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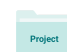

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The European Health Promoting Hospitals (HPH) project: how far on?

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SUMMARY

Back in 1986, the World Health Organization (WHO) produced the Ottawa Charter for Health Promotion. The intention of the charter was to create a framework that conveyed the notions of capacity building into a structured process for health promotion action in specific settings. This charter subsequently provided the vehicle from which the Health Promoting Hospital (HPH) initiative was launched, culminating in the Budapest Declaration of Health Promoting Hospitals (WHO, 1991). The aim of this paper is to investigate the nature and progress of the European HPH movement. Despite the fact that 'pockets' of concerted and progressive activity and evaluation have emerged from the HPH initiative, the majority of the available literature demonstrates a more limited impact than perhaps the WHO might have anticipated for its efforts over the last 15 years or so. Indications are that many of the member European HPH states have struggled to move beyond the 'project' phases of their planned programmes. This is not to detract from the considerable efforts that have been made to establish HPH networks or the continuing attempts to recruit further members/institutions into the movement. Nevertheless, this account concludes that a more concerted evaluation of European HPH progress is needed to accurately measure its impact and progress. If the situation remains unchanged, perhaps a fundamental review of the strategy is worth considering.

Key words: health promoting hospitals; settings-based health promotion

INTRODUCTION

Back in the mid-1980s, the World Health Organization's (WHO) Ottawa Charter for Health Promotion led to the development of a series of 'settings-based' health promotion strategies (WHO, 1986). One of the settings singled out for particular attention was that of the Health Promoting Hospital (HPH) in 1988. It is one of five major action areas designated for a settings-based health promotion role, the others being the workplace, the community, schools, and the home and family. Interestingly, Lavis and Sullivan (Lavis and Sullivan, 2000) have argued the plight of the 'State' as a further setting. Subsequently, the WHO has produced further documents that highlight the progress and reform of the HPH programme (Milz and Vang, 1988; WHO, 1990; WHO, 1991; WHO, 1996; WHO, 1997). Notably, the progress of HPH has resulted in a series of influential reports that include *The Ljubljana Charter on Reforming Health Care, The Budapest Declaration on Health Promoting Hospitals* and *The Vienna Recommendations on Health Promoting Hospitals* (WHO, 1996; WHO, 1996; WHO, 1997). This ongoing dialogue reflects the fact that hospitals, as institutions with the potential to actively promote the health and well-being of their clients and workforce, have consistently been urged to consider and attempt concerted health promotion reform. In particular, the heralded shift of health service priority and resources from tertiary to primary health care has resulted in hospitals being encouraged to actively pursue broader health promotion practices.

The changing emphasis towards public health reform means that hospital-based health professionals are now obliged to focus their health activities to reflect the broader determinants of health that occur within a much wider ranging health promotion context.

This account aims to highlight the general progress of the European HPH schemes in light of the changing nature of health service delivery. In doing so, it also seeks to ascertain the progress made by those health care professionals who have been called upon to implement health-promoting reform as part of their evolving role.

THE ROLE AND FUNCTION OF HEALTH PROMOTING HOSPITALS

Within a settings-based framework, the HPH strategy is designed to incorporate the principles of capacity building and organizational change, as hospitals steer towards the re-orientation of service delivery to promote health within and outside its physical boundaries. This re-orientation is designed to demonstrate the organization's obligation in meeting the changing needs of society, as the hospital shifts its focus from specific acute curative service delivery towards the delivery of health services across the whole health and social care continuum.

In the mission statement of the English National Network of Health Promoting Hospitals and Trusts, their principle aims are set out (English National Network of Health Promoting Hospitals and Trusts, 2003). They include improving health, empowering active citizens, protecting the environment, developing public health capacity and modernizing health care systems.

The Vienna Recommendations for Health Promoting Hospitals (WHO, 1997) provides further guidance as to the role and function of HPHs. The recommendations are divided into the 'fundamental principles and strategies for implementation' and include:

- A focus on health with a holistic approach as opposed to just curative services.
- Centering services that contribute to the empowerment of patients.
- A formation of close links with other levels of health care systems and community.
- Fostering commitment through encouraging participatory, health-gain-oriented procedures that involve all professional groups and build alliances with professionals outside the hospital setting.
- Encouraging participatory roles for patients according to their health potential and improving patients' well-being.
- Improving the hospitals communication and cooperation with social and health services in the surrounding community and optimize links between different providers, users and actors in the health care sector.
- To train and educate personnel in areas relevant to health promotion and train project leaders in this field.

The WHO Network of Health Promoting Hospitals has also recently commissioned a working group within it to develop standards for health promotion in hospitals. This activity is still very much in its infancy and there exists an open request to everyone for testing of the standards. The standards relate to patient pathways and define the activities that concern health promotion as an integral part of all hospital services offered. Currently the five core standards are patient assessment, management policy, patient information and intervention, promoting a healthy workplace, and continuity and cooperation.

WHAT HAS BEEN ACHIEVED TO DATE?

The HPH concept is accompanied by an array of complex debates that are not readily accessible to all. Even the WHO (WHO, 2003a) acknowledges that the concept of HPH is 'confusing'. Consequently, Bakx *et al*. (Bakx *et al*., 2001) state that the discussion surrounding the meaning and relevance of the HPH concept is still very much ongoing. Hospitals themselves are complex institutions that are diverse and ever changing. To compound this, Hancock (Hancock, 1999) suggests that the hospital can also sit in at least two others of the five settings, namely those of workplace and community.

The complex organizational structures of many hospitals may serve to exclude them from the demands of broad health promotion activities. The WHO (WHO, 2003a) refers to the fact that most health professionals in the hospital setting do not readily associate health promotion as part of their role. Hilgerson and Prohaska

(Hilgerson and Prohaska, 2003) also argue that the extent to which hospitals and their staff can and want to move 'upstream' with health promotion reform is still unknown. Subsequently the hospital setting is the least visible of all the Ottawa Charter settings. For instance, Roe *et al.* (Roe *et al.*, 1999), in their systematic review of the literature pertaining to health promotion setting alliances, refer to every setting except that of the hospital. In general, there is a considerable dearth of literature surrounding the concept and progress of the European HPH programme. This is disconcerting considering its overall importance and potential impact on health service care delivery. The lack of literature is especially notable in relation to the evaluation of HPH activities. Having said this, other literature refers to the lack of research and evaluation activity for all settings-based health promotion activity (Wilkinson, 1999).

Where evidence of HPH evaluation exists, much of it refers to the lack of progress made and the need for further reform (Hancock, 1999; Johnson and Baum, 2001; Rustler, 2002). Blinkhorn (Blinkhorn, 2002) adds that most HPH initiatives have only been undertaken as pilot schemes and have begun to fade as the initial funding has dried up. Consequently, the hospital setting is consistently described as lagging behind other health and social care settings in attempts to incorporate health promotion initiatives among service roles (Nagle *et al.*, 1999; Aujoulat *et al.*, 2001). This also reflects the fact that acute hospital settings are rarely the main agents in health promotion strategies, with many organizations remaining hesitant about incorporating HPH initiatives into their structure and culture (Bakx *et al.*, 2001; WHO, 2003a). Deccache *et al.* (Deccache *et al.*, 1999) similarly suggest that a great deal of resistance has accompanied the HPH movement and that progress to date has been slow. While 22 European countries are currently signed up to the HPH initiative, there are some notable omissions, namely countries such as Spain, Romania, Ukraine and Turkey. It does appear, however, that the movement is spreading rather than diminishing. The WHO (WHO, 2003a) highlights that there are now 25 HPH European networks which, since January 2001, have seen the number of signed-up HPHs rise from 534 to 649. Some countries have more than one network, for instance Italy has six, the UK has three and Germany has two.

As stated earlier, the available evaluative evidence tends to highlight partial rather than complete success and often cites the dilemmas encountered, rather than the opportunities presented, in achieving any degree of success. Most of the available evidence relates to the mid-European experience, although countries such as the Russian Federation, Estonia, Lithuania and Kazakhstan are also members. Aujoulat *et al.* (Aujoulat *et al.*, 2001) cites the evaluation of the French HPH experience and presents the findings as problematical and insufficient to allow for effective health promotion reform in hospitals. Their findings suggested that many of the French HPH projects lacked the facility to affect a concerted health promotion reform programme (see Table 1).

The French progress report of 2002 mirrors Aujoulet *et al.*'s above-mentioned concerns and suggests that there is no money to spend on health promotion in hospitals and that consequently the development of the HPH network in France is 'slow'.

Similar problems to those stated above can be found throughout the European HPH movement in the *Health Promoting Hospitals Network Progress Reports for 2002* (WHO, 2003a). Nearly all of the 22 European member states report commonly encountered problems (see Table 2).

Table 1: The problems faced by French HPH projects (Aujoulat *et al.*, 2001)

Lack of appropriate indicators to effectively evaluate health promotion activity
Failure to facilitate the participation of the target populations
Lack of cross-sectorial and interdisciplinary working practices
Lack of appropriately trained personnel
Prioritized funding in favour of bio-technical health care regimes
Failure to enable the participation and empowerment of individuals

Table 2: Commonly reported problems by European HPH network members

Lack of clear strategy/aims
Lack of funding/resources
Lack of training facilities
Lack of national/regional health service policy commitment and support
Lack of health promotion priority in hospitals
Difficulty in implementing overall organizational HPH structures rather than specific localized projects

Part of the problem for certain member states lies in the lack of detail in their HPH network progress reports, especially with countries such as the Netherlands. The HPH progress dilemma is also compounded by the fact that some member states are able to demonstrate concerted progress more clearly than others, denoting a lack of consistency between member states and organizations. Some countries have taken on the challenge to a greater degree than others, although this may well represent the differing wealth between member states. It appears that the UK, Ireland, Germany and Poland have responded best and evaluated more sustained activity than most.

The most positive evaluative outcomes manifest as the formal networking that occurs between member institutions and states. Yearly conferences, progress reports, a newsletter (www.hph-hc.cc) and regular policy updates help to maintain the momentum of the movement. In 2003, the HPH movement held its 11th annual conference, entitled *Re-orientating Hospitals Towards Better Health in Europe: New Governance, Patient Orientation and Cultural Diversity in Hospitals*, in Florence, Italy (www.univie.ac.at/hph/florence2003/htm/scope.htm). At the time of writing of this article (5 months after the conference) the conference outcomes are yet to be published in the public domain. The 12th international conference on HPHs will be held in Moscow in May 2004. Details on the purpose, aims and scope of the 2004 conference are available at http://www.univie.ac.at/hph/moscow2004/. A number of the member states have also set up dedicated websites with links to other HPH organizations (see Table 3).

The networking has also produced the facility for running an online Post-Graduate Certificate in Health Promoting Organizations, coordinated through the University of Sunderland (UK).

Table 3: A selection of European HPH member-states' website addresses

www.hphenglishnetwk.demon.co.uk (England)
www.hospital21century.org (Russian Federation)
www.liu.se/fhvc/hfs/ (Sweden)
www.dnfgk.de (Germany)
www.forebyggendesygehuse.dk (Denmark)
www.tervis.ee/programmemid (Estonia)
www.info.kma.lt/LithHPH (Lithuania)
www.csioz.gov.pol (Poland)
www.provita.sk (Slovakia)

DILEMMAS FACING HEALTH PROMOTING HOSPITALS

Defining the nature and impact of health promotion activities in HPHs leads to one of the main problems for the HPH movement. Most of the detailed activity would be more appropriately defined within the context of Health Educating Hospitals. Much of the available literature describes disease management objectives and outcomes alongside a particular focus on the promotion of 'smoke-free' hospitals [i.e. (Ashcroft, 1996; Moller and Pederson, 1999; Quinn *et al.*, 2001)]. It appears that the fundamental HPH objective for moving away from pockets of health programme activity, which are primarily based on disease management/avoidance activities, are seldom realised. This is not surprising, however, and perhaps inevitable given that many European countries stress the lack of government-related policy support, lack of individual organizational management commitment and lack of resources set aside for health promotion in hospitals (Deccache and van Ballekom, 2001).

A further dilemma that HPH initiatives face relates to the level and degree of organizational change that occurs in hospitals. Many HPH institutions state that their health promotion activities consist of a collection of health promotion programmes that may or may not be related to each other. The need for hospitals to adopt health promotion activities as core values within the organization, rather than institutions serving as organizations that merely deliver a few *ad hoc* health promotion projects, has been stated previously (Kickham and Rushmere, 1998; Johnson, 2000). In essence, HPH initiatives are less likely to succeed where they fail to implement 'whole' organizational and cultural health promotion reform that influences the role and function of all health professional employees. This said, single hospital health promotion projects can be used as a vehicle towards the broader aim of wider development within the organizational setting and contribute to the organization's capacity to take on new initiatives (Whitelaw *et al.*, 2001; Yeatman and Nove, 2002). This can only occur though where the hospital then links individual projects and views them as a spring-board for a concerted and organizational-wide reform programme.

The HPH movement works on the assumption that health promotion improvement is the most

effective vehicle for organizational development (Quinn *et al*., 2001). Others concur with these sentiments but specify that their effectiveness depends on the methods and strategies that are used. Many are now championing the use of Action Research (AR) activities as a particularly appropriate means of implementing and evaluating 'whole system' health-promoting organizational reform. AR is seen by many as a method that fulfils both the enabling and the empowering goals of health promotion, as well as the principles of participatory learning that underpin preventative health education approaches [Green, 1996; Boutillier, 1997; Wilkinson *et al*., 1997; WHO, 1998; Tones, 2000; National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO), 2001; National Health Service South West Regional Office (NHS-SWRO), 2002]. This said, my colleagues and I have already expressed concerns that the health promotion community has yet to take up this mantle concertedly (Whitehead *et al*., 2003).

In line with the principles of organizational change strategies, the WHO (WHO, 2003a) states that 'the HPH project facilitates change to promote Total Quality Management (TQM) of the hospital'. Significant barriers to organizational development under this auspice, however, continue to exist. This can be criticized for the fact that TQM in its most limiting form does not support the ethos of health promotion reform in that it is management-focused and hierarchical. In another form, however, TQM may be considered appropriate to use in light of more recent change-management and participatory Project Management (PM) reforms (Dearden *et al*., 1999; Hodgson, 2002; Porter, 2002). It depends on the management philosophy of individual organizations as to how effectively whole organizational reform can be implemented through the marrying of management-related and health promotion programmes. Johnson (Johnson, 2000) has already stated that there are very few examples of institutional health promotion programs to draw upon. Viewing health promotion as a driving device that helps prompt the need for effective organizational change is a useful start (Ashcroft, 1996).

Perhaps the main driver for HPH reform in Europe is the capacity for hospitals to affect and influence public health reform and therefore directly influence the health of their surrounding communities. Hospitals and their leaders are being held increasingly accountable for the health status of local populations (Olden, 2003). This represents the greatest challenge for the HPH movement and perhaps its biggest failure to date. A broader vision would see the development of not just what could be termed as HPHs, but institutions that could be classified as Public Health Hospitals. A Public Health Hospital is one that develops its staff to move away from increasing medicalized subspecialization to an increasing understanding of the wider health agenda (Wright *et al*., 2002). It does this as part of a health-promoting capacity-building process that leads to an organization's overall structural development, as well as offering a support structure for wider community health promotion initiatives through collaboration with public health agencies (Yeatman and Nove, 2002; Hilgerson and Prohaska, 2003).

Johnson and Baum (Johnson and Baum, 2001) state that until a hospital is truly a health promoting organization in its own right, it cannot broaden its approach to improve the health of the community that it serves. Hospital services that are developed with little consideration of the systems that concern themselves in estimating the health needs of the local and wider community will remain insular and somewhat limited in their influence and scope. Vang (Vang, 1995) argues that hospitals need to equally divide their health promoting activity into two categories: those that are directly aimed at reforming the institution and those that are aimed at reforming the surrounding community. According to Pelikan *et al*.:

> A health-promoting hospital promotes patients' health by . . . using episodes of acute illness or injury as windows of opportunity to promote health, for instance by providing or organizing rehabilitation, and empowering patients to . . . make better use of primary health care services . . . It networks with the relevant local services and associations to build alliances for continuous care and health promotion, thus becoming an agent for health development in the community. [(Pelikan *et al*., 1997), p. 25.]

Achieving any sort of public health/community agenda presents a tall order for most hospitals in Europe. Indeed it represents a formidable challenge given some of the sentiments and apparent divisions that exist. For instance, Wright *et al*. assert that:

> Traditionally, public health professionals have scorned hospitals as the antithesis of community health.

Secondary care remains notably distant from public health practice and policy . . . hospitals are often viewed as being too downstream to be relevant to public health. [(Wright *et al*., 2002), p. 152.]

Weil and Harmata (Weil and Harmata, 2002) suggest that because of their need to focus on fiscal management issues, too many hospitals have now set aside their mission to promote and protect the health of their surrounding communities. Similarly, Guilmette *et al*. (Guilmette *et al*., 2001) state that hospital priorities of reducing in-patient stay periods and other functional outcomes means that health promotion issues do not receive the attention that they deserve. If signed-up HPH organizations struggle to influence the health promotion agenda of their surrounding communities, to what degree can non-HPH institutions be effective? This said, some argue that any health promotion activity has the potential to tip the balance in favour of wider reform. For instance, Johnson and Baum suggest that:

. . . although hospitals are the high temples of sick care, the extensive resources that they command mean that even a small shift of focus has the potential to bring about an increase in resources dedicated to health promotion and, in time, health benefits to a community. [(Johnson and Baum, 2001), p. 282.]

Despite the difficulty of the task, it is nevertheless one that must be undertaken if hospitals are to avoid existing in 'splendid isolation' from wider health policy or the health of the communities that they serve, and where any health promotion activity is 'more symbolic than authentic' (Wright *et al*., 2002; Olden, 2003). Whitelaw *et al*. (Whitelaw *et al*., 2001) outline their Health Promoting Health Service activity, which widens the role of the hospital setting to this effect. Perhaps another way of looking at the issues faced is not so much looking to re-structure whole organizations/institutions or beyond in terms of whole health services, but to break things down into more manageable reform. As a means of promoting HPH's restructuring, practitioners could focus on 'health-promoting wards'. Coakley (Coakley, 1998) suggests that focusing on health promotion in the ward setting could facilitate a public health role if wards acknowledge the 'peripheral' services that are often associated with them.

Encouragingly, some examples do exist where hospitals have looked to or have developed health promotion outreach programmes that describe a partnership between community and hospital [i.e. (Ashcroft, 1996; Mavor, 2001; Quinn *et al*., 2001; Whitelaw *et al*., 2001)], but these are still few and far between. Uddin (Uddin, 2001) suggests that hospitals can be viewed as self-contained community health centres in their own right. McKee (McKee, 2000), however, disagrees and doubts the extent to which hospitals can influence and deliver major improvements in community-related health. Stout's (Stout, 1995) prediction that many hospitals would begin to build 'fitness centres' as an extension of community outreach services has not come to fruition. To some extent, it could be argued that 'drop-in/walk-in' health centres, where they are available, serve as a bridging facility between hospital and community. Part of the HPH initiative, however, appears to hinder rather than assist this process. The WHO has set up a HPH standards committee as mentioned above. Most of the standards refer to the self-contained goals of topic-specific individual behaviour change programmes. Unfortunately, there is only implicit rather than explicit mention of public health or health policy-related standards. Hungary, in its 2002 Annual Report, states that the 'heterogeneity of different regions/networks makes it difficult to create universal standards' (WHO, 2003a). In addition to this, in 1999 the WHO and 'The Network' organized a conference in Phuket (Thailand) from which the Phuket Declaration and the 'Towards Unity for Health—Partnerships among Stakeholders' initiatives evolved (WHO, 2003b). The overall aim here is 'to improve the relevance and performance of the health service delivery system to better meet peoples needs' (WHO, 2003b). While it is implicit that the stakeholders and sectors mentioned might include hospitals in the network, there is a strong community emphasis within the programme and none of the existing projects directly involve the hospital setting.

Bringing hospital-based health professionals on board with the HPH movement has proved to be both complex and difficult. Blinkhorn (Blinkhorn, 2002) is critical of the fact that doctors, nurses and allied health professionals devote most of their time to clinical duties and, health promotion activities aside, often do not provide basic health education programmes. The WHO acknowledges that most hospital staff believe that health promotion is not part of their function (WHO, 2003a). The medical

establishment is notably the most difficult health professional area to target in terms of hospital-based health promotion reform. Johnson (Johnson, 2000) argues that it is very difficult for hospital clinicians who have been trained to think exclusively in terms of disease-based care to apply health promotion principles to their practice, while Blinkhorn (Blinkhorn, 2002) states that most medical funding agencies have actively resisted the opportunity to establish health promotion settings. At the same time, it is difficult for health promotion, as a relatively young discipline dealing with highly complex interventions, to compete with the dominant culture of evidence-based medicine (Pelikan *et al*., 2001). This said, there is a growing concomitant awareness of health promotion in hospitals, in line with the growing awareness of the limitations of acute medicine (Johnson, 2000). The challenge here is not just to try to provide a different type of health-related service provision, but to staff a service with professionals that are prepared to adopt a different health-related mindset (Wright *et al*., 2002).

CONCLUSIONS

It appears that health promotion reform has perhaps not impacted on the hospital setting as much as was originally intended or set out in the Ottawa Charter. The level of commitment ranges from those hospitals that do little more than move beyond traditional health education programmes, to a selective few that have achieved significant policy-driven organizational reform and re-orientation (Johnson and Baum, 2001). This reflects the acknowledged disparity between HPH organizations at a local, national and international level. As such, a wider evidence-base is required to champion the European HPH movement, especially as there is a dearth of literature that measures its impact and direction. Paradoxically, of the empirical evaluative literature available, ~50% of it is written by authors working outside the hospital setting (Aujoulat *et al*., 2001). More empirical studies by those that work within and better understand their own organizations would seem more appropriate.

The European HPH project has been in place for 15 years or so now. If the HPH movement is to move beyond the situation where it may exist as 'an idealism that sounds good in theory' (Cullen, 2002), a concerted and accurate review of its activities is due. To avoid the situation where HPH practice developments might be misconstrued as having little impact, its institutions must approach health promotion reform in a realistic, consistent and concerted manner that is driven by evidence and advocacy. Collectively, a main challenge for the health promotion agencies lies in convincing hospital organizations that health promotion initiatives ease rather than add to any organizational reform burden and improve chances for overall effectiveness, whilst providing fresh ways to tackle existing problems (Pelikan *et al*., 1997). The HPH movement, both worldwide and in Europe, is best served as an integral part of regional health service strategies and when it is integrated into regional policies in an explicit and structured manner.

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