

Health Promotion in Hospitals: Evidence and Quality Management

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Eighteen Core Strategies for Health Promoting Hospitals

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Introduction

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

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

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

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The situation of hospitals is characterised by a permanent and increasing pressure of their dynamic environments to adapt to changing political and economic, professional and consumer expectations concerning the process and content of hospital services. Two general tendencies can be distinguished within the trend of hospital reforms:

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

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

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

Following the Ottawa Charter, the term of “enabling” has been developed into the more specific concept of empowerment, “a process through which people gain greater control over decisions and actions affecting their health” [11]. Empowerment relates to individual actors, social groups or communities and combines measures aiming at strengthening actors’ life skills and capacities (e.g. to express their needs, present their concerns, devise strategies for involvement in decision-making) with measures creating supportive physical, cultural and social environmental conditions which impact upon health. Processes to achieve both may be social, cultural, psychological or political.

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

- participatory (involving all concerned in all stages of the project)
- holistic (fostering physical, mental, social and spiritual health)
- intersectoral involving the collaboration of agencies from relevant sectors)
- equitable (guided by a concern for equity and social justice)
- sustainable (bringing about changes that individuals and communities can maintain once initial funding has ended)
- multistrategy (using a variety of approaches – including policy development, organizational change, community development, legislation, advocacy, education and communication – in combination).

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

Health promotion underlines the psychological and social dimensions of health outcome and adds health literacy as a specific

measurable outcome dimension of (educative) empowerment processes – as far as services are concerned. By the settings approach, health promotion introduces health impacts of the setting as relevant effects of hospitals to be observed, controlled and improved. The total health gain of the hospital thus can be understood as the sum of outcomes of services and impacts of the – material and social – clinical and hotel hospital setting. This widening of the expected outcome also leads to a widening of the focus for quality improvement of the processes and underlying structures. The conceptual distinction that is most relevant for distinguishing between different health promotion strategies to be implemented in or by hospitals to improve health, can be summarized as *service oriented* strategies (strategies 1, 2 and 4, 5 in Table 1 below) vs. *setting oriented* strategies (strategies 3, 6).

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

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

Service oriented strategies include quality improvement of already existing clinical and hotel services (strategies 1, 2) or strategies introducing new, primarily educative services with mid-term or long-term health effects (strategies 4, 5). Strategies can be distinguished according to their orientation of treating or managing specific diseases (strategies 2, 4) and strategies oriented at services for maintaining or improving positive health (strategies 1, 5). Concerning settings, strategies developing the hospital setting itself (strategy 3) can be distinguished from strategies of participation of the hospital in developing the community setting (strategy 6) or other settings within the community (e.g. workplaces or schools). By being oriented at

improving health gain and not just clinical outcome, these six strategies do not only apply to patients (and their relatives), but in a somewhat modified way also to staff and members of the community the hospital serves and is situated in, resulting in 18 strategies for health promotion in hospitals.

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

Patient-oriented strategies

HP quality improvement strategies for acute hospital services

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

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

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

In order to avoid hospitalisation as far as possible, it should be made a principle to allow for as much self-care as possible, and to provide as much professional care as necessary. To make self-care possible under the difficult conditions of partly severely ill individuals outside their usual household environment, and subjected to the bureaucratic imperatives of the hospital organization, professional care has to be as empowering as possible, and needs to take into account cultural

differences of patients. Empowerment again includes physical, mental and social dimensions, knowledge, skills and motivations. This again can be seen as the specific contribution of health promotion.

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

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

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

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

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

The concept of empowerment stresses the necessity that individuals take control over their health – which means in the context of the hospital that patients are not only seen as objects of interventions but also as co-producers of these interventions – an idea that fits well to other traditions of analysing services as co-produced. As the co-producer has to actively contribute to the process, he / she has to be actively empowered for making this contribution. This sort of

empowerment cannot be achieved by the clinical/technical interventions themselves, but by communicative/educative interventions. Medicine has to open itself towards education. Education refers to the transfer of knowledge (data, information), training of skills and enhancement of motivation.

The concept of health gain defines the relevant output of the hospital interventions in a more complex way: clinical outcome + quality of life + patient satisfaction + health literacy. These outcomes refer to all three aspects of health: physical, mental and social. The treatment process itself has to become more complex. The focus stays on effective treatment, but in order to optimise health gain, aspects of disease prevention, health protection and health development have to get due attention within treatment (systematically avoid risks, use opportunities to build health resources – biological, mental, social).

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

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

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

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

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

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

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

These three patient-oriented strategies, aiming at enhancing the quality of acute care hospital services by health promotion, have a considerable potential to increase the health gain of hospital interventions. But since the duration of hospital stays where these interventions can be applied gets shorter and shorter, many hospitals are expected to also provide other types of services, securing the sustainability and long-term effects of hospital treatment.

New HP services for hospital patients

Empowerment of patients for health promoting management of chronic illness

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

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

Hospitals have to take this mid-range perspective on the illness career into account by either providing necessary disease specific support by themselves or by referring patients to other, specialised providers in the health care system. The more complex and the more rare the disease and its treatment gets, the more likely it remains a task of the

hospital itself, but this of course requires adequate legal and financial regulation which allows to provide these services systematically.

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

Empowerment of patients for health promoting lifestyle development

The health gain of hospital interventions can be even further increased when taking on a more long term perspective. Future health can be improved by lifestyle changes – thus reducing disease related risks and developing positive health potentials and resources [17] [18] [19]. It is primarily educative services (information, consultation, training) that can be utilised to influence individual lifestyles. These type of services can be offered by different types of providers, e.g. other providers in health care, social services and adult education.

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

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

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

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

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

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

Promoting health of staff

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

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

Empowering staff for health promoting self-reproduction / self care

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

Empowering staff for health promoting co-production at work

Hospital work (treatment, care, and support services) have not only effects on the health of patients, but also an impact on the health of the providers of these services. This is well-recognised (but not always adequately fulfilled) in working regulations and occupational medicine. The added value of health promotion is to draw the

attention to self-control of the determinants of health in the work-process and thus the empowerment of staff by owners and management for health promoting work-processes and behaviour.

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

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

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

Empowering staff for health promoting management of occupational illness.

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

Empowering staff for health promoting lifestyle development.

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

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

As far as lifestyles are concerned, for patients as well as for staff these do not only depend on individual characteristics, but also on living

conditions in the community. In addition, living conditions have a general important influence on the quality of life. Therefore, the hospital can improve its potential health impact on staff through participation in staff-oriented community development. Classical examples would be the provision of kindergartens around the clock; the availability of public transport and housing for hospital staff, staff-friendly opening hours of shops and other community services.

Promoting the health of the population in the community

Of course the hospital is affecting the health of its community firstly by effects on its actual patients and on the health of its staff. But the hospital has also effects on the health balance of the population in its neighbourhood / catchment area which can be targeted and improved.

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

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

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

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

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

Hospital stays are getting shorter and shorter, therefore hospitals have to accept the responsibility for continuity of care after hospital discharge. In this case they have to empower professional providers in primary care / extra-mural health services and lay carers for specific

patients to optimally take over care after discharge from the hospital. The hospital has to accept its responsibility for managing the interface with those taking care of patients after discharge. The specific contribution of health promotion to this process is the focus on empowerment.

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

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

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

Empowerment of community population for health promoting management of chronic illness.

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

Empowerment of community population for health promoting lifestyle development.

A similar argument applies for lifestyle development.

Participation in health promoting community development for the general population.

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

An overview of the 18 Strategies for health promoting hospitals

By putting the six general strategies for the three target groups patients, staff and the community together, we get a matrix of 18 core strategies for Health Promoting Hospitals, which are summarised in the table 2.

Some general remarks:

- The strategies are (partly) overlapping.
- The strategies (partly) build upon each other.
- The strategies better have to be planned in relation to each other (in order to make use of synergies).
- It makes use to bundle single measures around specific thematic policies (e.g.: smoking).

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

Table 2: 18 core strategies for Health Promoting Hospitals

HP for/ by ...	Patients	Staff	Community
HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>self-reproduction</i>	Empowerment of patients for health promoting self care / self maintenance / self reproduction in the hospital (PAT-1)	Empowerment of staff for health promoting self care / self maintenance / self reproduction in the hospital (STA-1)	Empowerment of community health promoting self care / self reproduction by adequate access to hospital (COM-1)
HP quality development of treatment & care, by empowerment of stakeholders for health promoting <i>co-production</i>	Empowerment of patients for health promoting participation / co-production in treatment and care (PAT-2)	Empowerment of staff for health promoting participation / co-production in treatment and care (STA-2)	Empowerment of health professionals in the community for health promoting co-production in treatment and after-care of patients (COM-2)
HP quality development for health promoting & empowering hospital setting for stakeholders	Development of hospital into a supportive, health promoting & empowering setting for patients (PAT-3)	Development of hospital into a supportive, health promoting & empowering setting for staff (STA-3)	Development of hospital into a health promoting & empowering setting for the community (COM-3)
Provision of specific HP services - empowering illness management (patient education) for stakeholders	Empowerment of patients for health promoting management of chronic illness (after discharge) (PAT-4)	Empowerment of staff for health promoting management of occupational illness (STA-4)	Empowerment of community population for health promoting management of chronic illness (COM-4)
Provision of specific HP services - empowering lifestyle development (health education) for stakeholders	Empowerment of patients for health promoting life style development (after discharge) (PAT-5)	Empowerment of staff for health promoting life style development (STA-5)	Empowerment of community population for health promoting lifestyle development (COM-5)
Provision of specific HP activities – participation in health promoting & empowering community development for stakeholders	Participation in health promoting & empowering development of community infrastructures for specific patient needs (PAT-6)	Participation in health promoting & empowering development of community infrastructures for specific needs of staff (STA-6)	Participation in health promoting & empowering community development for general population (COM-6)

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

Putting health promoting policy into action

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

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

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

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

Concerning outcomes

The wider definition of health gain as argued above, has also to be monitored, therefore there is a need for defining specific indicators for

the health promotion interventions (clinical outcomes + holistic health, quality of life, patient satisfaction, equitable health and – health promotion specific – health literacy).

Concerning structures and processes relevant for producing these outcomes

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

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

- Networking with health service providers (liaison services) and other stakeholders in the community should be actively sought.

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