hospitals staff.

The Veneto Regional Network of HPH already established some alliances for its growth: the first with the Regional Centre of Health Education which is involved, as

centre in collaboration with WHO, in developing healthy schools and healthy workplaces networks. Another alliance was established with the Italian Network of Healthy Cities, sponsored by the National Italian Association of Communes (ANCI) with the support of the Ministry of Health. In March 1996 the Ministry of Health (Service of International Relations and European Community Policies) designated the Veneto Region Network of HPH as coordinating institution of the Italian Network of HPH. Moreover, the coordinator of HPH Veneto Network was designated as focal point for this initiative and official representative of the Ministry at a WHO-EU-LBI Workshop held in Vienna.

Since March 1996, selected documents to regional Ministers of Health were mailed and meetings and contacts were held with representatives from hospitals of many italian regions. The 1st National Conference of Health Promoting Hospitals took place in Padova in January 1997; following this Conference, in Piemonte, Lombardia and Sicilia some hospitals are establishing HPH Regional Networks. The Italian Network of Health Promoting Hospitals will be implemented as an organization of autonomous HPH Regional Networks in agreement with the WHO Regional Office for Europe. This form of organization is the basis of HPH Italian Network statute that the Ministry of Health and the HPH Veneto Network have been preparing and which is now under scrutiny.

In 1997, the main challenge of the HPH Veneto Region Network at the regional level will be the implementation of all local projects and the Coordinating Centre will be monitoring and supporting this process. Moreover to extend alliances, the HPH Veneto Region Network will contribute to establish the Veneto Region Network of Health Promoting Nursing Homes, as far as LHUs have also the responsability of some social services which are in strict relationship with nursing homes.

The next important challenge for the Veneto Region Network of HPH at national level, in order to help the development of the HPH Italian Network, will be the assistance of other italian regions in the implementation process of regional networks (particularly Piemonte, Lombardia and Sicilia), the planning and distribution of a national newsletter of HPH and the planning of the 2nd National Conference.

The Lithuanian Network of Health Promoting Hospitals

Irene Miseviciene

General network structure

The Lithuanian network of HPH was established on 3. 12. 1996 during the 1st National Conference of HPH. Representatives from 17 hospitals took part in the conference. The agreement to join the network as full members was signed by 8 hospitals. Three hospitals decided to be observers.

Alliance building

The Lithuanian network of HPH has a close collaboration with Kaunas Medical Academy, as the WHO collaborating centre for cardiovascular and other noncommunicable diseases, epidemiology and prevention . Since 1982, decision-making bodies of such WHO centres have coordinated projects.

Options for participation

Hospitals who want to become the members of the Lithuanian Network of Health Promoting Hospitals have to:

- endorse the Ottawa Charter for health promotion and Part 1 of the Budapest declaration;
- obtain the formal agreement of the management of the hospital;
- run at least three programmes on health promotion during the time of the project;
- finance its own activities;
- participate in at least two task forces on the development of programmes/activities;
- participate in the business meetings of the Lithuanian Network (participation in international conferences on Health Promoting Hospitals would also be advisable);
- present an annual report on the programmes in progress, including objectives, time frame, achieved results and expected outcomes;
- provide information to the Coordinator of the Network (the type of information needed to be approved by the member hospitals at a business meeting);
- contribute to the financing of coordination through a membership fee of 300 Litas.

Activities in 1996 and plans for 1997

At present, 10 hospitals are involved in HPH projects. Three hospitals are located in cities and 7 hospitals in rural areas. The total number of subprojects being carried out in 9 hospitals is 51. Four main areas of common interest have been selected. The Kaunas Academic Clinic, as the first HPH in Lithuania since 1994, organized several meetings for chief physicians of Lithuanian hospitals, to acquaint them with the WHO HPH project. The 1. National Conference of HPH was organized Dec. 1996.

Activities planned for 1997 are to design a logo; develop an action plan for the Joint Committee of the HPH Network; develop working groups on priority topics; organize two workshops relating to specific themes; develop a national HPH data base of international experience; develop fund raising strategies; build alliances; publish a national newsletter twice a year; organize a national HPH conference; increase national HPH membership by 20%.

Optional activities planned are: to develop existing documentation, agreements, between the coordinating centre and participating hospitals and between the Lithuanian HPH network and WHO; regulations of the HPH Network Joint Committee and descriptions of each subproject including aims, targets, methods of implementation, time frame and evaluation.

Areas of common interest

The lithuanian network of HPH consists of 10 Hospitals with 57 Subprojects. Areas of common interest are:

Quality of Care

- Economics in the hospital (1)
- Infections in hospitals (5)
- Nutrition for diabetics (3)

The well-being of personnel and patients

- The tobacco-free hospital (4)
- Nutrition (3)
- The baby-friendly hospital (2)
- Breastfeeding (4)

Health promotion and disease prevention

- Take care of your health (3)
- Health education of diabetes patients (4)
- Health education of patients with bronchial asthma (3)
- The prevention of depression (1)
- The education and training of rheumatic patients

The Polish National Network of Health Promoting Hospitals

Jerzy Karski

Development

The Polish Network of Health Prornoting Hospitals was established in 1992. It was an initiative of the Department of Health Promotion, National Center for Health System Management in Warsaw. The first hospital deciding to be a member of the Network was the Child Health Center in Warsaw, which soon, together with Upper Silesia Rehabilitation Center „Repty“ at Ustron, became members of the European Network of Pilot Health Promoting Hospitals. Currently, i.e. in April 1997, the Polish Network of Health Promoting Hospitals is composed of 34 Member Hospitals. Out of them, 16 hospitals are also members of WHO/EURO Network of HPHs

According to the letter of the Network Statute, there are four Business Meetings of the Member Hospitals Representatives held annually and one of them to be the National Conference of the Health Promoting Hospitals with participation of the Network Member Hospitals Representatives and non-member hospitals staff from all over the country, interested in the Project. Development of the Polish National Network of HPHs can be characterized by the following milestones:

1992 – Establishment of the Polish National Network of Health Promoting Hospitals.

1993 – The First International (European) Conference of the Health Promoting Hospitals in Warsaw [Memonal Hospital – The Child Health Centre],

1994 – The First National Conference of the Health Promoting Hospitals in Ustron [Upper-Silesia Rehabilitation Centre],

1995 – The Second National Conference of the Health Promoting Hospitals in Warsaw – Miedzylesie [The Rail Central Hospital]

1996 – The Third National Conference of the Health Promoting Hospitals in Kalisz held in October 5–6th, 1996

1997 – The 4th National Conference of the Polish HPHs, held in Lublin.

Organisation

The structure of the Polish Network of Health Promoting Hospitals consists of:

a) the main group, i.e 19 general hospitals, including 2 university medical school teaching hospitals and 1 central (countrywide cover) hospital. Other hospitals of the group are mainly local, district or regional 200–300 beds hospitals.

b) another group of 6 “Mother and Child Hospitals“, with 200–600 beds.

c) and specialized hospitals (psychiatry, rehabilitation, cardiology, oncology, neurology and rheumatology hospital).

Amongst the personnel of the Network Member Hospitals, about 14% (3–78%.) of physicians and 16% (1 – 80%) of nurses and midwives have been engaged in health promotion activities. Average percentage of another „white“ personnel of the hospi-

tals engaged in health promotion activity has been assessed to be about 34% (as from 1 to 100%.) i.e. therapists, psychologists, dieticians etc.

The Majority of the Member Hospitals established their own permanent health promotion team (with, e. g. Programmatic Council, the HPHs Project Board, Health Promotion Team etc.). The leader of the team is usually a physician or nurse. The team is responsible for the implementation and coordination of the obligatory[1] and additional health promotion projects (at least three), as weIl as for the collaboration with the remaining hospital personnel, hospital management staff and with representatives of the local community.

Apart from the Network Statute (published in the Vienna HPHs European Coordinating Center Newsletter No 5, May 1995), the Network has his own self-evaluation system for his Member Hospitals.

Results

Each National Conference of Health Promoting Hospital resulted in applications for Network membership. There is some relationship between the number of hospitals being Network Members and the environmental health-related hazards and density of their region. The more environmental risks and the higher the population density in the region, the more hospitals jointed the Network. Since 1992, the Polish Network of HPHs Representatives have attended almost all European HPHs Business Meetings and Conferences.

A questionnaire survey (conducted in 1997) showed that during the 5 years of the Polish Network, the hospitals have been undertaking many health promotion activities, gaining both positive and negative experiences. The number of hospitals joining the Network keeps rising. At present, 39 (June 1997), hospitals are members of the network. Increase of the interest is connected with the raising health awareness of the hospital staff, with apprehension of benefits and positive changes resulting from the health promotion programs and improvement of health care services quality, which are more and more fullfilling patients' expectations, as well as with increasing work satisfaction and professional prestige. Some persons, however withdraw from the health promotion activities because of lack of time and funds for health promotion, lack of additional wages for personnel dealing with health promotion as an additional job along with the burden of basic medical responsibilities.

Incorporation of health promotion proved favourable for positive changes in the hospitals (concerning interpersonal communication and collaboration among various professional hospital groups, diminishing of stress connected with work, changes related to interpersonal relationships and the style of the hospital management).

[1] Members of the Polish Network of HPHs are obliged to deal with 5 compulsory projects:
1. Incorporation af health promotion into the hospital structure. 2. Health education. 3. Healthy food and healthy nutrition management in the hospital. 4. Anti-tobacco activity and alcohol and drugs contraints. 5. Cooperation with local community and administration.

Art for health's sake: A vision of the Health Promoting Hospital

Carrie Jain

In 1995, members of staff from Altnagelvin HPH Pilot Hospital in Northern Ireland began working on an innovative Arts Project. Best described as a visualization project, the intention was to produce a series of posters or teaching aids which would represent the concept of the Health Promoting Hospital.

The idea of visually representing concepts and ideas which may be difficult to express verbally, is not new. Artists struggle to express their thoughts, ideas and emotions through their artistic works, while complex scientific concepts are rendered more accessible by means of simple diagrams. Health promotion theory is no exception, of course. Indeed the models used for defining health promotion are many and varied!

Art and Science are often thought to be uneasy bedfellows and health care is often equated with science. But art is being used increasingly in health care settings and can help to demedicalise the environment and act as a medium for patients, users and staff to express themselves.

Our project began following a meeting with an organisation known as 'Artscare Northern Ireland'. This contact provided us with the opportunity to work with professional artists to achieve our aim of making the concept of the Health Promoting Hospital accessible to a wide audience. Most importantly, the staff working on the Pilot Hospital sub-projects were to be involved in producing something of their own which would be both lasting and useful, as well as offering a new way to represent their work.

Aims and methods

The aims of the Visualization Project were to

- Promote understanding of the Health Promoting Hospital concept to a wide range of hospital staff.
- Stimulate discussion and debate
- Involve staff in achieving the aims of the European Health Promoting Hospital Pilot Project.

A series of discussions were held with the seven Pilot Hospital sub-project group members and the artists. Time was spent discussing the work of the projects, clarifying ideas and producing draft posters which, following further discussions, were amended.

This stage of the process was not an easy one for either party. Staff, with no experience of working in this way, found it difficult to express how they wanted to represent their projects. The artists were, perhaps, approaching the project from a somewhat different angle and it took time to resolve differences and to produce a mutually acceptable end result. I would say that at this stage a lot of learning took place on both parts! However, we ended up with a very positive result – eight Posters representing

the themes of the sub-project groups and the stages of change through which the hospital can grow and develop into a truly health promoting organisation.

What we had wanted from the outset was not a set of pretty pictures, but a set of working tools to be put to practical use. This is what we now had and our next step was to expose the posters to a wider audience. We decided to do this by means of a series of workshops for a wide cross section of staff. We felt that the workshops would also offer scope for assessing our progress in meeting the aims of the pilot hospital project. We therefore decided to draw up a questionnaire for workshop participants, which would give us some indication of the level of perception, knowledge and progress of the pilot hospital project.

The aims of the workshop were

- To evaluate existing knowledge and understanding of the Health Promoting Hospital concept.
- To assess the potential of the Visualization Project to increase understanding of the Health Promoting Hospital.
- To determine the most effective course for the future Health Promoting Hospital.

Results

Although considerable efforts were made to enable staff to attend the workshops, numbers were disappointingly low and consisted entirely of nursing staff. Nevertheless, we feel that despite this the workshops were worthwhile. In fact the information gained from them has already directly contributed to the formulation of a future health promotion strategy for the hospital.

Participants were given the opportunity for structured discussion of the posters in terms of the messages they contain, and where and how they could be most appropriately used. There was a very enthusiastic and animated response to the workshops with a range of opinions being aired. Overall, participants found the posters “thought provoking”, felt that they “broadened their ideas” and said that their involvement in the workshops made them feel that their “opinions were valued”.

There was a broad consensus as to where the posters should be used. All participants saw potential for their future use but felt strongly that they were not suitable for general display though they could be used in Accident and Emergency Departments and Labour wards. They felt they would be particularly useful as an integral part of health promotion teaching groups.

Participants also completed the questionnaire designed to assess their current involvement in health promotion activity and staff awareness of the Health Promoting Hospital Pilot Project. We found that 75% of participants were aware that Altnagelvin is a Pilot Hospital. Health promotion activity focused mainly on smoking prevention and cessation, nutrition and breast self-examination. The most commonly used methods were providing information leaflets, talking and discussion and specific advice giving. We also discovered that few staff became involved in activities such as health promotion campaigns or stop smoking groups and that they were not focused on the importance of providing a health promoting environment.

This is, of course, a superficial overview of the information gained. We will to be utilising the information to identify the full range of issues to be addressed as we plan the structure and strategy for health promotion in Altnagelvin towards the millennium.

Recommendations

- Plan and prepare
  – do not underestimate the time needed for this stage.
- Consult
  – widely, with everyone who is to be involved.
- Define
  – work towards clarifying the aims and expected outcomes of your project.
- Enable
  – Identify a key person with excellent communication skills to liaise with artists and staff.
- Document and evaluate.

The Visualization Project has, for us, been both challenging and worthwhile. To anyone contemplating a similar project we would say – Yes, do it!

A “Visualisation Workshop Approach“ to launch a Health Promoting Hospital

Annie Meharg, Ken Meharg

Introduction

At the Conference in Vienna we made a poster presentation and a tape-slide presentation of our visualisation of the Health Promoting Hospital Concept developed in co-operation with Altuagelvin Hospital Nothern Ireland. We discussed with several participants how we would apply this visualisation to the development of a new Health Promoting Hospital within a network. In this paper we will set out our method.

Aims of the project

I. to attract staff interest in the development of a Health Promoting Hospital
II. initiate involvement and participation of the hospital staff
III. to launch and develop subsidiary projects
IV. to provide a theoretical and practical framework for planning the future of the Health Promoting Hospital
V. to market the HPH Concept within the hospital and the wider community

Method

Participant observation: we move to the location and live on site. All workshops adopt an arts approach, centred on drawing, painting, and designing and screen-printing posters. No previous experience is needed.

Phase I: Building a launching platform

(1) Participants are asked to discuss the fundamental conditions or „resources for health as outlined in the Ottawa Charter for Health Promotion (WHO, 1986). These are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. We begin with discussion of these issues, and then show a tape-slide programme with a script constructed from The Ottawa Charter, illustrated with slides taken locally.
(2) Participants are asked to consider: firstly, how these relate to their day to day experiences of working in the health service; and secondly, how they would like to see their hospital develop in future. To facilitate this second discussion we use the Budapest Declaration and an “objectives framework” based on a simple analysis of a health service. This framework is: public involvement, health promotion, primary health care, community care (non health-service agencies which have an influence on health), human resources management, infrastructure, access/waiting times, specific client groups, redistribution of resources and value for money.

We have tape-slide programmes and paintings to help facilitate discussion of these concepts. The participants are then asked to come up with different ideas for change

based on a combination of one topic from the ,,resources for health” list and one from the “objectives framework” list. In this way a good spread of issues is assured.

(3) The participants work in pairs to choose the issue, define the target audience and produce the design for each poster. They then work collectively to screenprint a number of chosen designs, usually 10 per five day workshop, and 20 – 30 copies of each, full colour size A2. All work is presented in the visual and verbal vernacular. We usually run at least three weeks of workshops in order to get 30 or so posters.

Phase II: Evaluation, discussion and planning the launch

(1) Each poster is field tested with a sample of its intended audiencc to evaluate its effectiveness in attracting attention and communicating its intended message.

(2) We have a collective discussion of’ the results of field testing. The designs are revised where necessary and the posters reprinted. Our workshop procedures follow the model, laid out in the “Heallh for All” Strategy of WHO.

(3) By now the participants fall into several more or less clearly defined interest groups. After a collective discussion the participants agree to split into a number of subsidiary groups. These subsidiary groups each elect a project coordinator, and decide on a timetable for the rest of the project.

Phase III: Launching the Sub-groups

(1) Each subsidiary group meets separately with us and we have a further discussion of the Ottawa Charter and the Budapest Declaration on Health Promoting hospitals (WHO).

(2) We analyse the Health Promoting Hospitals Concept itself. The tool we use is:

$$R \infty \frac{\pm(\Delta c + \Delta P)}{\Delta T + \Delta I}$$

Where R is behavioural resistance to change, ΔC is the degree of cultural disturbance, ΔP the degree of political disturbance, ΔT is period of change and ΔI is the degree of involvement and participation of those expected to implement the change.In words this states that: Resistance to change is directly proportional to the cultural and political disturbance and inversely proportional to the period of change and the degree of participation of those expected to implement the changes.

We use our series of tape-slide programmes entitled “A Change to Health Gain Orientation“ to explain the Health Promoting Hospital Concept in terms of change in direction, resistance to change, transformation of culture, shift in power structure, period of change, degree of participation planning and implementation, marshalling resources, capability installation and strategy development. In this way the formula is used to develop a morphological analysis of HPH from the four basic points of view of organisational development, staff involvement, patient/user’s experience and wider community involvement, giving participants a chance to ,,see the whole picture” of the development of a Health Promoting Hospital.

(3) Developing the morphological analysis we discuss a set of “strategic principles“ and ,,user’s rights“ in relation to the ,,resources for health“ and the ,,objectives

framework". This forms the beginning of the process of strategy development for subsidiary group action within the context of the overall development of the hospital in relation to the Health Promoting Hospital Concept. We follow a process laid out in our picture series „launching subsidiary groups".

(4) Finally we design a poster and a leaflet calling for wider involvement in the subsidiary group, and organise distribution. When new participants join, the subsidiary group has a set of educational materials made by its own members, and the beginnings of a strategic plan.

Phase IV: Consolidation of subsidiary groups within the hospital

We work with individual subsidiary groups to develop health promotion materials for use within the hospital and to attract wider staff involvement in their groups.

Phase V: Developing the subsidiary groups within the community

We work with subsidiary group representdtives and community groups in various settings such as schools, leisure centres, church halls, cornmunity centres, arts centres, playgrounds to develop health promotion rnaterials for use in the community.

Attempts to evaluate the implementation of a "Quality Management System" – The Vienna Hospital Association's Demonstration Project

Ursula Dickbauer

Four hospitals, one geriatric center and one nursing home of the Vienna Hospital Association were selected to implement Total Quality Management in order to demonstrate how it works in health organisations. Before the project was started 4 aims which should be reached in three years were defined:

- Introduction of an integrated quality management system, which is able to support the continuous quality improving process of the clinic and which gets a self-evident part of daily work of each staff-member.
- Development of the clinic to a learning organisation, which is able to react flexibly and adequately on new challenges and problems.
- Support of the aims of the Vienna Hospital Association which are in this context: increasing the patient- and staff-members' satisfication and increasing the efficency of work done in hospitals.
- To set a demonstration-effect and example for other hospitals so that they also get motivated to strengthen their activities on quality management work.

The main tasks to reach these aims in each institution are:

- to build up a TQM-structure
- to do intensive work force training for the staff-members to enable them to solve the quality problems by themselves and for the top-management to enable them to lead the quality improving process in their institution.
- to define and supervise the interfaces to other projects in the clinic and to the environment in general.
- to do inward and outward communication to inform, motivate and integrate the staff-members as well as to spread our efforts in quality improvement.
- and to control, organise, coordinate and evaluated the whole project.

We evaluate on different levels: Every quality circle work gets evaluated whether or not the realisation of its problem-solutions improved quality. Also every seminar, training course and workshop gets evaluated if it reached the expectations of the customers.

The aim of the evaluation of the implementation of the TQM system is to rate to which extent a TQM-System has been implemented in each of the institution and to which extend the organisation itself has changed. We do this in every hospital threefold: First by looking at hard facts, second by looking at soft facts and third by looking at the fact if and how the QM work continous to exist *after* the project concludes in the end of 1997.

The hard facts we evaluate are: The number of employees trained in QM-methods, the number of Quality-Management Coordinators, the number of quality circles

which had been installed and brought to an end successfully, the number of staff-members who worked in a quality circle and the number of staff-members who did this more than once.

We evaluate the soft facts by using four different types of questionnaires: one for the „senior leaders“ (top-management and the members of the QM-conference), one for the quality circle members, who are already involved in QM-work, one for the vicinity of the quality circle, and one for all other employees who are more or less involved. The main topics covered by the questionnairs are: commitment of leadership; has TQM been adopted by the organisation; what do the staff-members working on any level of the organisation know and think about TQM; what do they think will the result of TQM be in the long run; and personal hopes and expectations regarding the implementation of TQM.

The senior leaders and the quality circle members are of course highly involved and mostly also motivated at the beginning of the project. What we expect at the end of the project is that *each* staff-member is more or less involved in TQM-activities.

The questionnairs are subdivided in core questions and specific questions. The core questions are equal in all four versions as there are for instance general questions for the persons knowledge about and attitudes towards the project, for its opinion about the profit and cost of the QM, its believe in QM. The specific questions view the persons specific involvement in QM, the work of the quality manager, the work of the quality management conference, and of the quality circle, the promotion of the QM-process by the top management. Every item is rated from 1 to 6, 1 means „absolute“ 6 means „not at all“. We ask as well for the profession, gender, if the person is in a leading position and at the end for concluding comments. We ask for the leadership because we assume that if leaders get convinced of the work on quality the implementation of TQM is easier and more efficient.

The size of the sample varies between 100% of the staff-members as in the small institutions with 200 to 300 employees and 30 % as in the big institutions with about 3000 employees. The survey happens twice: first at the beginning of the project and second after concluding it, so that the amount of change and the degree of implementation can be measured. In the first run the average return stroke from all 6 QM-demonstrational institutions reached 33%. The questionnaires were sent back anonymously to the Department of Organisational Development where the results were evaluated.

We evaluate the results twice: first we compare between the different occupational groups in each hospital and second we compare between the six instiution. We make this second comparison because we want to learn which circumstances and criteria as for instance the quantity of employees, the size of the institution, its special task, its different problems during the project (f.i. Reduction of beds and employees) and so on influence the implementation of TQM positvely or negatively.

The biggest challenge was to reach all hierachical levels and professional groups with only one questionnaire. The biggest shortcoming was that we didn’t translate the questionnaire in different languages. So we lost some of the german speaking staff-members.

Settings as environments for health

Marion Woan

This paper briefly describes:

- the settings based approach to health promotion,
- it presents the origins and evolution of settings,
- the nature of organisations and
- pitfalls for organisations using the settings approach.

I do not offer any answers to the questions, problems or issues posed. However, they could hopefully form the basis of further analysis or discussion at another time. I believe that if we are aiming to encourage others to get involved in settings based health promotion, it is important that we understand the theory and add to that growing body of knowledge.

There are several published definitions of health settings but they are principally the same. They focus on settings being population or systems based approaches to health promotion as opposed to individual based interventions. Settings are not new. References exist from the 19th century. For example there is an account of Scottish schools in the 1880s providing free, hot midday meals for children in order to enhance their powers of concentration and improve their impoverished health. Case studies begin to appear in the literature of health promotion interventions being sited in schools or communities in the 1960s and 1970s. However the term 'settings' is not used in the writings. There are no overt references to settings prior to the mid 1980s.

The rebirth or renaissance of health promotion was stimulated by the Alma Ata Declaration in 1977 – Health For All by the year 2000. The Ottawa Charter then gave settings shape and purpose through the principles of advocacy, enablement and mediation. It brought health issues into all sectors of social life. The settings approach addresses environments, resources and lifestyles which may facilitate or hinder the development of people's health potential. After 1986 the settings approach became a valid and legitimate method of developing health promotion into the culture and business of organisations. This was led and supported by WHO. It became a much more formal process, and settings acquired a capital 'S'. Health Promoting Cities, Schools, Hospitals, Prisons all refer to the WHO series of projects. All the literature relating to these projects uses organisational development to achieve their aims.

Organisations are usually complex structures made up of large groups of individuals and they have common goals. These are the strengths of using organisations to develop health promotion. Organisations enable objectives to be achieved that could not be achieved by the efforts of individuals on their own. Hospitals for example are very successful organisations. However, doubts have crept in about the effective use of resources matched to positive health outcomes and other social and humanitarian considerations.

Managing change to bring about health gain is not easy whatever method is used and there may be a naiveté amongst some settings theorists who suggest that a settings

approach, rather than a problem centred one is more straight forward. Due to the nature of organisations there are many obstacles to overcome. Organisations are made up of individuals and individuals have different perceptions and beliefs about health. Defining health must be meaningful to individuals and large organisations will have difficulty doing this. Also the clear reasoning of health promotion is difficult for any organisation, be it a school, hospital or prison as it does not fit comfortably into the established way of thinking and doing things. Present health care systems focus on illness. The treatment of illness is not only better organised, but also apparently easier to organise than health. How does an organisation learn to treat health?

In order to develop health, an organisational infrastructure in hospitals, schools etc. this is not a problem, but what about communities that have multiple organisations working alongside each other or settings that do not have a recognisable infrastructure? Bureaucracy can impede change. In National Health Service hospitals in England the Directorate system (a process of dividing the organisation into small business units) has in many cases made the internal networking very difficult. Because of their size, organisations are usually renowned for their poor communications both internally with their staff and externally with their clients or customers and their neighbouring organisations.

Building cooperation to change the organisation is a difficult process, and this is often underestimated by energetic enthusiasts. People and social systems have limited capacity to change. It is also worth remembering, too, that change, particularly when managed poorly, often has a detrimental effect on health. Coordination and cooperation are essential if the settings approach to health promotion is to succeed. However success will depend on different sectors and agencies, most of them outside the recognised health service, coming together to create a health philosophy and ways of collaborative working. This is a huge managerial task, and very difficult for outsiders, too, trying to get a foot in the door.

Finally then, there are many hurdles to cross and it is made even more difficult by society's ever increasing expectations of organisations, particularly those in the health sector. The questions and comments posed during this paper did not come with answers, but at the very least they should give rise to further thought and analysis about the practical implementation of the settings approach to health promotion.

Geriatric training for the Vaugirard Hospital staff

Anne Laurence Le Faou, Matthieu de Stampa, Lucile Mercier, Dominique Jolly

Assistance Publique-Hôpitaux de Paris (AP-HP) is a federation of 50 University public hospitals (30.000 beds, 85.000 employees). The board managers of Vaugirard Hospital (VH), the most recent AP-HP geriatric hospital have wanted it to become a model of good practice. Working in geriatrics requires very specific training for the staff. But in France, there is no geriatric specialty for medical doctors, nursing staff, social, technical and administrative personnel . In the past few years, professionals have begun to express the need to develop specific training for healthcare workers. As a result, a survey was conducted in Vaugirard Hospital in 1997 in order to know more about the curriculum of the staff in geriatric care and the needs of continuing education for the near future.

Methods

This survey consisted of a questionnaire, made up of 10 questions. and an additional open question to obtain qualitative information concerning the motivation of the staff to work in geriatrics. The questionnaire was filled in by the staff. One hundred and sixty people out of 320 staff members were randomly chosen from the hospital personnel file. It was decided to take half of the people in each professional group: medical doctors, nursing staff, social personnel, technical personnel and administrative personnel. The Epi-info software was used to analyse the data.

Results

One hundred and fortyeight out of 160 answered the questionnaire (92.5%). The distribution for each professional category was the following: nursing and medical staff represented 58.8% of the replies, social, technical and administrative personnel made up 41.2% of the replies.

The first question concerned specific training in geriatrics beyond the initial schooling : 79% of the people were not trained in geriatrics. Taking into consideration each professional category, the percentages of trained people are the following: social activities manager (100%); chief nurses (50%); physiotherapists (43%); medical doctors (33%); nurses (33%) and auxiliary nurses (32%).

The second question explored the need to be trained in geriatrics among the staff who had not been trained previously. 69.5% (n = 81) are willing to take part in training sessions. The most frequent request concerns care for the terminally ill (59%). Auxiliary nurses have asked for theoretical training (24%). 10% of the replies concern the need for training in psychology to work with elderly people. Finally, 7% of the staff is interested in technical care. Concerning care for the terminally ill, we can observe that a large percentage of the persons directly in charge of elderly patients would like to attend specific sessions : auxiliary nurses (80%), medical doctors (80%), nurses (66%) and physiotherapists (50%).

The third question referred to the professional experience in geriatrics before working in Vaugirard. It appears that only 61.5% of the staff has this experience, thus explaining the request for continuing education in this field. Among the 57 replies, the results for each category are the following: Chief nurses (67%), auxiliary nurses (59%), medical doctors (55%), psychologists (50%), physiotherapists (42%), nurses (38%), catering team members (35%), administrative board members (12.5%) and the social activities manager (who was hired at the beginning of the hospital project). In addition, the staff was asked about their everyday work insisting on difficulties and satisfactions when working with elderly people.

One of these difficulties concerns the behaviour troubles which are pointed out by 17% of the auxiliary nurses, 16% of the nurses, 14% of the physiotherapists, 12% of the technical workers and 5% of the catering team members. The main problem the staff have to face is dealing with the difficulty with Death and Dying. It concerns 23.5% of the auxiliary nurses and 22 % of the nurses.

The satisfactions at work focus firstly on the help they are able to give to the elderly person. This point is very important for auxiliary nurses (42.5%) while it appears less fundamental for administrative staff (25%), nurses (16%), chief nurses (16%), medical doctors (11%) and catering members (10%). On the other hand, the improvement of the health conditions of the patient is the most positive point for medical doctors (44%), nurses (33%), physiotherapists (28%) and auxiliary nurses (17%).

The choice of working in geriatrics was tested : for 59% of the nursing and medical staff have chosen to work in geriatrics, it was the case (100% of the M.Ds, 100% of the chief nurses, 77% of the nurses, 57% of the auxiliary nurses and 55% of the physiotherapists). Finally, 68.3% of the Vaugirard Hospital employees consider that they have a very challenging job.

Conclusion

Taking into consideration these results, it appears that there is a lack of trained people due to the lack of recognition of the geriatric specialty in France and that the staff is confronted with difficulties. The initial training is insufficient in France. Since the ninetees, the nursing schools have included in their curriculum a specific program in geriatrics . But the assessment of the present training needs shows that these needs specifically concern care for the terminally ill. The staff is willing to improve its knowledge. It must be added that for the most part, health care professionals choose to work in geriatrics especially for M.Ds. and nursing staff. These results will help the decisionmakers to organise the training programme of the staff because the final goal of Vaugirard Hospital board managers is to have the staff trained in geriatric care to help them adapt their attitudes, broaden their knowledge while improving their working conditions.

The contribution of patient satisfaction surveys to organizational development

Katharina Heimerl

Health promotion in hospitals is closely linked to the notion of empowerment both for patients and for staff members. To support an active and participatory role of the patient in the hospital is one of the aims of the health promoting hospital as it was defined in The Budapest Declaration (Pelikan, Krajic 1993). Consequently, it is one of the strategies of the network of Health Promoting Hospitals to develop the hospital as a health promoting environment for the patient. Programs which focus on health and health needs of the patients are in the center of the strategy of the 'health promoting hospital' (Krajic, Kolb, Pelikan 1996).

What are the elements of a program that names itself patient-centered? I would like to draw from an other example of a very large program that put the patient in the center of the attention: The Picker-Commonwealth program for patient centered care defines seven dimensions of patient centered care (Gerteis, Edgman-Levitan, Daley, Delbanco 1993):

- Respect for patients' values, preferences and expressed needs
- Coordination and integration of care
- Information, communication, and education
- Physical comfort
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Transition and continuity.

The first dimension leaves us with one crucial question: How can we respect patients' values, preferences and expressed needs if we do not know what they are? The first step towards patient-orientation consequently requires knowledge about patients' needs – to help patients not only to feel needs but to express them and to express which of their needs are unmet.

What is patient satisfaction?

Patient satisfaction surveys attempt to 'measure' or maybe better attempt to observe patient satisfaction. Unfortunately there is a paucity of theory concerning patient satisfaction in the literature, the most elaborate paper dating back to the year 1982 (Linder-Pelz 1982). She describes patient satisfaction as 'individuals positive evaluations of distinct dimensions of health care'. In a German paper satisfaction is summarized by: 'the correspondence between expectations and experiences and between wish and reality' (Güntert et al. 1996). Surveys that follow this definition of patient satisfaction consequently measure expectations of patients first and then the extent to which those expectations are met in reality. However, the notion of patient satisfaction as it is defined here has been abandoned (Satzinger 1997), for several reasons. The most important reason for leaving that very concept is that satisfaction rates

generally are ‘too high’. Too many surveys yield satisfaction rates that exeed 90% when they ask the question: how satisfied are you with the service? This is certainly a very agreeable result for the service providers, one that encourages them to continue the way they are working, which it should. But in terms of organizational development such results are of no help for the decision how to improve the service.

Recent patient questionnaires have therefore changed the underlying concept from patient satisfaction to problem rates (Gerteis, Edgman-Levitan, Daley, Delbanco 1993; Cleary 1991). In a prestudy certain dimensions are determined as being of outstanding importance in the patient’s eyes. An example for these quality dimensions from the patient’s perspective is given above. Within those dimensions marker questions are defined which are known to be problematic in most services. Patients are then asked whether they have encountered a specific problem in each of these dimensions. High problem rates in certain dimensions indicate the need for change in that dimension.

Organizational development and patient satisfaction

Organizational development supports organizations to better adapt to the changes of their environment. Its goal is to increase the organization’s effectiveness. Not only in terms of economic efficiency, but also in terms of quality of work and service. In health care it is one of the priorities of organizational development to increase employee satisfaction and patient satisfaction with the service. Organizational Development is a notion, that has an overwhelming amount of very different definitions. Without undertaking the attempt to cover all possible definitions of organization development, I would like to summarize relevant aspects in OD on which there is agreement in important definitions (e.g. French, Bell 1990; Sievers 1993; Comelli 1993)

- OD is a planned and systematic process
- OD aims at helping organizations to achieve greater effectiveness in terms of improved quality of life, increased productivity, improved product and service quality
- OD aims at increasing the problem solving capacity of the organization
- OD is a participatory approach that aims at involving all ‘stakeholders’ of the organization.

French and Bell add that the Organization Development process is conducted with the help of an OD consultant and through applying theory and technology of applied social science research and action research.

Why Study Patient Satisfaction for Organizational Development?

Patient satisfaction studies support the organizational development processes in several ways as it is summarized in Table 1:

1. Patient surveys feed data into a systematic and planned process

They are systematic inquiries that can be fed into the systematic process of organizational development. Patient satisfaction surveys yield systematic data, that help to design a program or a service. Special attention has to be given to the feedback

Table 1: Why Study Patient Satisfaction for Organizational Development?

Aspects of Organization development	Aspects of patient surveys
Planned and systematic process	Feed Systematic data about patients needs into the process
Improve service quality	Look at client quality as one aspect of quality
Participatory Approach	Support participation of patients as important stakeholders

process: How are the data fed back to the organization? Results have to be presented in a way that allows for a learning experience for staff members (Grossmann 1995b). This requires that staff is involved in designing and conducting the patient survey from the very beginning (Satzinger 1997).

2. Patient surveys contribute to the quality improvement process

Patient surveys look at quality from the patients perspectives. In the current debate around quality patient satisfaction plays an increasingly important role. There are different approaches for including patient perspectives into the quality debate, I am only describing three of them:

(1) The differentiation into two dimensions of quality: dimension one being technical excellence and dimension two being the subjective experience of patients (Gerteis, Edgman-Levitan, Daley, Delbanco 1993)
(2) To look at quality from the different stakeholders' perspective which yields the notions of client quality, professional quality and management quality (Ovretveit 1990). Patients perspectives on quality are one aspect of client quality according to Ovretveit.
(3) To include patient satisfaction as a measure of outcome quality (Köck, Ebner 1996).

Learning from the patients about certain problems that they encounter will help to improve the quality of the service.

3. Patient surveys support an important group of stakeholders to participate in the process of health care delivery

Organizational development is a participatory approach that includes all relevant players (stakeholders) in the process. Health care professionals work every day and all day with patients. Why should there be a need to question patients, since there is such an intensive relationship between patients and health care professionals? On the other hand health care organizations have to fulfill several very important tasks that go beyond the primary task of providing quality services to patients (Grossmann 1995a): they secure employment, they are relevant purchasers of health care technology products, they are training and teaching institutions for health care professionals, they have the responsibility to conduct biomedical research. The primary task of service provision sometimes gets 'out of focus'.

Health care services can be defined as professional bureaucracies. 'The standards of the Professional Bureaucracy originate largely outside its own structure, in the self-governing associations its operators join with their colleagues from other Professional Bureaucracies' (Mintzberg 1993, p. 192). Health care organizations therefore follow the rules of what Mintzberg calls 'the power of expertise'. For laypersons to be able to participate actively in any process in such professional health bureaucracies their perspectives have to be acknowledged as expertise. Patient surveys are a possible way to do so.

How can the research of patient satisfaction contribute to organizational development?

Research in Organizational Development must position itself between the organizational and its perspectives and organizational consulting. As a means of orientation for this position, a working paper has been developed, the major points of which are summarized below (Gotwald et al. 1997):

- In contrast to conventional organizational research, organizational development research focuses on the professional interests of three directly involved systems (The organization, consultancy, and research) in order to produce results applicable in practice. This requires a fundamental understanding of the different logic that applies in each of the three systems.
- The expectations of all three systems involved must be defined at the beginning of the study and an appropriate method must be found for dealing with contradictory expectations.
- Data collection in the course of research and feedback of the results always constitutes an intervention into the system under scrutiny (organization or client system, consultant system, and consulting system). A mode of intervention must be chosen which promotes the development of the organization concerned.
- A possible approach would be to carry out research in close cooperation with organization consulting. Yet the perspectives of consulting and research must be set apart. Consulting attempts to stimulate an organization to a positive self-development and provide the necessary support whereas research attempts to gather general knowledge on the organization, the consulting and the interaction between the two, regardless of the success or failure of consulting. Despite the close relationship to consulting, a distinction must be made between a genuine research perspective and a consulting perspective.
- The results and reports of organizational development research constitute a service to the organization and the consultants, and these results must therefore be presented in a form that is beneficial and applicable to them.

Patient surveys are research projects. To generate applicable results is a challenge to methodology, a discussion that exceeds the scope of this paper. As research projects, in the first place patient surveys yield long reports. Only if the organization succeeds in translating the results into options for change, will they contribute to organizational development. This requires the cooperation with organizational consultants, either internal consultants such as quality managers or external consultants.

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Part 9

Quality Control and Management

Introduction: The Vienna Quality Management Project

Gabriele Strohmeier

The Vienna Hospital Association (VHA) owned by the community of Vienna is a large organization divided into the groups: top-management, 20 hospitals of different kinds and sizes, 10 nursing homes/geriatric centers and nursing homes for disabled people. It has 16.300 beds, 32.000 employees, 325.000 in-patients per year and an anual budget of 29.5 billion Austrian Shilling. In the late 80's the top-management established the organizational development department to find the best way for the hospitals to assure/improve their quality.

The steps of the draft development were: Research of literature and an exchange of international experiences (1989); competition for project participation between the hospitals and nursing homes of the VHA and selection of the six best entries (1993); project-plan development and start of the project (1994) and evaluation and end of the project (1997).

The Total Quality Management-system built up in 6 hospitals consists of:

1. *The introduction of the QM-structure (see paper U. Dickbauer):*
   To reach real quality improvement a clearly defined QM-structure (this is: QM-conference, quality-manager, several QM-coordinatores, quality-circles, quality-committees) has to be installed parallel to the primary organizational structure.
2. *Training and education:*
   All QM-training and education seminars are organised interdisciplinary and interactive. The participants come from different health organizations which leads to a most satisfying learning effect and exchange of experience.
3. *Coordination of the interfaces:*
   Providing an efficient advance the QM-project has to be coordinated in its relationship to other projects in the clinic as well as to other projects of the VHA.
4. *Communication inwards and outwards:*
   The implementation of TQM needs common project marketing strategies in order to involve the staff-members in the quality-process and public relations so that the customers learn about the quality efforts.
5. *Coordination, organization, documentation and evaluation:*
   The project-management and controlling is mainly the duty of the QM-conference and of the quality-manager.

Quality-Circle: Changing structures in Geriatric Hospitals (see paper G. Gatter)

Since the number of geriatric patients sufferring from different kinds of diseases has increased within the last three decades, the structure of the organizations had to be changed according to the specific needs of this group of patients. As quality of life, rehabilitation and living in the former surrounding are the primary needs of old patients, these aspects have been focused. They have established a new structure of treatment and care based on TQM with the main goal of psychosocial rehabilitation and reintegration of geratric patients in their former living surroundings. The results of a three year period show the method being effective because the number of rehabilitated patients has increased together with the satisfaction of patients and em-

Total Quality Management in Hospitals – How to build up a QM-System

Ursula Dickbauer

Four hospitals, one geriatric center and one nursing home of the Vienna Hospital Association were selected to implement Total Quality Management in order to demonstrate how it works in health organisations. The TQM-System we built up consists of five cornerstones, which will be described below.

1. Introduction of the QM-Structure

To reach *real* Quality Improvement a clearly defined QM-Structure has to be installed parallel to the primary Organisation-Structure:

- *The QM-Conference*
  This is the top decision making committee in the QM-process. It consists of the top management, staff members which represent the whole heterogenity of the clinic, the quality manager and the external project consultant. It´s job is to lay down the Quality Policy and Structure, to establish priorities concerning the choice of problems to work on, to place orders for the constitution of quality-circles and committees and to control the project in general.
- *The Quality Manager*
  He/she takes over the organisational leadership of the quality improvement process and with that all coordinative activities. Furthermore she gives seminars and trainings, advises quality-projects, moderates different meetings as the QM-conference and takes measures to develop the quality consciousness of the staff.
- Quality Committees
  These groups are working on hospital relevant themes (for instance hygiene, ethics, education) or on the concerns of an occupational group (for instance nursing-committee).
- *Quality Circles*
  Contrary, the QCs work on solving concrete problems. They are made up by those employees who are directly concerned with the problem, no matter which occupational group or hierarchical level they belong to.
- *Quality Management-Coordinators*
  These are staff-members who are engaged in the quality-work are in addition to their normal duties.

2. Training and Education

The QM-Philosophy is based on the assumption that staff-members can improve quality by themselves if they get trained and educated on problem-solving-instruments and receive enough support by the top-management. Our training and education programm is built up like a pyramid: the basis are the QM-Info-Seminars which are organised by the quality manager. Its object is to give more detailled information

about the QM-Philosophy and project and to begin the discussion about quality. All our staff-members should participate in one of these Seminars (three hours).

The next stone of the pyramid are the Workshops on QM-Basics: The aim of this workshop is to enable the participants to take part in a quality circle. This is reached by teaching and discussing QM-Theory and Methods. 10–15% of our staff members should take part in this workshops (3 days.) These Workshops and the following training courses get organised by the Department for Organisational Developement of the Vienna Hospital Association. They are all interdisciplinary and put together by members of different hospitals, geratric centers and nursing homes which leads to a most satisfying learning effect and exchange of experience. 3–5% of our staff-members should become a „Quality-Coordinator“ so that the QM-process reaches the whole organisation. The participants get enabled to facilitate quality circles and to take over different coordinating tasks in the QM-Process (14 days).

The top of the pyramid is the „Quality-Manager-Training-Course“. Depending on the size of the organisation 1–3 members should be released for the all-coordinating, organising and advising duty. (40 days theory).

3. Coordination of the Interfaces

- To safeguard an efficient advance the QM project has to be coordinated in its relationship to other projects in the clinic.
- To make the challenging task of implementing TQM for each one of the six demonstrating-institutions a bit easier some cooperations have been initiated as for instance: common seminars and meetings for the top-management, common workshops for the staff-members, a common newsletter has been published, and every year a congress on TQM is hold. All these cooperations have been organised by the Department for Organisational Development.
- The „Mission Statement“ of the Vienna Hospital Association shall be adapted in each hospital or nursing home in the near future. It has to be assured, that the mission statement becomes part of the quality work.
- The transition from the QM-project to the routine has to be well prepared so that it is possible to continue quality work after the project ended with little external support.

4. Communication inwards and outwards

We have to distinguish between the communication with those staff-members who are already involved in the project and those members who have to be interested in active participation. The first group has to be supported with identity-forming actions as for instance meetings for exchance of experience, public acknowledgement for successful Q-circle-work through the top-management. The second group has to get motivated to the quality work. For the communication with this group we use means of project-management, we give written informations about our quality-circles and committees, we publish a house organ, we invite them to our QM-conferences so that they can see which kind of work we do here, ask questions or bring in quality problems.

The Department of Organisational Development is publisher of a project-magazine called „New Quality“, organises conferences on QM, participate in conferences, read papers about the project and the quality work and others more.

Each hospital which is implementing QM has its own public relations strategy. For instance one hospital organises summer-festivals for the customers, asks them what they think about us, what they expect from us, puts advertisments into local magazines, we informs the hospital refering centers and doctors about organisational changes when it is relevant for them.

5. The project has to be coordinated, organised, documented and evaluated

This is mainly the duty of the quality manager. We distinguish between two kinds of evaluation: the outcome and the process evaluation. We measure the outcome first by using a questionnaire for the staff-members which should show how the organisation developed during the time of the project. Second, we measure the outcome by evaluating the quality-circle-work and third, by comparing the input with the output.

Optionally, every demonstrational house can also do process evaluation. This is a self assessment for the top-management which was developed in accordance with the European Quality Award to show which influence the top-management has on the success of the project and to improve the management-work in general.

Changing of structures in geriatic hospitals – From globality to individuality

Gerald Gatterer; Angelika Rosenberger-Spitzy

Introduction

The number of geriatric patients sufferring from varions kinds of diseases has increased within the last three decades. To cope with these problems, the structure of geriatric hospitals has to be changed according to the specific needs of this group of patients. In the „Centre of Geriatrics am Wienerwald" we established a new structure of treatment and care concepts oriented on terms of „Total Quality Mangement". The „Centre of Geriatrics am Wienerwald" is one of the reference houses of the project „Quality Mangement" of the „Wiener Krankenanstaltenverbund" (Vienna Hospital Association).

Description of the main problems

In the prior structure of geriatric hospitals in Vienna, patients with different kinds of disease have been placed unspecific somewhere in a nursing home. Care in these houses was oriented on terms like „to keep the patient warm", to feed them and to clean them. There was no individual treatment according to the specific needs of subgroups of patients e.g. demented patients. The number of rehabilitated patients was low, there was a high burn-out rate of the staff and the image of nursing homes was that of a „last step to heaven".

So we tried to establish an new structure of treatment oriented on the specific needs of the patients. There should be defined structures for subgroups of geriatric patients as physical rehabilitation, psychosocial rehabilitation, short-term care and long-term care as well as a hospice and specific structures for demented patients. To do this selection, all inpatients are diagnosed according to physical, psychical and social functions in a geriatric assessment. The aim of this change of structure was to preserve and train these functions, to improve patients life-quality and to increase the number of rehabilitated patients. Furthermore work-satisfaction of the staff and defined standards of quality should increase, too.

Results

The paper presents the results of a three year follow up period of one of these new concepts called „Psychosocial Rehabilitation". This is a new concept to reintegrate geriatric patients to return to their former living surroundings. In the past it was hard to reintegrate longterm geriatric patients from wards into their former living surroundings. Usually there was no adequate instruction of the patients to cope with these problems. So many patients stayed in hospitals or nursing homes though it was not necessary. The main psychic problems of rehabilitation are anxiety, depression, loneliness, alcoholism and hospitalism. Most times there are inadequate living situations e.g. stairs or no bathroom and problems with the family or treatment at home.

To cope with these problems we created a new way of in patient treatment, similar to the external situation. The planning of reintegration at home is now done together with the patient. There is a training of cognitive, social, physical and behavioral functions according to the needs of the patients. Behavioral psychotherapy shall help to cope with psychic problems. As there is no medical treatment and care for 24hours a day at home, medical treatment in these new department is organised in the form of an out-patient clinic from 8:00 to 12.00 am and the patient is asked to go to this clinic in case of pain. Care is oriented in terms of reactivation and training of activities of daily-living. The whole staff motivates the patient that he is able to leave the hospital. Very important is the integration of the patients family in the process.

There is a shaped reintegration at home starting with visits and short stays and ending with living at home with the help of extramural organisations. In the first part of staying at home the patient is visited by a nurse, social-worker or psychologist from the interdisciplinary team of the department to cope with the fact of living alone. Figure 1 shows the results of the three-year-period of rehabilitation.

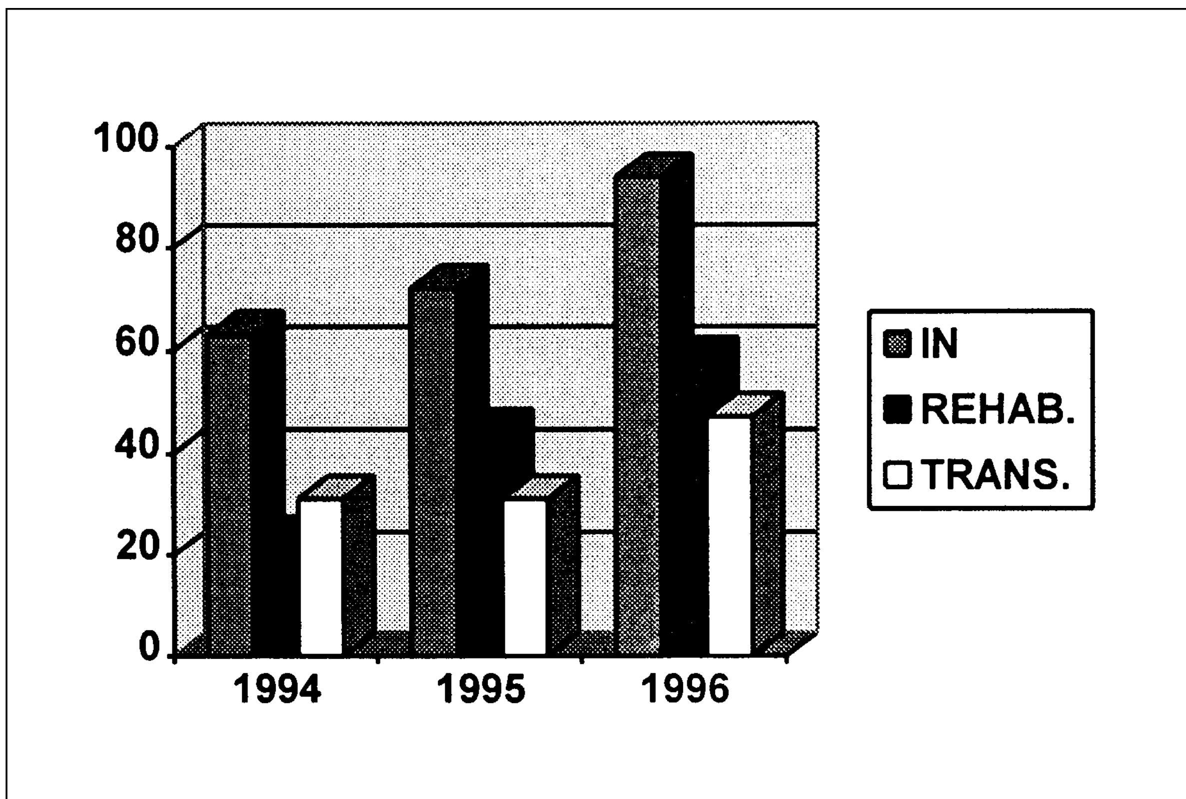

Figure 1: Number of rehabilitated and misplaced patients within a three-year-period.

As can be seen from Figure 1, the number of in-patients and rehabilitated patients has increased significantly within this period. At this time the rehabilitation-quotient of this department is about 66%. But on the other side, the number of misplaced patients (transferred to another department in care of illness) has increased too. From this point of view, psychosocial rehabilitation is effective in rehabilitating patients with primary psychic illness at home, but the criteria of assessment have to be strengthened to reduce the number of misplaced patients.

Conclusion

Psychosocial rehabilitation is a new structure of treatment, to reintegrate geriatric patients in their former living surroundings. Results of a three year period show the method being effective, because the number of rehabilitated patients has increased significantly. So quality-management structures may be helpful to create new ways of care oriented on the specific needs of the patients.

Main problems are a lack of adequate residence-homes for geriatric patients, who need a little more structure as at home but no stationary treatment in a geriatric hospital. Also the coordination of extramural assistance and the cooperation of external and internal professions has to be improved. In case of limited personal ressources in the department, assistance of the patient at home has to be shortened. There are problems with the patients family, too, who often want them to be treated in the nursing home as it is easier for them.

As there are similar results in physical-rehabilitation, hospic and assessment, the way of changing the structures of Geriatric Hospital am Wienerwald is continued. At the moment we are planning structures for demented patients oriented towards preservation of cognitive functions, independence and security. From our point of view quality management concepts can help to improve quality of life of geriatric patients with dementia and other diseases in stationary fields and should therefore be prompted and integrated into new concepts of rehabilitation.

Quality of Care: System Quality in the Azienda Ospedaliera Ospedali Riuniti di Bergamo (Italy)

Antonio Bonaldi, Marco Salmoiraghi, Claudio Sileo, Stefano Zenoni

Introduction

Improving the quality of care seems to be one of the most important challenge of the modern health care system. The quality of health care has heen defined in various ways in the last decades: the common determinants of the quality of care seem to rely on health promotion, disease prevention, informed participation of patients, attention to the scientific base of medicine, and efficient resources utilization. Perspectives on quality are different and include, with varying emphasis, the health care professionals, the patients, the health care organizations. In any case the involvement of physicans and other health care professionals is crucial. To deliver and ensure good health care, specific measures are necessary to systematically and continuously evaluate and enhance the quality of care.

We report on the experiences of the Azienda Ospedaliera Ospedali Riuniti di Bergamo in providing a systematic approach for quality improvement of the health services through the active participation of the health care professionals. Specific groups of work for selected topics are formally established.

Methods

In January 1995 the Azienda Ospedaliera Ospedali Riuniti di Bergamo launched a program of quality improvement of the health services. The quality program assumed an active collaboration between the hospital administration (medical and administration directorate) and the health care professionals working in the hospital. The Azienda Ospedaliera Ospedali Riuniti di Bergamo is situated in the North of Italy and is composed of 48 wards and services, 1550 beds and about 3500 health care professionals. The catchment area covers the population of the Province of Bergamo (about 900.000 residents).

A preliminary letter about the objectives of the quality program circulated among all health care professionals and administrative personnel of the hospital. In the meantime they were asked to participate in the program. Specific areas of interest for quality improvement were identified and included: the health technology assessment, the evaluation of appropriateness of hospital admissions, the performance indicators, the clinical guidelines for the diagnostic and therapeutic procedures, and the Chart of the public health services. For each topic a working group was formally established. The working teams are multi-professionally and multi-disciplinary-oriented and include an average of 20 people: their enrollment was exclusively-based.

The main methodological issues concerning the measures of quality and the process improvement were provided by internal and external experts in the evaluation of health care. Periodic meetings and reports for monitoring the progress of the project have been strictly scheduled.

Results

After their formal institution, each group was initially engaged in discussing the contents of their programs. The main activities and preliminary results of the 5 working group are summarized as follows:

Health technology assessment group

Main objective is to provide technical, scientific and economic informations in order to make decisions about the acquisition of new 'innovative' health technologies and the evaluation of in-use health technologies with regard to the costs, the effectiveness and the safety. In 1996 the activities of the group were focused to:

- methods to be employed in the current evaluation of health technologies;
- literature review of previous experience of technology assessment;
- definition of a flow chart for requesting new or 'innovative' health technologies and the preparation of a form for their application;
- activation of pilot projects concerning a preliminary evaluation of the actual requests of heath technologies (e. g., intravasal ultrasound devices).

With regard to the informational aspects, a specific workshop, devoted to the problems related to the technology assessment, was organized in 1996 with the participation of experts in the evaluation of health care.

Evaluation of appropriateness of hospital admissions group

Main objective is to evaluate the appropriateness of hospital utilization in order to understand the impact of avoidable admissions, according to a standard protocol named Protocollo Revisione Uso Ospedale (PRUO) and to promote interventions oriented to reduce them. In 1996 the group conducted a study according to PRUO, based on the Appropriateness Evaluation Protocol (AEP) with the supervision of an external panel of experts.

The results of the study were discussed in detail with the staff of wards and services. The rate of inappropriate admissions was 47% and the rates of inappropriate pre- and post-operative days of stay were 54.5% and 36.1% respectively. In this study the main reasons for inappropriate use of hospital seem to be related to internal organizational problems rather than external factors. The study demonstrates that AEP-like protocol (PRUO) is applicable in assessing the general appropriateness of hospital use, and finding overutillization of the hospital services. Further analysis could be addressed to evaluate the effectiveness of the intervention through simple and reliable indicators.

Performance indicators group

The main objective is to identify the performance indicators in assessing different areas of interventions of the hospital, to evaluate their variations compared to standard criteria, and to offer the most suitable changes. The activities of the group proceeded from a preliminary review of the literature and an evaluation of other experiences. It was agreed to identify a minimal set of quality indicators, characteristical-

ly differentiated in generic, based on administrative data, easily comperable with other data, and in specific indicators that usually require more elaboration. Different clinical settings were individuated, included medicine and surgery wards, medical and surgial day-hospital, surgery rooms, services (laboratory, radiology, microbiology, etc.). In order to prepare an efficient monitoring system of the clinical activities, the following steps were considered:

- survey devoted to the collection of data about the activities of the wards;
- activation of a pilot phase to test the application of definite indicators in a restricted number of wards;
- presentation of the results of the pilot phase to the hospital personnel;
- extension of the project to the whole wards and services of the hospital.

Guidelines of the diagnostic and therapeutic procedures group

The main objective is to elaborate evidence-based guidelines concerning the diagnostic and therapeutic procedures and to enhance the compliance to good clinical practice criteria. The first year activities concentrated on the use of pre-operative tests in patients admitted for elective surgery. The research started from the folIowing items:

- audit of actual clinical practises in hospital;
- systematic review of literature about the role of pre-operative tests (i. e., X-rays, blood tests, electrocardiogram, etc.) in different settings;
- definition of reference criteria for judging the usefulness of pre-operative tests (indication versus screening tests).

Both legal and organizational implications were considered in the evaluation process. A detailed report concerning the major problems discussed was circulated among the clinicians, in particular surgeons and anaesthetists.

Chart of the public health services group

The main objective is to promote a significant change of the relationship between the hospital health services and the public, providing an effective information system about the hospital procedures in collaboration with public voluntary associations.

A survey devoted to obtain information about the hospital health services was launched in 1995. A detailed questionnaire about the type of medical specialties, the names of the specialists, the opening hours of the clinics, the procedures for admissions, the costs of visits was distributed to the wards. Another questionnaire collected information about hospital admissions, the quality of hospitalization and the discharges. A specific software program for the management of the information was realized.

A Chart of the public health services was prepared and an information desk, specifically devoted to the public was established in 1996 in the context of the 'Office for public relations'. The latter functions on a regular basis, providing periodic reports about current activities. The evaluation system relies on questionnaires for the users and continuous monitoring of the requests.

Discussion

Quality of care as a new field of work has achieved a more or less stable position in health care. Health care professionals are increasingly faced with new and old demands, through laws and regulations of health authorities and professionals organizations, to set up a systematic and continuous quality improvement. Provision of care is a complex process and demands changes of attitudes and structural adaptations in the organizations.

The quallity improvement *per se* includes a variety of mutual related activities, such as tracing problems, clinical guidelines, protocols, targets for good clinical practice, and reviewing actual performance. An interesting point of view is to consider quality improvement as an activity closely related to practice, covering a key position between research on health and the patient and research on health services.

Quality improvement uses specific procedures and processes, based essentially on the following activities: identification of quality problems; setting guidelines and criteria; collection of data and evaluation of actual care. The project of quality improvement activated by the Azienda Ospedaliera Ospedali Riuniti di Bergamo is a structured program, strongly practice oriented.

Our experience demonstrates the feasibility of a quality of care sytem centered on active participation of the health care professionals. lmproving quality in the delivery of health care needs a structured program of various but related activities, planned along strict organizationaI criteria.

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The Public Health Service Chart: The experience of the Azienda Ospedali Riuniti di Bergamo (Italy)

Luisella Barberis, Antonio Bonaldi, Francesco Locati

Aims

In the last few years several initiatives have been implemented aiming to improve of the relationship between citizens and the local authorities, and the citizen's Chart represents one of the key elements. With regard to the health care, increasing problems seem to be present when people needing care get confronted with the Public Health services. Often people do not know where to go when faced with a health problem, since they are not familiar with the services offered by the hospital. This not only projects a negative image of the hospital, but causes also a considerable waste of time and resources both for the patient and hospital personnel, creating difficulties in having access to relevant information. There fore the aims of the program were:

- to enhance a positive image of the hospital, promoting mutual respect and offering clear guidelines to health personnel and patients;
- to offer more simplified and appropriate access to services through an efficient information system;
- to give people who demand care, accurate and detailed answers related to what the hospital offers, and making it easy for them to go to the exact area where their needs can be taken care of.
- to allow hospital personnel, especially those directly involved with the public, to have a clear idea of the spectrum of services available within the hospital.

Methods

Within the context of a program for improving the quality of care a Chart of the public health services has been implemented and the project for an information desk, named Punto Informazione Utenti (PIU), is a part of it. The project is supervised by the Medical Director of the hospital and relies on 'ad hoc' staff specially trained in collecting and spreading information. First of all a specific file has been introduced and designed for each ward:

- type of specialties and names of clinicians;
- type of out-patient clinic:
- health services available;
- timetable and days per week in which the clinic is open;
- modalities for booking and for access;
- required certificates;
- waiting times;
- charges;
- modalities of access to private care.

All information has been controlled with regard to: admission, discharge, hospital staying, hospital services and emergency.

Results

A Chart of the public health services of the Azienda Ospedaliera Ospedali Riuniti di Bergamo is currently available both as a brochure and on floppy disk containing a complete view of the whole activities of the hospital. Since April 1996 an information desk (PIU') has been operating at the main entrance of the hospital which is open to the public during the week with one or more members of staff, specifically trained. The information desk is capable of handling most of the queries related to more than 4000 different health services spread out in more than 400 reference points within the hospital. All relevant information have been selected and computerized (the software program has been devised by a privat company). The constant updating of the program is carried out by trained personnel according to clear guidelines. To allow for a quick and easy access to information some computerized forms were prepared. These forms contain the following detailed information: specialties; type of out-patients' clinic or service; type of instrumental tests and therapy available; telephone number of out- patients' clinic or service; location; names of clinicians; days and timetable of out-patients' clinic; modalities for booking an appointment and/or examination; waiting lists; charges; fees for private consultations and date when information filed.

Furthermore two aids for evaluation have been set up: a questionaire for the patients to gather data about the functioning of the system and the automatic entry of the number of requests to the information.

Discussion

The Public Health Services Chart represents an important tool in the process of improving the relationship between the public and the health professionals. The publication of the Chart is part of a general program aiming at improving the quality of care which includes the establishment of an 'Office for Public Relations' and an information desk PIU. The latter would be able to support the collaboration with other public organizations in terms of health promotion. In fact, during the implementation of the program the wider public has been involved through regular contacts with volunteers' associations and groups working on behalf of patients. The information desk started in April 1996 and handles all main queries relating to the large amount of available services within the hospital.

Essential is the role of specifically trained staff for gathering, handling and making available all relevant information received, and undergoing a stable process of ascertainment and updating. The information desk which focuses on the access and on the availability of health care, is open not only to the public, but also to the hospital personnel, making it possible, in this way, to enhance the circulation of the relevant information.

Experience over last few months shows that inquiries often contain requests for much more complex problems. Crucial for a good functioning of the program is the capability to give prompt and clear answers, even concerning the most complex public requests.

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In-hospital pseudo-infections due to contamination of medical devices marketed as sterile: A challenge for quality control

Francesco Locati, Antonio Golio, Annalisa Grigis, Maria Lucia Di Vita

Introduction

Interest in hospital-acquired infections is increasing and many programs have been devised for their control in the last decades. One important surveillance method for the prevention and control of hospital acquired infections is based on a systematic review of microbiology data in order to identify and follow- up patients with suspected nosocomial infections.

This alertness system is also important for detection of pseudoinfections or pseudoepidemics that refer to clusters or epidemics not due to a true infection. Prompt identifaction and confirmation of pseudoinfections have several implications for the patient, allowing to avoid the administration of needless or improper anti-biotics, the concealing of an actual pathogen, and a delay in ordering tests for an alternative diagnosis

We report the experience of the Azienda Ospedaliera Ospedali Riuniti di Bergamo about the recognition of three different outbreaks of pseudoinfections over a 2-year period (1994–1995).

Methods

An infection surveillance program is currently available on a stable basis in the Azienda Ospedaliera Ospedali Riuniti di Bergamo. A multidisciplinary group of experts, composed of a microbiologist, an infectious diseases specialist, a hygienist, a pharmacist and an epidemiologic nurse, has been established in the setting of the local Committee of Nosocomial Infections Control that also includes other health professionals. The multidisciplinary group for infection control routinely participates in the activities of in-hospital infections prevention and control, providing a weekly report of the main problems.

The monitoring system is based on a regular review of centralized microbiology records of in-hospital patients by the Microbiology Unit staff in order to promptly recognize the occurence of clusters or epidemics. Investigational survey is prompted in the presence of a cluster of suspected infection, according to a standard protocol that includes review of the clinical records, the procedures of collection, handling and processing the clinical specimens, and direct contacts with the personnel.

Results

1st outbreak.

In the period JuIy 1994 the Microbiology Unit isolated *Burkholderia pickettii*, a non fermentativ gram-negative bacillus, from blood culture specimens of 9 patients, 8 from Infectious Diseases Department and 1 from Hematology Department. According to a standard protocol, the multidisciplinary group for infection control activated

an epidemiological investigation for the detection of a possibles ource of pseudo-bacteremia. A comprehensive list of all possible sources of bacterial contamination during the blood specimens taking and processing procedures was drawn up. Clinical and demographic data were obtained by reviewing medical records and stable contacts with the wards personnel were kept on. A preliminary analysis of the available data permitted to exclude the role of the processing procedures (Bactec 860 – Becton Dickinson) of the specimens in question. A detailed review of the clinical records restricted the imputability to the specimens collection. In particular in-use tests for antiseptic solutions (chlorhexidine), marketed in sterile blisters, isolated *Burkholderia pickettii* from the batch used for the skin preparation on the patients before blood taking. The contaminated batch was immediately withdrawn and the health authorities notified.

2nd outbreak

In December 1995 the Microbiology Unit isolated *Burkholderia cepacia*, a non fermentive gram-negative bacillus, from blood culture specimens of 11 patients and from peritoneal fluid of 1 patient admitted in 7 different wards. The result of the epidemiological survey showed characteristics similar to the previous episode, isolating *Burkholderia cepacia* from the batch of an antiseptic solution (Chlorhexidine), marketed in sterile Blisters, utilized for skin preparation of the patients. The contaminated batch was withdrawn and the health authorities notified.

3rd outbreak

In Jannuary 1995 the Microbiology Unit communicated an unusual number of isolations of *Fusarium verticillioides* from various specimens (liquor, fluids of broncho-aspiration, pus and other body fluids) of 13 patients admitted in 6 different wards in the period September-December 1994. The epidemiological investigation started in the Department of Heart Surgery where most patients were admitted. Each suspected source of possible contamination were carefully evaluated, including the specimens collection, handling and processing procedures. The analytical tests performed on medical devices permitted to evidentiate the isolation of *Fusarium verticillioides* from the holders used for the collection of various body fluids specimens. The specimens holders, marketed as sterile, were widely used for the collection of urine and sporadically for the collection of other body fluids. The batch of contaminated holders was promptly withdrawn and the health authorities notified

Discussion

Pseudoinfections or pseudoepidemics refer to the isolation of an infective agent from the patients specimens without the patient having any manifestations of infectious disease. According to some authors pseudoinfections or pseudoepidemics could be considered as a consequence of medical progress, reflecting intensifying interest in nosocomial infections and the increasing complexity of diagnostic clinical microbiology. Pseudoepidemics of all types comprised 11% of 181 nosocomial outbreaks investigated by the Center for Disease Control, Atlanta, between 1956 and 1975. Sixty percent of these nosocomial pseudoepidemics presented as outbreaks of bacteremia, respiratory tract infections, or gastroenteritis with gram-negative bacte-

ria (i.e. *Burkholderia cepacia, Serratia* spp., *Klebsiella* spp.) are the most frequent isolated etiologic agent.

Investigation for the source of an outbreak proved challenging to distinguish between the occurence of a pseudoepidemic or an actual epidemic. Our monotoring program, based on a regular review of microbiology laboratory records, functions as an alerting system able to activate the procedures for the detection of a pseudoinfection or a pseudoepidemic. Their prompt identification is obviously very important: patients may unnecessarily be treated with antibiotic therapy; true infection may be masked by the growth of contaminated species; the positive cultures may prevent or delay further search for an alternative diagnosis.

Among factors useful in recognizing a pseudoinfection or a pseudoepidemic, the isolation of 'uncommon' pathogens with uncommon frequency is one of the most important. A comprehensive list of all eventual sources would be kept in mind. The sources of a contaminating microorganism could be multiple, unusual and, in some cases, unexpected. Although less probable, an intrinsic contamination of the medical devices marketed as sterile and commonly used in the routinary activities couldn't be excluded. For these reasons detection of pseudoinfections may be difficult. Investigation survey would be supported and co-ordinated by a multidisciplinary group for infection control, composed of individuals with expertise in hospital hygiene, microbiology, infectious deseases, pharmacy; other experts, if necessary would be contacted. The result of the investigation would be timely communicated to the hospital administration for adopting the necessary precautions in terms of policy surveillance (i.e., withdrawal of the contaminated product, notification to health authorities and to manufactures). In relation to the two outbreaks of pseudobacteremias observed in 1994 and 1995, the local Committee of Nosocomial Infections Control of the hospital established to perform routinely microbiological tests on a significative part of every new batch of antiseptic solutions before their distribution to the wards.

Conclusion

Efficient surveillance methods should rely on the utilization of appropriate quality control procedures, the alertness of the microbiology laboratory staff and the effective communication among the infection control professionals. Based on this experience, quality control of medical devices marketed as sterile could be an emerging problem.

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Nosocomial Infection in the Red Cross University Hospital, Vilnius

Vida Kleziene, Gediminas Degutis

Red Cross University Hospital in Vilnius, Lithuania, has joined the national HPH network in December 1996. One part of this project is to prevent nosocomial infections. This work is coordinated by the Head of the Hospital and managed by a joint committee. The main aim of this program in our hospital is to prevent the spread of nosocomial infections (NI), by establishing rational use of antibiotics and introducing better hygienic practice. As a starting point a prevalence study is conducted since December 1996. The aim of this study was to obtain objective information on the general features and prevalence of NI in different departments. Traditional methods of prevalence studies used by Meers in the national survey of infections in hospitals in UK have bean applied. 348 patients (mean age 52.1 years) were investigated. 18.1% of all patients had an infection. The prevalence of community acquired infections was 12.6%, prevalence of NI 6% (see Table 1 and 2 and Figures 1 and 2).

Naturally the nosocomial infection rates and their severity depending on type of patterns were higher in surgical (15.4%) and traumatological (15.0%) departments. 22.4% patients were treated with antibiotics. Penicillin and gentamycin were used most frequently.

Table 1: Amount of nosocomial and community aquired infections in different departments of the hospital

Department	**Number of patients investigated**	**Nosocomial infections**		**Community acquired infections**	
		number	**%**	**number**	**%**
ICU	9	2	22.2	0	0
Urology	35	3	8.6	11	31.4
Traumatology	40	6	15.0	3	7.5
Surgery	39	6	15.4	3	7.7
Microsurgery	23	3	13.0	1	4.3
Neonatology	6	0	0	0	0
Obstetrics I	5	0	0	0	0
Obstetrics II	11	0	0	1	9.1
Gynecology	26	1	3.8	1	3.8
Therapy	54	0	0	15	27.8
Gastroenterology	33	0	0	1	3.0
Endocrinology	26	0	0	5	19.2
Rheumatology	41	0	0	3	7.3
Total	**348**	**21**	**6.0**	**44**	**12.6**

Table 2: Types of hospital aquired infections

Type of the infection	Acquired in our hospital	
	Number	%
Superficial infection of the wound	7	33.3
Deep infection of the wound	4	19.0
Fever undetermined	4	19.0
Upper respiratory tract	2	9.5
Pneumonia	1	4.8
Subcutaneous abscess	1	4.8
Intestinal	1	4.8
Peritonitis, abscess	1	4.8
Total	**21**	**100**

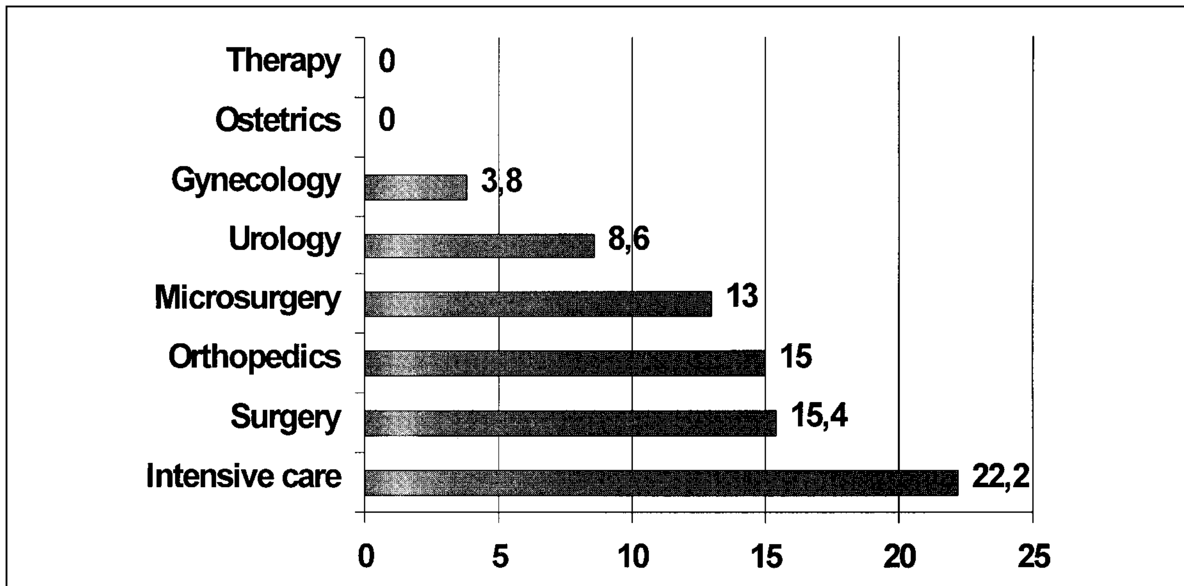


Figure 1: Prevalence of Nosocomial infections in different departments

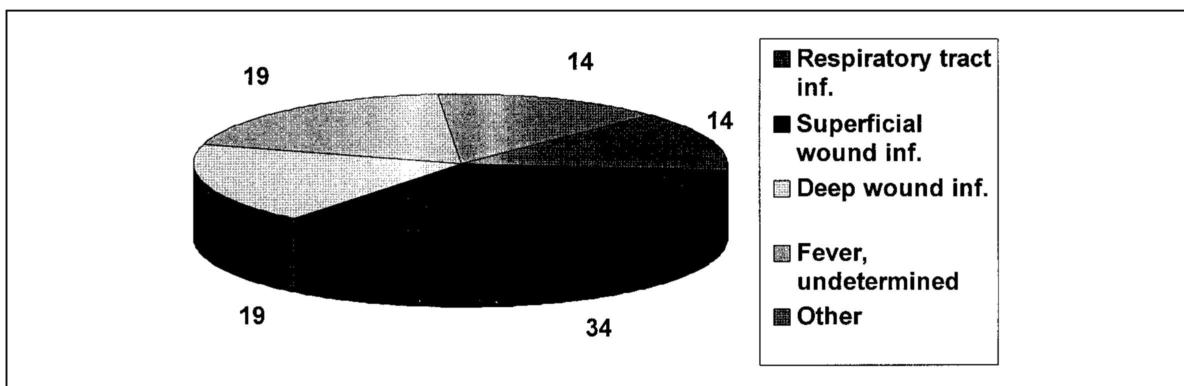


Figure 2: Structure of Nosocomial infections (%)

Conclusions. The survey data revealed priorities for preventive measures which will be dealt with in the ongoing program.

Authors

ARKADOPOULOS, Nikolaos Dr.
Areteion Hospital
32 Skoufa Street
GR-10673 Athens
Greece
+30/13604894
+30/164508701
ispm@compulink.gr

ASHCROFT, Stephen J.
Chief Executive
Royal Preston Hospital
Acute Services
Sharoe Green Lane
Fulwood
Preston, PR2 4HT
UK-England
+44/1772710692
+44/1772710194

AUJOULAT, Isabelle
Coordonnatrice
Centre Hospitalier Victor Jousselin
Unité de Prévention et d`Education
(U.P.E.)
44, Avenue Kennedy
F-28102 Dreux
France
+33/237515459
+33/237515459
UPE.dhgDREUX@wanadoo.fr

BAKER, Susan
Health Promotion Constultant
132 Ashby Street
Brisbane Old 4103
Australia
+67/38487131
+67/38443014
baker@powerup.com.au

BARBERIS, Luisella
Azienda Ospediali Riuniti
Largo Barozzi 1
I-24122 Bergamo
Italy

BAUGUT, Gunar Dr.
DKI GmbH Deutsches Krankenhaus-
management
Beratung u. Forschung
Am Bonneshof 6
D-40474 Düsseldorf
Germany
+49/211454880
+49/2114548850
dki_gmbh@t-onlie.de

BELANGER, Michel Prof.Dr.
University of Bordeaux
Bordeaux IV
Avenue Leon Duguit
F-33608 Pessac
France
+33/556/84.85.86
+33/556842931

BERGER, Hartmut Dr.
Ärztlicher Direktor
Philippshospital
Psychiatrisches Krankenhaus
D-64560 Riedstadt
Germany
+49/6158/183*201
+49/6158/183.233

BONALDI, Antonio Dr.
Azienda Ospedaliera
Ospedali Riuniti de Bergamo
Largo Barozzi Nr.1
I-24128 Bergamo
Italy
+39/35269018
+39/35247245

CERATTI, Francesco Dr.
Medical Director
Vittore Buzzi Hospital
L. Sacco Hospital
Via G. B. Grassi 72
I-20157 Milano
Italy
+39/2/35.79.92.00
+39/2/39.00.01.16

COMERFORD, Denise
Health Promotion Nurse
St. Vincent`s Hospital
Dep. of Preventive Medicine/
Cardiology
Elm Park
IRL - Dublin 4
Ireland
+353/1/283/9444
+353/1/283/8123

COURTNEY, Annie
Health Promotion Coordinator
Altnagelvin NHS Trust
Western Health & Social Services
Board
Glenshane Road
Londonderry BT47 1SB
UK-N.Ireland
+44/504 45 171/3697
+44/504 311 020

DICKBAUER, Ursula Mag.
Quality Manager in Health Care,
Sociologist, Registered Nurse
Kinderklinik Glanzing
Glanzingg.35-37
A-1190 Wien
Austria
+43/147615431
+43/147615369

DOHERTY, Denis Dr.
Chief Executive Officer
Midland Health Board
Standing Committee of thei European
Community
Arden Road Tullamore
IRL- Cooffaly
Ireland
+353/506/21.868
+353/506/51.760

DOHERTY, Margaret
Altnagelvin N.H.S. Trust
Health Promotion Liason Office
Glenshane Road
London Derry BT 47/I
UK-England
+44/150445171
+44/1504611218

DWYER, Judith
Chief Executive
Flinders Medical Centre
Health Promotion Unit
AUS-5042 Bedford Park
Australia
+61/8/82044067
+61/8/82045834
jdwyer@fmcmail.fmc.sa.gov.au

EYSYMONTT, Zbigniew Dr.
GCR „Repty“ - Ustron
Ldvojowa Street
PL-43-450 Ustron
Poland
+48/335544177
+48/33544177
repty-us@cieszyn.petex.bielsko.pl

FAVARETTI, Carlo Dr.
Medical Director, Coordinator of the
Veneto Region HPH Network
Hospital of Padova
ULSS No. 19
Via Badini 57/1
I-15011 Adria
Italy
+39/426940513
+39/4269009901
cfavaret@protec.it

FIELDING, Pauline PhD, BScHons, RGN
Nursing Director
Preston Acute Hospitals NHS Trust
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston PR2 4HT
UK-England
+44/1772/710.802
+44/1772/710194
pauline.fielding@nursing.pah-tr.nhs.uk

FISHER, Sian
Royal Preston Hospital
Estate & Facilities
Sharoe Green Lane North
Fulwood, Preston, PR2 8DU
UK-England
+44/1772710208
+44/1772774029

GARCIA-BARBERO, Mila Dr.
Hospital Programme
WHO-Europe
Health Services Department
Scherfigsvej 8
DK-2100 Copenhagen 0
Denmark
+45/39171865
+45/39171270
mgb@who.dk

GATTERER, Gerald Dr.
Geriatric Hospital am Wienerwald
Department of Psychology and Psychotherapy
Jagdschloßg.59
A-1130 Wien
Austria
+43/1805160758
+43/1801103763

HAFEZ, Ghada Dr.
Director, Regional Director
Word Health Oranization
Health Protection and Promotion
Regional Office for the Eastern Med.
Sultan Abdel Aziz Street
ET- Alexandria 21511
Egypt
+212/4830090
+212/4838916
hafezg@who.sci.eg

HALMOS, Tamas Prof. Dr.
Orszagos Koranyi Tbc es
Pulmonologiai Intezet
Pihenö ut 1
H-1529 Budapest XII.
Hungary
+36/1/200.28.79
+36/1/200.28.79

HEIMERL, Katharina Dr.
IFF-Abt. Gesundheit
Goldschlagerstr.78/15
A-1500 Wien
Austria
+43/1/9858028
+43/1/5234331-18
gesundheituoe.iff@univie.ac.at

HILDEBRANDT, Helmut Mag.
Hildebrandt GesundheitsConsult
GmbH
Borsteler Chaussee 53
D-22453 Hamburg
Germany
+49/40/5148550
+49/40/51485514
101.17312@germanynet.de

HNILICOVA, Helena PhDr.
Postgraduate Medical School
School of Public Health
Ruska 85
CZ-10005 Prague
Czech Republic
+42/2748462
+42/27484624

HÜLLEMANN, Klaus-Diethart
Univ.Prof.Dr.
Ärztlicher Direktor
Klinik St. Irmingard
Osternacher Straße 103
D-83209 Prien am Chiemsee
Germany
+49/8051607526
+49/8051607562

JAIN, Carrie
Assistant Health Promotion Manager
Westcare Business Services
Lilac Villa
12c Gransha Park
Clooney Road
L' Derry BT47 1WJ
UK-N.Ireland
+44/150445171
+44/1504865128

JANECKOVA, Hana Ph.Dr.
Postgraduate Medical School
School of Public Health
Ruska 85
CZ-10005 Prague
Czech. Republic
+42/2748462
+42/27484624

JOHNSTON, Margaret
Borders Community
Health Services NHS Trust
Huntlyburn House
Melros
Roxburgshire
United Kingdom
+44/1896662300
+44/189682287

JOLLY, Dominique MD, PhD, Prof.
2, rue Saint Martin
F-75006 Paris
France
+33/1/40.27.41.36
+33/1/40.27.41.54

KABIR, Sarifa
Preston Acute Hospitals NHS Trust
Accident and Emergency Department
Sharoe Green Lane North
Fulwood
Preston Lancashire PR1 9HT
UK-England
+44/1772710889
+44/1772710333

KARSKI, Jerzy B. Dr.
National Center for Health
System Management
Deuga 38/40
PL-00238 Warsaw
Poland
+48/226353620
+48/22314712

KAUTZKY, László Dr.
Országos Korányi Tbc és
Pulmonologiai Intézet
Pihenö ut 1
H-1529 Budapest XII.
Hungary
+36/1/200.28.79
+36/1/200.28.79

KENNEDY, Mark
Health Promotion Co-ordinator,
Monklands Hospital NHS Trust
Monkscourt Avenue
Airdrie
UK-Scotland
+44/1896662300
+44/1236760015

KICKBUSCH, Ilona Dr.
Director
WHO/EURO
Division of Health Promotion and
Education
20, avenue Appia
CH-1211 Geneva 27
Switzerland
+4122\791.28.87
+4122\791.41.86
kickbusch@who.ch

KILIAN, Reinhold Dr.
University of Leipzig
Dept. of Psychology
Johannisallee 20
D-04317 Leipzig
Germany
+49/3419724522
+49/3419724539

KLEZIENE, Vida Dr.
Vilnius University
Red Cross Hospital
Zygimantu 3
LT-2000 Vilnius
Lithuania
+370/616258

KORN, David M.D.
Donwood Institute
175 Brendcliffe
Toronto M4G 3Z1
Canada
+1/4164253930
+1/4164257896
dkorn@donwood.org

KOVACS, Martha
Markusovszky Teaching Hospital
Markusovszky ut. 3
H-2700 Szombathely
Hungary
+36/94311542
+36/94327073

KRAJIC, Karl Dr.
Ludwig Boltzmann-Institute
for the Sociology of Health and
Medicine
Universitätsstr. 7/2
A-1010 Vienna
Austria
+43/1/42.77-48.283
+43/1/42.77-48.290
karl.krajic@unive.ac.at

KRISTENSON, Margareta Dr.
Centre for Public Health Science
S-58185 Linköping
Sweden
+46/13/22.50.75
+46/13/22.50.95
margareta.kristenson@phyc.li.se

LE FAOU, Anne-Laurence Dr.
Assistante
Assistance Publique Hopiteaux de Paris
2 rue Saint Martin
F-75006 Paris
France
+33/140274745
+33/1/40274164
dai@sap.ap-hop-paris.fr

LOCATI, Francesco M.D.
Ospedaliera Ospedali Riumiti de
Bergamo
Medical direction
Largo Barozzi 1
I-24122 Bergamo
Italy

MARCATO, Giorgia Dr.
Padova Teaching Hospital
Health Direction
Via Giustiniani 3
I-35100 Padua
Italy
+39/498213381
+39/498213395

MCCARTNEY, Raymond
Project Manager
Altnagelvin Area Hospital
Glenshane Road
Londonderry BT47 1SB
UK-N.Ireland
+44/504/45.1.71
+44/504/31.10.20

MEHARG, Annie
58 Sea Road
Castlerock
Co. Deriy, BT52 4T
UK-N.Ireland
+44/1265/848093
+44/1504/261884

MISEVICIENE, Irena Prof.
Deputy Director
Kaunas Medical Academy
Inst. of Biomedical Research
Eiveniu Str.4
LT-3007 Kaunas
Lithuania
+370/7731073
+370/7796498
CMTI@GEN.KMA.LT

MURSA, Wolfgang
Managing Director/Project Coordinator
Diakonie Krankenhaus Alten Eichen
Wördemanns Weg 19-35
D-22527 Habmburg
Germany
+49/4054872419
+49/4054872443

NOVAK-ZEZULA, Sonja Dr.
Ludwig Boltzmann-Institute
for the Sociology of Health and
Medicine
Universitätsstr. 7/2
A-1010 Vienna
Austria
+43/1/42.77-48.287
+43/1/42.77-48.290
oenetz.soc-gruwi@univie.ac.at

NOWAK, Peter Mag.
Ludwig Boltzmann-Institute
for the Sociology of Health and
Medicine
Universitätsstr. 7/2
A-1010 Vienna
Austria
+43/1/42.77-48.280
+43/1/42.77-48.290
peter.nowak@unive.ac.at

O'RIORDAN, Ann
Project Coordinator
James Conolly Memorial Hospital
Health Promoting Hospitals Project
Blanchardstown
IRL- Dublin 15
Ireland
+3531 820 3565
ihphnet@iol.ie

PAUL, Rainer Dipl.Psych.
Philippshospital
Psychiatrisches Krankenhaus
D-64550 Riedstadt
Germany
+49/6158/183.267
++49/6158/183.233

PELIKAN, Jürgen M. Univ.-Prof.Dr.
Ludwig Boltzmann-Institute
for the Sociology of Health and
Medicine
Universitätsstr. 7/2
A-1010 Vienna
Austria
+43/1/42.77-48.230
+43/1/42.77-48.231

PRICE, John
Prince Philip Hospital
Llanelli, Dyfed
South Wales SA14 8QF
UK-Wales
+44/1554772271
+44/1554756567

PURZNER, Karl Dr.
Psychiatrisches Krankenhaus
Baumgartner Höhe 1
A-1140 Wien
Austria
+43/910602002
+43/1910604981
PUK@pkb.magwien.gv.at

RUSHMERE, Annette
Health Promotion Project Manager
Wessex Institute for Health
Research Institute
Romsey Road
Winchester, SO22 5DH
Unitea Kingdom
+44/1962863511
+44/1962844759

SCHUMANN, Konrad Dr.
Pflegedirektor
Städtische Kliniken Chemnitz
Flemmingstraße 2
Postfach 948
D-09116 Chemnitz
Germany
+49-371-333 32 40
+49-371 333 33 480

STOESSEL, Ulrich Dr.
University of Freiburg
Dept. of Medical Sociology
Hebelstr.29
D-79104 Freiburg
Germany
+49/761/2035520
+49/761/2035516
stoessel@ruf.uni-freiburg.de

STOLARCZYK, Anna
Memorial Hospital
Child Health Center
Al. Dzieci Polskich 20
PL-04736 Warsaw
Poland
+48/22151461
+48/22153154
stolar@rocketmail.com

STROHMEIER, Gabriele
Vienna Hospital Association
Schottenring 25
A-1010 Wien
Austria
+43/1/5311487754
+43/1/531149987754

TAYLOR, Eunice Dr.
Research Fellow
University of Central Lancashire
Faculty of Health
Preston, PRI
UK-England
+44/1772/893416
E.A.I Taylor@UCLANAC.UKi

TROJAN, Alf Prof.DDr.
Dir. of Dept. II, Deputy Dir. of Inst.
Univ. Krankenhaus Eppendorf
Inst. for Medizin-Soziologie
Martinistr.52
D-20246 Hamburg
Germany
+49/40/4717-4247
+49/40/4717-4934
nickel@uke.uni-hamburg.de

WOAN, Marion RN RM BSc(Hons)
HPH Coordinator
Preston Acute Hospitals NHS Trust
Royal Preston Hospital
Fulwood
Preston PR2 9HT
UK-England
+44/1772/710.655
+44/1772/710726
marion.woan@nursing.pah-tr.nhs.uk

WOODS, Lorna
Sharoe Green Hospital
Sharoe Green Lane South
Fulwood
Preston, PR2 8DU
UK-England
+44/1772/711309
+44/1772/711474

ZIELINSKA, Anna Dr.
Silesian Rehabilitation Center
UL Budoweana 101/4
PL-41808 Zobne 8
Poland
+48/321/85.30.71*212
+48/321/85.41.23

The National/Regional Network Project of Health Promoting Hospitals in Europe

Project Partners

WHO - Regional Office for Europe

Dr. Mila GARCIA-BARBERO
8, Scherfigsvej
DK-2100 Copenhagen
Tel.: ++45-39 17 12 70
Fax: ++45-39 17 18 65
E-mail: mgb@who.dk

Coordinating Centre

Univ.Prof. Dr. Jürgen M. PELIKAN
Mag. Hubert LOBNIG
Ludwig Boltzmann-Institute for the Sociology of Health and Medicine
Universitätsstraße 7/2
A-1010 Vienna
Tel.: ++43/1/4277-48281
Fax: ++43/1/4277-48290
E-mail: hph.soc-gruwi@ univie.ac.at

Coordinating Institutions in the Countries

Austria

Mag. Alice GRUNDBÖCK
Mag. Peter NOWAK
Ludwig Boltzmann-Institute for the Sociology of Health and Medicine
Universitätsstraße 7/2
A-1010 Vienna
Tel.: ++43/1/4277-48288
Fax: ++43/1/4277-48290
E-mail: oenetz.soc-gruwi@ univie.ac.at

Belgium

Flemish community

Mr. Jan DAMS
Ministerie van de Vlaamse Gemeenschap
Administratie Gezondheidszorg
Markiesstraat 1
B-1000 Brussels
Tel.: ++32/2/5073633
Fax: ++32/2/5073635

French community

Mr. Jacques DUMONT
Université Libre de Bruxelles
Hôpital Erasme
Département Infirmier
Information et Education du Patient
Route de Lennik 808
B-1070 Bruxelles
Tel.: ++32/2/5553420
Fax: ++32/2/5556755
E-mail: igdumont@ulb.ac.be

Bulgaria

Dr. Bencho BENCHEV
National Center for Health Promotion
15. D. Nestorov St.
BUL-1431 Sofia
Tel.: ++359/2/5812408
Fax: ++359/2/591146

Denmark

Ms. Hanne JAPPE
Bispebjerg Hospital
Bispebjerg Bakke
DK-2400 Copenhagen NV
Tel.: ++45/35/312401
Fax: ++45/35/313999

Finland

Dr. Jarmo KARPAKKA
Oulu Deaconess Institute
Albertinkatu 18B
FIN-90100 Oulu
Tel.: ++358/8/3132011
Fax: ++358/8/373769
E-mail: jarmo.karpakka@odl.fi

Dr. Mattii LIUKKO
Finnish Association of Local Authorities
Toinen Linja 14
FIN-00530 Helsinki
Tel.: ++358/9/7712611
Fax: ++358/9/7712652

France

Dr. Anne-Laurence LE FAOU
Assistance Publique-Hôpitaux de Paris
Direction des Affaires Internationales
2, rue Saint-Martin
F-75004 Paris
Tel.: ++33/1/40275638
Fax: ++33/1/40274164
E-mail: dai@sap.ap-hop-paris

Germany

Prof. Dr. Klaus-Diethart HÜLLEMANN
Klinik St. Irmingard
Osternacher Straße 103
D-83209 Prien/Chiemsee
Tel.: ++49/8051/607-526
Fax: ++49/8051/607-562

Greece

Assoc.Prof. Dr. Yannis
TOUNTAS, MPH
Ass.Prof.Dr. Kiki TSAMANDOURAKI
Institute of Social and Preventive Medicine (ISPM)
32, Skoufa St.
GR-106 73 Athens
Tel.: ++30/1/6450870-1
Fax: ++30/1/3604894
E-mail: ISPM@compulink.gr

Hungary

Dr. Laszlo KAUTZKY
Orazogos Korányi tbc és Pulmonológiai
Intézet
Pihenö ut 1
H-1529 Budapest XII
Tel: ++36/1/2002879
Fax: ++36/1/2002879

Ireland

Ms. Ann O´RIORDAN
James Conolly Memorial Hospital
Blanchardstown
IR-Dublin 15
Tel: ++353/1/8213844
Fax: ++353/1/8203565
E-mail: ihphnet@iol.ie

Italy and **Italy/Veneto Region**

Dr. Carlo FAVARETTI
Regione del Veneto
Azienda ULSS n. 19
via Badini 57/A
I-45011 Adria (RO)
Tel: ++39/426/940513
Fax: ++39/426/900901
E-mail: cfavaret@protec.it

Italy/Lombardia Region

Dr. Francesco CERATTI
Ospedale Luigi Sacco
Via G.B. Grassi 72
I-20157 Milano
Tel: ++39/2/35799200
Fax: ++39/2/39000116

Lithuania

Prof. I. MISEVICIENE
Kaunas Medicial Academy
Institute for Biomedical Research
Eiveniustr. 2
LIT-3007 Kaunas
Tel: ++370/7/731073
Fax: ++370/7/796498

Luxembourg

Dr. Yolande WAGENER
Ministry of Health
Dept. of Prevention
22, Rue Goethe
L-2320 Luxembourg
Tel: ++352/4785544
Fax: ++352/291121

Netherlands

Ms. Jorien C.H. BAKX
Nationaal Instituut voor Gezondheids-bevordering en Ziektepreventie (NIGZ)
De Bleek 13, Woerden
Postbus 500
NL-3440 AM Woerden
Tel.: ++31/348/437637
Fax: ++31/348/437666
E-mail: nigz@nigz.nl

Poland

Dr. Jerzy B. KARSKI
National Centre for Health System Management
UL Dluga 38-40
PL-00238 Warsaw
Tel: ++48/22/6353620
Fax:++48/22/8314712

Portugal

Prof. Dr. J.M. Caldeira DA SILVA
Universidade Nova de Lisboa
National School of Public Health
Avnida Padre Cruz
P-1699 Lisboa Codex
Tel.: ++351/1/7575599
Fax: ++351/1/7582754

Dr. Emilia NATÁRIO
Ministério da Saúde
Direccao Geral da Saúde
Alameda D. Afonso Henriques, 45
P-1056 Lisboa Codex
Tel.: ++351/1/8475515
Fax: ++351/1/8462967

Spain/Catalonia

Dr. Jordi CODINA
Dr. Marti DALMASES I ARNELLA
Fundacio Parc Tauli, Parc Tauli
E-08208 Sabadell
Tel.: ++34/3/7236673
Fax.: ++34/3/7234915

Sweden

Prof. Dr. Johannes VANG
Dr. Margareta KRISTENSON
Linköping University
Centre for Public Health Sciences
S-58185 Linköping
Tel.: ++46/13/221434
Fax: ++46/13/225095
johannes.vang@fhvc.lio.se

United Kingdom, England

Mr. Dominic P. HARRISON
Health Promotion Unit
Sharoe Green Hospital
Sharoe Green Lane
Fulwood
UK-Preston, PR2 8DU
Tel: ++44/1772/711773
Fax: ++44/1772/711113
dominic@blueskies.enta.net

United Kingdom, Northern Ireland

Mr. Raymond MC CARTNEY
Altnagelvin Area Hospital
Glenshane Road
UK-Londonderry BT47 1SB
Tel: ++44/1504/45171
Fax: ++44/1504/611218

United Kingdom, Scotland

Ms. Anne KASKONAS
Stobhill NHS Trust
133 Balornock Road
UK-Glasgow G21 3UW
Tel: ++44/141/2013289
Fax: ++44/141/2013887

United Kingdom, Wales

Ms. Brenda STEPHENS
Health Promotion Authority for Wales
Ffynnon-las, TY-Glas Avenue
Llanishen
UK-Caerdydd/Cardiff CF4 5D2
Tel: ++44/1222/752222
Fax: ++44/1222/756000
E-mail:
brendas@ hpwales.demon.co.uk

Overseas:

Canada

Mr. Ted MAVOR
Grand River Hospital
P.O. Box 9056
Kitchener, Ontario
Canada, N2G 1G3
Tel: ++1/519/7494300-2375
Fax: ++1/519/7494208

„The Budapest Declaration on Health Promoting Hospitals, May 1991“

Part 1

Content and Aims for Hospitals participating in Health Promoting Hospitals – an International Network

Beyond the assurance of good quality medical services and health care, a Health Promoting Hospital should:

1. Provide opportunities throughout the hospital to develop health-orientated perspectives, objectives and structures.
2. Develop a common corporate identity within the hospital which embraces the aims of the Health Promoting Hospital.
3. Raise awareness of the impact of the environment of the hospital on the health of patients, staff and community. The physical environment of hospital buildings should support, maintain and improve the healing process.
4. Encourage an active and participatory role for patients according to their specific health potentials.
5. Encourage participatory, health-gain orientated procedures throughout the hospital.
6. Create healthy working conditions for all hospital staff.
7. Strive to make the Health Promoting Hospital a model for healthy services and workplaces.
8. Maintain and promote collaboration between community based health promotion initiatives and local governments.
9. Improve communication and collaboration with existing social and health services in the community.
10. Improve the range of support given to patients and their relatives by the hospital through community based social and health services and/or volunteer-groups and organisations.
11. Identify and acknowledge specific target groups (e.g. age, duration of illness etc.) within the hospital and their specific health needs.
12. Acknowledge differences in value sets, needs and cultural conditions for individuals and different population groups.
13. Create supportive, humane and stimulating living environments within the hospital especially for long-term and chronic patients.
14. Improve the health promoting quality and the variety of food services in hospitals for patients and personnel.
15. Enhance the provision and quality of information, communication and educational programmes and skill training for patients and relatives.
16. Enhance the provision and quality of educational programmes and skill training for staff.
17. Develop an epidemiological data base in the hospital specially related to the prevention of illness and injury and communicate this information to public policy makers and to other institutions in the community.

Part 2

Criteria for Hospitals – an International Network

Basic Recommendations

1. Acceptance of the priniciples declared in the «Ottawa Charter on Health Promotion».
2. Acceptance of the document «Content and Aims for Health Promoting Hospitals»

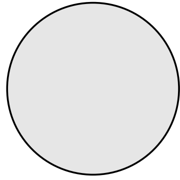
Specific Recommendations

Acceptance of the criteria of the European «Healthy Cities» project as they relate to the hospital:

1. Approval to become a Health Promoting Hospital to be sought from the owner, management and personnel of the hospital (including representatives of unions, working council). A written submission will be required.
2. Willingness to cooperate and ensure the funding of programmes with an independent institution in relation to planning, consultation, documentation, monitoring and evaluation.
3. Evaluation to be undertaken annually in order to guide future action.
4. Willingness to develop an appropriate organizational structure and process, supported by project management to realise the aims of the Health Promoting Hospital.
5. Establishment of a Joint Project Committee (with representatives from the Pilot Hospital and institutions of research and/or consultation).
6. Nomination of a project manager by the hospital, who is accountable to the Joint Project Committee.
7. Provision of necessary personnel and financial resources as agreed by the Joint Project Committee.
8. Readiness to develop at least five innovative health promoting projects related to the hospital, the people who work within it, and the population served, with goals, objectives and targets for each project. Projects should be complementary to health promotion initiatives in primary health care.
9. Public discussion of health promotion issues and possible health promoting activities within the hospital by
   - Internal Newsletter
   - Public presentations within the hospital.
10. Provision of evaluation information at least annually to
    - the Joint Project Committee
    - the management
    - the staff
    - the public and to those who provide funding
    - other organisations, both local, national and international including WHO and the Co-ordinating Centre for the Network.
11. Exchange experience by networking with:
12. – other hospitals
13. – Health Promoting Hospitals – an International Network (participation in Business Meetings etc.)

14. – National Network (group of nominated observers from different institutions with an interest in health).
15. Link the Health Promoting Hospital projects with congruent local health promotion programmes, especially those within the Healthy Cities Network.
16. Prospective running period of the model: 5 years.

This declaration has been issued at the 1st Business Meeting of the International Network of Health Promoting Hospitals.



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

* The Vienna Recommendations were adopted at the 3rd Workshop of National/Regional Health Promoting Hospitals Network Coordinators, Vienna, 16. April 1997.

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.

The recommendations are divided into three parts:

1. fundamental principles
2. strategies for implementation
3. appendix: 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 wellbeing 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; and
6. form as close links as possible with other levels of the health care system and the community.

Principles for the creation of Health Promoting Hospitals

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:
   - exchanges of experience with implementing health promoting hospitals projects at the national and international 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

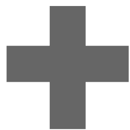
Hospitals that want to belong to the WHO Health Promoting Hospitals Network:

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 were no national/regional network exists
- members of thematic networks.

Hospital Unit
WHO Regional Office for Europe
8, Scherfigsvej
DK-2100 Copenhagen Ø
Denmark
Tel: +45 39 17 12 70
Fax: +45 39 17 18 65
E-mail: kja@who.dk



Ludwig Boltzmann Institute for the Sociology of Health and Medicine
WHO Collaborating Centre on Hospitals and Health Promotion
Universitätsstrasse 7/2
A-1010 Vienna
Austria
Tel: +43 1 42 77 48 286
Fax: +43 1 42 77 48 290
E-mail: hph.soc-gruwi@univie.ac.at