

Health Promoting Hospitals – Assessing developments in the network

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Abstract

Hospitals are specific organizational settings for health promotion efforts. As health care institutions they are already oriented at health, or better at ill health, but with a rather limited focus on health outcomes for patients. Therefore, the Ottawa Charter explicitly asks for the reorientation of health services. And, hospitals also have considerable health effects for other stakeholder populations. This specific potential and challenge has been taken up by the WHO network of Health Promoting Hospitals (HPH), in the last two decades.

Based on available literature the article relates the HPH concept to a more general paradigm of health promoting organizational settings; reconstructs the developmental phases of the international WHO HPH Network; elaborates on its concept development and implementation experiences, and discusses its rather limited investments in evaluation studies and the few assessments from outside.

HPH has developed a convincing comprehensive concept by demonstration projects, using systematically action and evaluation research. To a lesser degree, the same holds true for its developments of health promotion policies for selected vulnerable groups and linking HPH to quality methodology. But there is no systematic evaluation of health promotion in and by hospitals, especially for the networks and member hospitals of HPH.

Even if much of the relevant evidence for HPH comes and will have to come from more general clinical epidemiological, health promotion, quality, organizational and management research, there is need for specific HPH evaluation research, to better utilize, what can be learned from the social experiment of HPH.

Key words: hospitals, health promotion, settings approach

Introduction: Development of the international WHO Network of Health Promoting Hospitals (HPH)

This article aims at giving an overview of the developments of health promoting hospitals as a health promoting setting and an assessment of these developments, as far as possible, by published literature. For that, in a first step, five phases of the development of the network will be identified.

For hospitals and other health care institutions, the Ottawa Charter of WHO provided general principles of health promotion and the settings approach, but also the specific goal of reorienting core functions of health services. This challenge was taken up by the HPH movement since 1988.

The development of this network was not planned in well defined phases with detailed action plans and evaluations, like the healthy cities project, but it can be reconstructed as five more or less distinct, partly overlapping, phases with different foci of emphasis and specific milestones (Table 1).

In the *first* phase (1988-1992), based on the

Ottawa Charter [1], a draft concept for HPH was developed by experts, mainly from the WHO-EURO departments of Health Services and of Health Promotion [2]. To further develop, implement and test this concept a hospital and a research institution were sought for by WHO and found in Vienna, where a feasibility study and a demonstration or model project were undertaken. From its beginning, HPH used concepts of project management and organizational development. Based on the Vienna WHO Model Project, WHO and an international group of hospitals founded the WHO HPH network as a Multi City Action Plan of the Healthy Cities Project. As its first task, a consensual vision and concept for HPH, the Budapest Declaration [3] was developed and a European Pilot Hospital Project for implementing and testing the comprehensive concept started.

In the *second* phase (1993-1997) this project, with 20 hospitals from 12 European countries, many coming from “healthy cities”, was conducted and evaluated, leading to a refined vision and concept, Vienna Recommendations on

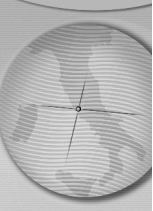


Table 1. Phases and selected milestones of the WHO HPH network

1) 1988-1992	Developing a concept and starting a project and network of HPH
	<ul style="list-style-type: none"> a. WHO Copenhagen workshop (1988) & publication of concept (1988) b. Feasibility study and initiation of demonstration project in Vienna (1989) c. Official start of HPH network as a MCAP of healthy cities project (1990) d. Budapest Declaration on HPH (1991) e. Preparation of European Pilot Hospital Project (EHPH) (1991-1992) f. WHO-CC Health Promotion in Hospitals, Vienna (1992)
2) 1993-1997	Testing the concept and establishing network infra-structures
	<ul style="list-style-type: none"> a. Conducting EHPH (1993-1997) b. Initiating annual conferences (1993) and newsletters (1993) c. Vienna Declaration on HPH (1997)
3) (1995) 1997-2000	Spreading HPH by regionalized networks and specifying it by task forces
	<ul style="list-style-type: none"> a. Establishing national and regional networks and annual coordinators workshop (1995-) b. Task force: Health promoting-psychiatric health care services (1998) c. Website d. Task force: Children and adolescents in hospitals (2004-) e. Task force: Migrant friendly and culturally competent health care (2005-)
4) 2001-2005	Standardizing of the concept & linking HPH to quality & evidence
	<ul style="list-style-type: none"> a. Working groups "Putting HPH Policy into Action"(2001- 2006), "Standards for Health Promoting Hospitals"(2001-2006) b. The WHO HPH/EFQM/BSC Pilot Project in the Immanuel Diakonie Group in Berlin (2002) c. WHO-CC for Evidence-Based Health Promotion in Hospitals, Copenhagen (2004)
5) 2006-	Restructuring the international network
	<ul style="list-style-type: none"> a. Independent secretariat (2005-) b. Introduction of a Governance Board for the international network (2006-) c. Preparation for status of European Association (2007-) d. Extension of scope to other health care organizations and internationalization of network (2008-)

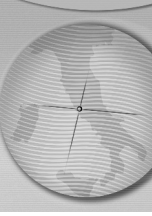
HPH [4]. Parallel, network structures were strengthened by annual international conferences and newsletters as means of internal and external communication. Pilot hospitals were obligated to initiate national or regional HPH networks to spread the concept, so WHO-EURO, partly supported by the EC, could start its official policy of regionalized network building as soon as 1995, with annual workshops for national/ regional HPH network coordinators. In addition to project management and organizational development, systematic network development became a third methodological pillar of HPH.

In the *third* phase (1998-2000) more national/ regional networks were started, the successful ones established annual conferences, newsletters etc. of their own. Also international task forces on specific themes of HPH were piloted. Whereas Tobacco Free Hospitals and Nutrition in Hospitals

proved not to be sustainable, a task force on Psychiatric Hospitals started successfully in 1998.

Within the *fourth* phase (2001-2006) the network reacted to the challenge of more and more hospitals taking up quality philosophy, methodology and management, and got interested in evidence based health care. Two international working groups "Putting HPH Policy into Action" and "Standards for Health Promoting Hospitals" clarified the concept by defining core strategies and implementation strategies and developed and tested standards for implementing HPH. Some hospitals and networks also specified and used the EFQM model for implementing HP in hospitals. So, systematic application of quality methodology became a fourth pillar of HPH.

The actual *fifth* phase (2006) is characterized by preparing more autonomous structures for the management of the international network and by



an official extension to other kinds of health care institutions than hospitals and to other continents than Europe. This policy recognizes ongoing trials and or with HPH hospitals and/ or HPH networks the also in Australia, in Asia (especially in Thailand and Taiwan), in Africa and in Canada.

In 2007 there do exist more than 30 national and regional networks of HPH with around 650 member hospitals.

In all phases of the development of HPH, *Italy* was represented well and made important contributions. In the EPHP two hospitals participated, one from Milan and one from Padua. The Italian network of HPH was built up very systematically and successfully by regional networks focusing on specific themes, like tobacco free, pain free or migrant friendly hospitals, and on quality methodology (e.g. using the EFQM model). Two of the international conferences of HPH were hosted by Italian cities and hospitals, Padua and Firenze. Italian representatives were or are active in an early advisory board, in the two working groups and in the new governance board of the international network. The task forces on Children and Adolescents; and on Migrant friendly Hospitals have been initiated and are coordinated by Italian institutions in Firenze and Reggio Emilia, respectively.

The settings approach of health promotion applied to hospitals

The concept of HPH is based on WHO's settings approach to health promotion. The development of healthy or health promoting, social or socio-ecological settings as a central health promotion strategy has been initiated by WHO in a number of health political documents [1, 5-9] and supported by projects and networks for specific social settings: cities, hospitals, schools, workplaces, regions, universities, prisons, islands etc..

Parallel to this, in health sciences, public health and health promotion a more academic discourse on the what (definition), the why (motivation), and the how (implementation & evaluation) of the settings approach has emerged: [10-20].

In order to apply the settings approach to hospitals, a clear understanding of this approach and of the hospital as a specific organization is necessary.

Organisational settings are of special interest for health promotion, since they are complex and multidimensional determinants or conditions, potential risks and potential resources, for positive and negative - physical, mental and social - health of different populations. This holds true,

because organisational structures and processes, products and services are relevant material, cultural and social conditions for individual and collective health-related reproduction, behaviour and action.

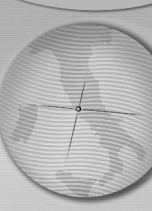
In principal, organisations can improve the health-related quality of these conditions in a proactive, comprehensive, integrated and continuous way, like they can invest in total and continuous quality management. Furthermore, by their quality of agency organisations can support other organisations to become more health promoting, engage in joint (benchmarking) projects and networks for developing health promotion (as several WHO initiatives have demonstrated successfully), and also can advocate and lobby for better health promoting (political) conditions in their relevant environments.

Health promotion in and by organisations has to be done by taking adequate organisational decisions and by investing attention, time and other limited organisational resources in implementation projects, organizational development and sustainable infra-structures for health promotion. For health promotion to be implemented effectively, efficiently and sustainable in organisations, it has to be integrated into the organisation's management system and core processes, and coordinated with primary and secondary goals and structures, like quality, sustainability or corporate social responsibility.

As far as the technical implementation of health promotion measures is concerned, this should follow standard techniques of organisational transformation, development, learning or re-engineering and use project management techniques [21], which have to be adapted, to health promotion principals, such as to be empowering, participatory, holistic, intersectoral, equitably sustainable and multistrategic [22].

Organisations will invest in health promotion either if (evidence based) health promotion interventions are seen as adequate solutions for internally demanding problems (e.g. for fulfilment of core business or securing human resources), or if there are strong external (e.g. political and legal) incentives to accept improving health gain, public health or population health as a relevant secondary goal. But, to generate evidence for and do evaluation on such a complex intervention approach is not a trivial matter and there is ongoing and partly controversial debates on these topics [19,20,22,23].

Anyhow, from the perspective of health promotion or public health organizational settings are of great interests as arenas where most



relevant health impacts for large populations are produced as unintended by-products of their everyday functioning, and as arenas which can positively modify their health effects by integrating health promotion measures into their structures and processes, and by that, produce intended health outcomes as well. Within the health promotion community there is an ongoing debate on the adequate design for comprehensive health promotion programmes in order to be called proper health promoting settings, and not just convenient health promotion projects.

What are the specific characteristics of the hospital as an organizational setting?

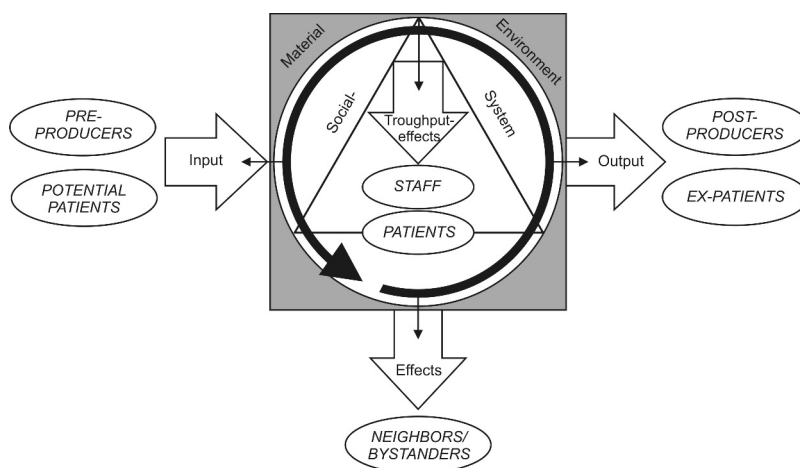
Hospitals are very complex, "high tech and high touch" organisations. Their core business is "people processing", or more specifically, intervening in the functioning of bodies and partly the minds of people. This is done by offering clinical services, for hospitalized patients also by providing hotel or home services. Relevant parts of these services are provided by staff members in co-presence of patients in interactive situations, where for good quality of services shared decision making and active co-production of patients is desirable. Complex clinical services are handled by highly qualified and varied professional staff which is characterized by a certain kind of autonomy in relation to the local hospital management and an additional loyalty to its cosmopolitan professional peer group. Mintzberg [25] in his classic analysis of organizations, differentiates five principal types of organizations: simple structure, machine bureaucracy, divisional structure, adhocracy and professional organization. Hospitals, as well as schools, universities or research institutions, he classifies as professional organization. There the necessary know how is concentrated with highly

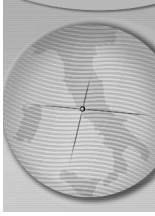
intrinsically motivated professionals who are characterized by intensive contact with the clients of the organization, relatively strict boundaries of interdisciplinary communication and an internal tendency of differentiation and specialization. Therefore, any outsider but also any specific insider trying to influence structures and processes, to become more health promoting, ought to conceive hospitals as differentiated multi-stakeholder organizations. The stakeholders differ in interests and shares of control over relevant structures and processes of a hospital, follow different kinds of logics and have to be convinced by specific types of arguments and evidence. Mintzberg [26] differentiates four worlds of the hospital, characterized by common and differing problem areas: medical cure, nursing care, management and economic leadership and the world of owners and financiers.

Using the general assumptions for socio-ecological settings for health promotion outlined above, the hospital as a specific setting influencing health can be outlined as in Figure 1. Here, the hospital is understood as an organisational social system autopoietically reproducing itself, its structures and processes, by communicating decisions. Therefore the simplest and most abstract definition of a health promoting hospital is, a hospital that effectively uses health promoting/health hindering as a criterion in all its decisions. This social system is linked to a specific material environment (including technical artefacts and tools) it partly controls, and partly is controlled by. This socio-ecological complex affects the health of different populations directly and indirectly in different ways.

The health of its *patients* who are processed by the hospital is influenced positively by effective

Figure 1. The hospital as a setting and multidimensional condition for the health of different stakeholder populations





cure and care processes and negatively by problematic side-effects of its treatment, but also by the health related quality of its hotel services and the quality of its material and cultural setting. At least the mental health and wellbeing of patients' *relatives* is also affected indirectly by the way the hospital treats its patients. To improve the health effect on patients and relatives the hospital has to develop primarily its core processes by quality management and integrating health promotion into these. Health of potential patients in the catchment area is also influenced by access to hospital services, this specifically holds true for migrants and ethnic minorities [27]. On the input side and on the output side it depends on the quality of the hospitals discharge-management and the services offered for illness management after discharge.

The health of *staff* is influenced by the generic health related quality of the hospitals working conditions and processes and also by the provision of compensatory health related measures. Also staff's *relatives* health is influenced indirectly by the effects the hospital has on its staff. To improve health effects on staff and relatives is the classical domain of workplace health promotion in hospitals.

The wellbeing and health of *neighbours* is affected e.g. by air pollution, noise or additional traffic attracted by the hospital.

Another groups whose health is affected indirectly but specifically by hospitals are on the input side *pre-producers* of goods and services bought by the hospital and on the output side *post-producers* who have to deal with the hospitals output of patient (= post services) and material output like waste etc.

From a public health or health promotion perspective, the holistic health of all these stakeholders has to be of interest, but by hospitals, primarily the health of patients is seen as relevant, and most hospitals still are focussed, rather narrowly, on the physical disease oriented clinical outcome of their services.

The specific paradigm and concept of HPH

Based on Ottawa Charter and results from demonstration projects, HPH vision and concept has been developed in consensus processes and defined in documents and publications: Milz & Vang [2], Budapest Declaration [3], Vienna Recommendations [4], a comprehensive paper from outside the network by Hancock [28], a summarizing paper from within by Pelikan et al. [29], papers from the working group "Putting HPH Policy into Action" [30,31] and from the working group "Standards for HPH" papers and manuals [32,33]. Whilst the earlier documents had a looser,

more additive and visionary character, the two working groups, influenced by developments in quality methodology, tried to be more systematic, clear, technical and precise. The working group "Putting HPH policy into action" defined 18 core Strategies (Table 2), which do not yet cover all possible health effects and health gains of a hospital outlined in the radical concept of the settings approach and its application to the hospital, but are already quite comprehensive.

The core strategies have been developed focusing on the three most important stakeholder populations, whose health is related to or affected by the hospital: Its patients (including their relatives), its staff (also including relatives as possible beneficiaries) and the inhabitants of the community a hospital serves. These three types of stakeholders have been identified and considered for health promotion measures early on in the network. The health, in a metaphorical sense, of the hospital as an organisation which as a fourth beneficiary also could benefit from health promotion measures, and had been included in earlier conceptualizations, has been considered by the working group only in the context of implementation strategies. To improve the health gain for each of the three human stakeholder populations, different types of health promotion strategies are defined, which relate to different core processes or structures of the hospital, which, at least in theory, can be separated analytically. *Strategy 1* relates to the processes within or in relation to the hospital affecting the reproduction or self-management of a person's life as basis for taking the specific roles of patients or staff or citizens i.e. processes of hotel or home for patients of work life for staff and of access to the services of the hospital for inhabitants of the community. *Strategy 2* is focused on specific health care or treatment processes related to the patient or staff role. And, *strategy 3* is oriented at the material, social and cultural structures of the hospital setting as a context for living and treatment processes, for the three stakeholder populations. Since these three health relevant types of strategies have direct effects on the quality of the core business of hospitals, they are expected to be applied by any hospital, attempting to be a HPH. In contrast, strategies 4-6 relate to specific health promotion services which can be offered by hospitals, but by other providers of health care, as well. Therefore, depending on the legal, organizational and financial regulations of the health system in which a hospital operates, it may make sense, either to offer these health promoting services itself, or, to better refer those

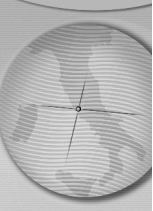


Table 2. 18 Health Promoting Hospital Core Strategies

	HP for ...	Patients	Staff	Community
HP quality development	1. Enabling for HP self management in living	PAT-1: HP living in the hospital for patients	STA-1: HP work life in the hospital for staff	COM-1: HP access to the hospital for citizens
	2. Enabling for HP Co-production of health in care	PAT-2: HP Co-production of patients in treatment	STA-2: HP Co-production of staff in work processes	COM-2: HP Co-production with services in region
	3. Development of a HP hospital setting	PAT-3: HP hospital setting for patients	STA-3: HP hospital setting for staff	COM-3: HP hospital setting for citizens
HP strategic (re-)positioning	4. Enabling for HP illness management	PAT-4: HP illness management for patients	STA-4: HP illness management for staff	COM-4: HP illness management for citizens
	5. Enabling for HP lifestyle development	PAT-5: HP lifestyle development for patients	STA-5: HP lifestyle development for staff	COM-5: HP lifestyle development for citizens
	6. Development of a HP community setting	PAT-6: HP community setting for patients	STA-6: HP community setting for staff	COM-6: HP community setting for citizens

in need, to other providers. Strategy 4 relates to stakeholders needs for specific health promoting illness management, *strategy 5* to needs for health promoting lifestyle development and strategy 6 to the environment of the hospital, where HPH could engage in or support developments towards a more health promoting community. For specific issues, like tobacco or nutrition, or vulnerable populations, like children or migrants, integrated issue specific health promotion policies can be developed which combine measures from different strategies. For all 18 strategies there is available information on objectives, indications, main topics/ routines – selected examples, guidelines and evidence in a web document [31].

For selected core strategies and aspects of these strategies the working group on Standards has developed 5 standards with 24 sub standards and 18 indicators. The five main standards are

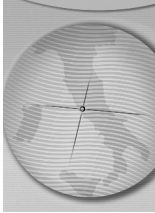
1. Management Policy
2. Patient Assessment
3. Patient Information and Intervention
4. Promoting a Healthy Workplace
5. Continuity and Cooperation

These standards have been successfully tested for feasibility in an international project, been translated to different languages and been used systematically in some of the HPH regional and

national networks. This well designed tool, which contains a selected core of the HPH concept in a nutshell, allows every hospital interested in using health promotion to start with a systematic self assessment, and, based on that, to develop an action plan for implementation reflecting its specific needs and potentials.

Implementing HPH

Implementing even limited changes in organizations effectively, efficiently and sustainably has to be done using planned and monitored project management. That holds true for quality improvement in general and also for introducing the specific quality of health promotion into the complex structures and everyday routines of a hospital. Therefore from its beginning the HPH network expected hospitals to implement any health promotion measures by systematic and documented project management and started a data bank on projects in member hospitals. But for implementing the comprehensive HPH approach more investment in health promotion infra-structures and resources is needed. Already in the first two demonstration projects, hospitals were expected to establish more general HPH structures within the hospital organization (HP manager, HP committee, HP focal points in hospital units etc.) to support the



realization of specific focused projects. These requirements were more systematically developed using quality philosophy and methodology by the working group “Putting HPH Policy into Practice” (Table 3). [31]

This table builds on three assumptions: First it follows Donabedian’s quality approach assuming that quality of health promotion *outcomes* has to be produced by quality of health promotion *processes*, which have to be made possible by quality of health promotion structures. Second it uses three steps of a reduced quality circle, health promotion quality has to be *defined*, to be

health promotion support structures are necessary and have to be integrated into the management system of the hospital, either as independent specific structures or integrated into quality and/or sustainability management structures.

Evaluation, evidence and research on HPH

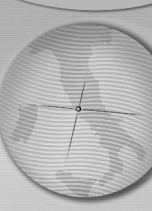
HPH started with systematic demonstration projects which used action research and had inbuilt rather strict documentation and evaluation obligations. Results of the evaluations of the “Vienna Model Project on Health and Hospitals”

Table 3. Seven Health Promotion Quality Management Strategies for Implementing the Comprehensive Concept of HPH, Following Donabedian’s Approach

Qualityfunction/ activity for quality of	Structures of services (& settings)	Processes of services (& settings)	Outcome/impacts of services (& settings)
1. Definition	S1 Define HP criteria & standards for structures	P1 Define HP guidelines & standards for processes	O1 Define HP targets for outcomes & impacts
2. Assessment Monitoring, Evaluation	S2 Assess for HP of structures	P2 Assess for HP of processes	O2 Assess for HP of outcomes & impacts
3. Assurance, Development Improvement	S3 Develop HP of structures by OD, PD, TD	X	X

assessed in a specific situation, before, where demanded, it can be improved; and, the results of improvement measures have to be *monitored* or *evaluated* in turn. And, third, it accepts that only structures can be directly influenced or improved, whilst processes and outcomes cannot. So seven strategies for implementation result, which have to be combined, to allow for total and continuous health promotion quality management in a hospital. Since in a meta-perspective, the quality of health promotion outcomes depends on the quality of health promotion related processes of definition, assessment and improvement, adequate structures to support these quality processes have to be secured. Therefore, a hospital dedicated to a comprehensive HPH approach: has to integrate health promotion values and principles, goals and targets, standards, criteria and indicators into its written vision, mission statement, policies, action plans, guidelines, manuals and protocols. It has to invest into health promotion programs, projects and dissemination strategies. It has to institutionalize a health promotion manager, a team, a committee and contact persons in all its units and, last but not least, a specific budget. Such

[34-36] and the “European Pilot Hospital Project on HPH” [37-40] have been published and been presented widely at international conferences for HPH (conference proceedings available under <http://www.hph-hc.cc/conferences.php>) and other conferences. These evaluation studies could only look at intermediate results, as defined by Nutbeam [41], of specific health promotion measures or programs of the HPH project. Results can be illustrated by two hospitals participating in the European Pilot Hospital Project. By the Vienna Model Project in the Rudolfstiftung Hospital, Vienna Austria, it was possible: “...to solve relevant problems of the hospital; ...; to ensure sustainability of the project results by establishing new professional roles, new communication structures and training of staff; to work continuously on the HPH-projects throughout 7 years (including funding of the last two years out of the normal budget of the hospital); to involve 250 staff members actively in the subprojects (more nurses than doctors and administration 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 from this project the European Pilot Hospital Project and the Austrian National Network of HPH." [35].

The evaluation of the Aretaieion Hospital, Athens Greece, by two questionnaire services, "one among all the professionals, and the other among the patients involved in the subprojects" found the following: "Major successes were reported to be the personnel training, the development of collaboration and teamwork, the improvement of the overall image of the hospital into the community, the improvement of the working conditions of the personnel....Problems of the Project were reported to be lack of funding, lack of time and personnel shortages, lack of health promotion background and lack of incentives." [40]

Also the work of the task forces of HPH, mainly targeting vulnerable patient groups like psychiatric patients [42,43], children and adolescents [44], migrants and ethnic minorities [27,45-47] and outside the HPH network for Gender Friendly Hospitals [48], has been built on and combined with research. The same holds true for picking up quality themes in HPH [49,50]: development of standards for HPH [33,51,52], combining the EFQM model with HPH [53,54] or evidence for health promotion in hospitals [55]. But, there is yet no systematic evaluation for HPH, comparable to that of the WHO Healthy Cities Project e.g. Therefore, the few publications from outside the network who try to critically assess the success of the network, can only partly base their assessments on empirical studies and ask for systematic evaluation [23,24,56-59]. These reviewers generally confirm the quality of the HPH concept, but mainly criticise three deficits in the implementation and evaluation of the concept. First, that too few hospitals at all are implementing the HPH concept. Interestingly enough, the criticism of non implementation is also valid for specific less complex health promotion interventions in hospitals and health care [60-62]. Second, that the concept is not implemented comprehensively or reorienting enough by the hospitals which do it, and third, that there is lacking evaluation and empirical evidence for the radical HPH or public health hospital approach. For the broader topic of Health Promoting Health Services even less literature is available [56,60,63-65] and there exist only very few evaluation studies, e.g. within the NHS in Scotland [66]. This lack of evidence partly has to be explained by the general difficulty of evaluating complex settings-based practice as discussed in the literature [16,20,67-69].

Conclusions

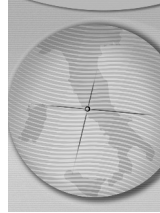
Using a radical model of health promoting settings, the effect of hospitals on health has to be seen as rather complex, since hospitals affect the health of many different populations in varied ways. But, evidence for actual or potential health effects only partly should be expected from specific health promoting hospitals research, like the one started by the Copenhagen WHO CC on evidence based health promotion in hospitals, but mostly has to come from other well established research traditions like clinical epidemiology, occupational health, environmental health, quality research or health promotion research in general.

The same holds true as far as the selection of evidence based health promotion interventions for improving generic health effects of hospitals is concerned. Many of the possible interventions will have to be chosen from life style or work place health promotion in general and only adapted to the specific conditions of hospitals. Specific development of and research in interventions mostly is needed for specific outcomes like health literacy or for developing clinical core processes to be more health promoting, or for the best practice of integrating health promotion into quality management. But this again has to be done in close cooperation with general health promotion, clinical and quality research.

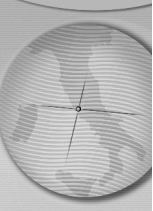
The quality and effectiveness of the implementation of these interventions in specific hospitals of course has to be controlled by local monitoring, documentation and evaluation and reviewed for universal knowledge generation. Compared to the healthy cities and to a lesser degree also the health promoting schools network, the practice of the health promoting hospitals network in its later phases has not been evaluated adequately or if at all. This potential should be exploited in the future by systematic evaluation research to improve knowledge on the feasibility, quality and sustainability of implementing health promotion measures in hospitals for specific thematic areas or for a comprehensive reorienting organizational development approach. The role and usefulness of the HPH networks and their structures should be evaluated systematically as well.

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