Theory of Health and Health Promotion in Organizations
Part 3 of 6

„Health promoting organisation settings in long-term care – Conceptualizing in the framework of the Vienna Organisational Health Impact Model“

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November 2010, Wien
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In societies of second modernity, the affiliation between the individual and the society has undergone a significant, though still not adequately understood shift which is of highest relevance for the investigation of health determinants. This shift relates to the almost society-wide blanket coverage with and the methodological accomplishment of organizations in the past, say, 50 years. Organizations are a specific type of social systems characterized by their far going autonomy and by their incomparably strong capacity of making decisions. To be a member of one or more organizations and to behave like expected is crucial for making a living anyway. Most people, therefore, have accepted the neoliberal transformation of state-owned into private companies in the recent past and the outsourcing of public functions into economy, and would, if forced to choose, probably rather abandon their nationality than their organizational affiliation, say: job.

The obvious consequences of this development are threefold: first, previously strong systems like the state, political parties, market economy or religion are weakened in the sense that they suffer a loss in controlling the societal developments and in guaranteeing basic social functions for all, second, almost everything good or bad in the society and in the individuals’ lives can be seen as a result of decisions that have been made by organizations on local or global levels, and this, finally, leads to a fragmentation of individual life contexts and biographies that forces individuals to develop what has been called a flexible and liquid or not-programmatic individuality characterized by strong self and social competencies and by an unquestioned readiness for change and adaptation. As a countermovement, of course, we can observe the emergence of old and new fundamentalisms that invoke irreparable securities.

For health promotion it is crucial to acknowledge that organizations are the locus where most people realize their important life interests, spend most of their time, and alongside with that, also spend a big part of their health. Organizations, therefore, are not only useful settings to reach people and act on them with health promotion measurements, but the very social systems which by their own processes and structures impact on health in a damaging or promoting manner.

A growing body of scientific knowledge indicates that. However, most of this research conceptualizes the organizations’ processes and structures in a quite under-complex way and does not give sufficient insight into the particular organizational realities and occurrences that shove people into illness or illness inducing behaviour. Consequently, it does not sufficiently indicate, whether specific interventions on the side of the organization targeted on its own core processes and structures can have any predictable health effects on the side of the individual.
It goes without saying that such research needs a theoretical model that defines and depicts the relevant factors and the possible relations between organization and health. Our institute’s response to this scientific task is the “Vienna Organizational Health Impact Model”, shortly called VOHIM. It was developed by a small group, Karin Waldherr, Jürgen Pelikan and me, in the course of one and a half years, starting with a literature review and the deconstruction of existing models and building on the conceptual thinking of modern system theory. We presented our ideas and draft versions several times to the whole team, stimulating discussions and receiving useful feedbacks. Early versions were presented on the Conference of Occupational Psychology in Vienna, spring 2009, and to our Scientific Advisory Board, who gave us important encouragements. One of the members, Maurice Mittelmark, commented on a very late version and influenced heavily the model’s final shape.

From the very beginning we had planned to present the model, its theoretical basis and practical implications to a selected group of experts before publishing. For that purpose, we organised the “International Symposium on Health and Health Promotion in Organizations”, which we dedicated to our former teacher and longstanding colleague Jürgen Pelikan at the instance of his 70th anniversary. The symposium took place between 2nd and 4th of June 2010 in Vienna. The model and several applications to specific settings were presented by the group of key researchers of the institute, while invited experts were asked to critically comment on that. Open discussions followed including the audience.

The model was presented by Wolfgang Dür, Rudolf Forster, Karl Krajic, Peter Nowak, Jürgen M. Pelikan, Karin Waldherr.

Commentators and discussants were Margaret M. Barry (National University of Ireland), Georg Bauer (University Zurich), Günther Bergmann (Klinik für Psychosomatische Medizin Göppingen), Marie-Louise Friedemann (Florida International University), Oliver Gröne (Autonomous University of Barcelona), Petra Kolip (Universität Bielefeld), Richard H. Noack (Austrian Society of Public Health), Louise Potvin (Université de Montréal), Rudolf Richter (University Vienna), Fritz B. Simon (University Witten Herdecke), Venka Simovska (Aarhus University), Georg Spiel (German Society for Evaluation), Werner Vogd (University Witten Herdecke).

The audience consisted of Christina Dietscher, Rosemarie Felder-Puig, Robert Griebler, Ursula Mager, Edith Flaschberger, Lisa Gugglberger, Philipp Hanak, Markus Hojni, Waldemar Kremser, Benjamin Marent, Florian Röthlin, Hermann Schmied, Monika Simek, Astrid Loidolt, Carolin Schmidt, all of them LBI-HPR team members, Nick Serrano from the University of Florida, Rainer Christ and Gerlinde Rohrauer-Näf from the Austrian Health Promotion Fund.
All presentations, comments, and discussions during the symposium are documented in this series of working papers, of which part one is fore-lying. For us, it is a starting point for the systematic publication of the VOHIM with all its underlying views and insights that, as we hope, may contribute to the thinking about organizations’ impact on health and the chances for health promotion.

As head of the developers group and director of the LBI-HPR I feel grateful to each and everyone who contributed in one way or the other to this achievement and take the opportunity to say: Thank you!

Vienna, November 2010

Wolfgang Dür
Health promoting organisation settings in long-term care – Conceptualizing in the framework of the Vienna Organisational Health Impact Model

Krajic K., Schmidt C., Schüssler S.

1 Introduction

The core research questions of the program line “Health Promotion in Long-Term Care (HP in LTC)” can be summarised as follows:

- What is the impact of long-term care organisations on health of users, their relatives and other informal carers and of course staff of these organisations?

- And how can these organisations improve/optimise their health impact by using concepts, strategies and specific interventions from health promotion?

- And how can the settings approach of health promotion be specified to become a developmental strategy for LTC organisations?

The program line “Health Promotion in Long Term Care” (HP in LTC) attempts to answer these questions in the context of the overall research program of LBIHPR, focusing on health promotion in organisational settings. This paper provides a first sketch of questions and theses that come up when trying to understand health promotion in LTC settings in the framework of the Vienna Organisational Health Impact Model (VOHIM) as the currently evolving common conceptual model for health promotion in organisational settings of LBIHPR (see Dür et al. 2010).

Long Term Care settings

Long-term Care (LTC) is defined as “a wide range of health and health-related support services provided on an informal or formal basis to people who have functional disabilities over an extended period of time with the goal of maximizing their independence” (Evashwick 2005). According to Schaeffer/Büscher (2009), there is a significant difference to the former understanding of LTC as a mix of basic support and custody of the patient/client.¹

There are three main areas (“settings”) of LTC with some further sub-areas:

- Stationary or residential care: Old age and/or nursing homes; assisted living for the elderly; psychiatric in-patient care; institutionalised care for the handicapped.

¹ A critical comment, important from a health promotion perspective: The Evashwick definition has a normative focus on “independence” which seems problematic, given the growing number of people with functional handicaps, many of them in the mental area. Balancing “independence” with other aims might be useful, and maybe “maximising autonomy” might be more appropriate from a scientific perspective.
Semi-stationary care: Day care (usually specifically organised for the target groups elderly, handicapped persons and mental health)

Home care: Formal and informal care in various combinations

Although the program line HP in LTC started out to work on the main research questions for organised (or organisationally supported) LTC in general, there was a decision to first focus on health promotion in residential care settings for the elderly. One of the arguments for prioritising residential care settings is that many LTC organisations assume overall responsibility for organising/supporting normal reproduction, as well as taking care of specific health and social needs. In Goffman’s terms (1961), they can be described as something close to “total institutions”. This makes them as organisations especially resourceful to influence health of people subjected to their everyday functioning and thus a most interesting target for the settings approach for health promotion. But residential care organisations are also considered to be rather problematic, though indispensable settings, and this again can be seen as reason to prioritise working in this area.

Whose health can be promoted in these settings?

Following suggestions formulated by Pelikan (2007a.), the program line combines health promotion perspectives for all groups affected by long-term care settings. That includes users (residents), staff, relatives and other members of personal networks, and finally all bystanders, who are systematically affected by (usually unintended) side effects of LTC. In the HP in LTC program line, specific attention is given to the residents/users, many of them being frail elderly with many health problems.

What do we know about Health Promotion in LTC so far?

Initiated in 2008, a literature analysis of LBIHPR in English and German language databases (Horn et al. 2010) has shown rather little systematic work on health resources and health promotion in LTC settings. Although over the last decades, there were some initiatives to establish a scientific discourse (e.g. Minkler 1984, Caserta 1995, recently Kayser-Jones 2009), this has neither lead to systematic research nor – as far as can be judged from its resonance in scientific discourses - to many initiatives, projects and programs in practice so far.

For the German speaking context, the literature review brought up a focus of health promotion work (scientific and practical) on health promotion for staff (mainly “health at the workplace” – programs; Brause/Horn/Schaeffer et al. 2010). Less attention has been given so far to health promotion for residents. Although there is a lot of interest in “healthy aging” which has lead to a wide range of policies, programs, initiatives and also research, this has been focussed on the “young old” so far; this group seems to offer still a lot of preventive potential. Much less attention from a health promotion perspective has been given to the older or the oldest old, especially the frail elderly (Horn/Brause/Schaeffer et al. 2010), who so far have not been seen as potential target groups for health promotion interventions.

And what about the settings approach for health promotion, aiming at improving the overall impact of physical and social settings? Up till now, health of the elderly has been addressed mainly in community settings and in health care (hospitals). Specific organisational settings like residential or nursing homes, sheltered living, day care centres and also organised home care have not yet been addressed with a complex approach trying to develop them into “health promoting settings.” and/ or do research on them in that di-
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rection. At least not under the heading of settings oriented health promotion, because concerning the health of residents, some specific overall concepts for quality development or reforms in long-term care/ nursing homes could be identified that show many similarities to health promotion approaches. As examples, the psycho biographical care theory of Böhm (http://www.enpp-boehm.com/en/home.html) or the Eden Alternative (http://www.edenalt.org/) can be mentioned. And workplace health promotion for staff has become more popular in the last decade as staff shortages prevail and demographic scenarios threaten upcoming crises.

Consequences for the LBIHPR program

Thus, developing scientifically sound concepts, deepening theoretical understanding and collecting/ developing empirical knowledge on something like the “health promoting residential care” or, more drastically expressing the paradoxes, the “health promoting nursing home” has turned out to be an innovative and rather experimental area of work. Since 2008, the LBIHPR\(^2\) has conducted the following projects:

- Literature review (first publications in German language available)
- Concept development (first publications in German language available; this working paper as first English language publication)
- Status quo analysis on health promotion in Austrian LTC/ care for the elderly (intermediate results published in German language)
- Development of tools for assessment, quality development, implementation and evaluation of specific interventions (ongoing)
- Testing complex approaches in the framework of pilot projects (a pilot project in 3 units located in Vienna 2011-2012 is in preparation)

2 Basic assumptions on health and health promotion in LTC for the elderly

(1) Looking at the central role that health/ disease play in the definition and in the core processes of LTC, it seems very important to point out the specific difference that health promotion can make – to explain commonalities and differences between health promotion and other strategies for improving health. This has been elaborated already for health promotion in hospitals and health care in general, where expectations for a specific concept of health promotion were manifest early on. So we can

\(^2\) The program line HP in LTC is carried out in collaboration with three partners responsible for health promotion development in Austria: the Fonds Gesundes Österreich, the health promotion agency of the City of Vienna (Vienna Health Promotion) and the Main Association of Austrian Social Security Institutions. As international scientific partner, the University of Bielefeld (headed by Doris Schaeffer, professor for the health science and chair of the nursing science department) contributes its specific LTC expertise and carries out empirical projects in the German context.
connect to work of Juergen Pelikan that has been done with regard to these expectations.

(2) In accordance with proposals of Pelikan 2007a; and Pelikan 2007b, we suggest to understand health promotion as a specific intervention strategy aiming at influencing health. Pelikan suggests distinguishing 4 strategies for intervention: Disease prevention, treatment of disease, health protection, and health improvement. These 4 types can be distinguished according to their logic of intervention - although specific measures often cannot be categorized in an unambiguous manner.

(3) This typology connects to various concepts propagated by the World Health Organization (WHO) but also to some central discussions in the health sciences, asserting that health is not simply the absence of disease, but a quality generated by reproduction of living systems in their environment. Health is understood as a precondition and a result, input and output of this normal reproduction, and its specific expression and variation can be observed independently of specific diseases. To clearly mark the difference from the medical concept, this dimension has been called "positive health" already in a paper by Bauer/Davies/Pelikan (2006) in Health Promotion International and further elaborated by Pelikan (2007b; Pelikan 2009).

(4) The proposition to consider (positive) health as an observable quality of living systems, that has to be permanently reproduced as part of its autopoietic reproduction in its relevant environment (Pelikan 2009, p.32) seem relevant also for conceptualising health promotion in long-term care for the elderly. In this field, especially the users usually are not healthy in the medical sense – many/ most of them are suffering of one or more chronic diseases. So treatment or management of disease, as well as secondary or tertiary prevention, of course are meaningful strategies to protect or improve health status. Even primary prevention concerning diseases they have not (yet) acquired can make sense as well.

(5) What about health promotion? We follow Pelikan (2007b, p. 79), who proposes that positive health and illness do (co-)exist as parallel aspects of self-reproduction. “[...]
good positive health is a precondition to control and fight illness, and illness has the potential to reduce positive health in the future. So, positive health is endangered by illness and by accidents, but also by another kind of biological process, ageing. Ageing, partly depending on the kind of living, will, to a certain extent, reduce or limit positive health, following the life-cycle of an organism.”(p. 79) Good positive health improves quality of life and life expectancy – illness/ disease usually reduces positive health.

(6) In his recent (German language) paper, there is a proposition by Pelikan (2009) especially interesting for HP in LTC. He proposes to distinguish three aspects of positive health: Functional capacity, well-being and attractiveness. These three aspects can be specified for each of the three systems that constitute a human individual: Body, mind, and social status.

- Functional capacity refers to functioning/ performance that can be observed/ measured in an “objective” way by scientifically based methods used by professional experts.

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3 Connecting to various other propositions, e.g. from psychology (e.g. Seligmann 2008).

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- Well-being refers to subjective personal experience.
- Personal attractiveness refers to the way other actors in a person’s relevant environment perceive somatic, mental, and social properties of this person, e.g. the way they look, they smell, etc. The assumption is that perceived (or ascribed) attractiveness contributes to survival of a living system in a quantitative as well as qualitative sense – in addition and partly independently of “objective” functioning or subjective well-being. Personal attractiveness is nothing given, it is something that must be reproduced and represented in a continuous way (Pelikan 2009, p. 35).

(7) Pelikan’s propositions of course relate to other concepts – function capacity to “functional health”, well-being to wellness and of course to (subjective, health related) quality of life. One could also discuss the relationship of “attractiveness” and “social identity” but, all this leads into complex discussions on the theoretical as well as on the empirical level – this has to be discussed elsewhere, no easy solutions in sight.

(8) In the Table presented below, we provide a short overview of the 3 dimensions and illustrate which issues could be addressed for each of the three systems. Each of the nine cells of this matrix and the issues specified in an exemplary way in each of the cells could become target of health related observation and consecutive health promoting action – each cell by itself, in combination or in a comprehensive way. Looking at this table from an angle oriented at potential deficits, we consider it an interesting instrument helping to understand how precarious the health situation of users of LTC can become or – turning around the perspective – how many possibilities there are to improve health resources.

Table 1: Issues for promoting positive health, categorized according to dimensions suggested by Pelikan 2009

<table>
<thead>
<tr>
<th>Functional capacity (judged by experts)</th>
<th>Body</th>
<th>Mind</th>
<th>Social Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senses/ nervous system, musculo-skeletal apparatus, metabolism, immunocompetence</td>
<td>Mental capacity</td>
<td>Social Resources: “capitals” (Bourdieu): economic, social (networks), cultural</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective Well-being (Quality of Life)</td>
<td>The physical situation (e.g. no pain)</td>
<td>The mental situation</td>
<td>The economic, social, cultural resources available</td>
</tr>
<tr>
<td>Attractiveness of the individual (perceived by others) on the basis of aspects of the three systems</td>
<td>Beauty, physical performance, neatness</td>
<td>Cognitive ability, empathy, judgement, capacity for action</td>
<td>Access to economic, social, cultural resources</td>
</tr>
</tbody>
</table>
3 Assumptions on preconditions for health promotion interventions in LTC settings: First propositions applying the VOHIM framework

Looking at the wide range of scientific knowledge on determinants of health, a complex picture appears: A large number of biological, psychological and social factors have an influence on the different dimensions of an individual’s health. In the framework of the health promotion approach which is central to research at the LBIHPR, especially those factors are focussed that exert their influence in specific spatial and social contexts or settings, where human beings live. Social settings are understood as structurally coupled units, as hybrids of physical and social structures (Pelikan/Halbmayer 1999). “Organisational settings” are understood as being characterised by the fact that (specific) organisations have a large degree of influence on structures and processes occurring in these settings. Dür et al. (2010) have developed the “Vienna Organisational Health Impact Model” (VOHIM) as conceptual model for a better understanding of health impacts and preconditions for health promotion interventions in these types of settings. Figure 1 (below) provides an overview how this model conceptualises health impacts of organisations on individuals.

Figure 1 The Vienna Organisational Health Impact Model VOHIM (Dür et al. 2010)

Organisations are conceptualised as systems with structures and processes (boxes A-D), which operate as self-referentially closed systems in their relevant social and material
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environments. Individuals are understood as units\(^4\) operating/acting in a self-referentially closed, though highly interdependent mode with their relevant social and material environments. Arrow 5 marks the main nexus between individual health and organisational performance. Dür et al. 2010 describe this central relationship not as direct causality, but rather in form of observation: “Whatever is going on in an organization, the performance box is observed not only by the organization, but as well by the individual, be it a staff member or a user”. So health impacts on the individuals are understood as depending (also) on individual structures and processes (somatic, mental and behavioural).

A more detailed description of the model – its overall status and the specific assumptions it contains – is not possible in the framework of this paper, see for this purpose Dür et al. 2010. What will be done in the following text of this chapter 3 is to provide some descriptions of outcomes, processes and structural aspects of LTC.

At this point, it is primarily the upper part of the model, conceptualizing the organization in its relevant environment which will be analysed as precondition for and target of settings-oriented interventions. A further elaboration of important questions around the individuals’ contributions in transforming organizational processes into impact on their health in its physical, mental or social dimensions (the lower part of the VOHIM model) will be part of another paper.

To provide better orientation, we summarize the objectives of the next sub-chapters:

- Part 3.1 provides some information on the health status of people affected by residential LTC – users/residents, staff and relatives. In terms of the VOHIM, this can be understood as referring to box F (individual dispositions as starting point for the organisations’ impact), but of course health status also refers to box H (individual achievements – quality of life – individual health as result of social and individual processes).

- Part 3.2 specifies core- and support processes of LTC organisations, which – in terms of the VOHIM – constitute their “operative performance”. In the focus of the VOHIM, these are the central factors on the organisation side of the model that are the source of health impacts; and health promotion interventions – those who address situative condiions - have to relate to these factors - e.g. try to influence them. The focus of attention of this part is on box C (organisational performance) and arrow 5 (potential impact on the individual).

- Part 3.3 discusses some aspects of governance of LTC settings (focussing residential LTC) (box A). The focus is on the contribution of the organisation and especially those structures and processes involved in governance –usually understood as responsibility of leadership/management. Leadership/management is to select an important part of the premises (box B) by deciding upon formal structures (arrow 1). A second, less obvious contribution of organisations is the evolutionary development of informal structures that are usually referred to as “organisational culture”.

\(^4\) Or rather structurally coupled units of different systems: Mind and body; there are also propositions to understand social status as a third type of individualised system.
In part 3.4, LTC organisations are looked at in their relationship to relevant societal environments. The main interest is in getting a better understanding of restrictions or opportunities created by legal and financial frameworks, by professional standards and by other organisations in the relevant environments. There is also the question, how LTC organisations – when developing in a health promotion direction – can draw upon resources available to them in their environment, e.g. knowledge, but also legitimacy from other, well established programs.

3.1 Health Outcomes: Health Status of residents, staff and relatives (VOHIM Boxes D und H)

This part contains results on health status of three groups:

(a) **Residents** of LTC facilities, whose health status is being described as especially difficult and who are considered most vulnerable, (b) LTC **staff** whose health status seems comparatively well documented and is interesting in its double role as a group subject to health impacts but also as a group highly relevant for quality of care of the residents. (c) For the (c) **relatives** of residents, it seems we don’t know too much, but we will argue why they seem relevant.

3.1.1 Residents

The literature review conducted in the framework of the program line came up with the result that in German speaking countries\(^5\) there are only few systematic epidemiological data on the health status of LTC users available. This holds especially true for residents of LTC facilities (with the exception of specific scientific studies in a limited set of facilities) and for data referring to status of the positive health dimensions (health resources, subjective quality of life) (Schaeffer/Büscher 2009).

Nevertheless, it seems very plausible that especially the users of residential LTC suffer not only of one or more chronic illnesses, but also of severe losses of their positive health. An example: Concerning the dimension „functional capacity of the mind“ German studies estimate that 50-80% of the residents are suffering of mental disturbances, mainly caused by one of the different forms of dementia (Schaeffer/Büscher 2009).

In a review (developed in collaboration with LBIHPR), Horn/Brause/Schaeffer et al. (2010) show that the literature provides the image of a frail, vulnerable population. Yet they also point at the fact that health monitoring so far is primarily disease monitoring, with a focus on deficits. We know little about health resources, and we also know little about health related quality of life of the residents.

Observation/ measurement of subjective well-being/ health related to quality of life of people with mental or communicative impairments is a difficult issue. For assessment, there are some interesting instruments/ procedures, developed and tested in the German speaking context, specifying five main dimensions (which can be understood as quality criteria for LTC organisations) relevant for quality of life: Empathy, autonomy, privacy,  

\(^5\) There seem to be much more systematic data in other countries, e.g. in the USA; this will be verified in a next step of research.
safety and acceptance. (Estermann/Kneubühler 2006; Kneubühler/Estermann 2008; for a recent application in an Austrian research project see Amann/Lang/Ehgartner et al. 2010)

There is some indication that the average health status of residents has rather decreased in the last decades – average age has risen, and the average medical status seems to be worse than in the past (for Germany e.g. Schaeffer/Büscher 2009). There seem to be two processes in the background of this development: Selection by the system and self-selection: Many countries had policies to shift LTC from residential care to home care. People who do not need the “full package” of stationary care are rather supported by home care as long as possible, building upon the contribution of informal carers, and support by professional home care services. Admission to publicly financed residential care is restricted to people with more complex needs.

So in residential care for old age, a high prevalence of chronic disease and functional impairment (increasingly also in the mental and communicative area) create dependency in everyday life. We will finish this section by presenting some hypotheses on a high vulnerability of LTC residents which in a next step will have to checked for their empirical foundation in the literature:

- As the external social networks of many residents seem to be drastically reduced, this implies dependency on staff and on the organisation.
- Dependency gets more problematic as the social position of residents is usually weak: Although entry into residential care is formally on a voluntary basis, often there are no more alternatives.
- Again, formally residents in many countries have a contract as a legal subject – but to act out their rights they need support - and – as they have lost many of their external social roles and status – many depend on support from the organisation.
- Economically, they have only few resources to strengthen their position: In most countries they have to contribute most of their income and also assets to cover the cost of care – and are publicly supported only after having spent all their economic resources.
- Collective representation – as a potential counterforce against organisational/ professional dominance (and abuse) in LTC seems weak.
- Systems of control/ advocacy seem in place, but primarily directed at more extreme violations of individual freedom and less as a means to influence everyday routines.

3.1.2 Staff

Health Status of staff is relevant from two Perspectives: First, LTC staff is a comparatively large and growing part of the working population and thus their health is a relevant target. Second, especially in personal human service organisations, it seems obvious that health of staff is an important factor for quality of services provided to the residents, e.g. large numbers of staff on sick leave challenges quality of services, reduced positive health is an obstacle to performance / quality of care.
Brause/Horn/Schaeffer et al. (2010) have produced a review on research on health of LTC staff in Germany (developed in partnership with LBIHPR; in print). This paper points out that LTC staff in general and especially residential care seems rather burdened and their resources to deal with the situation seem comparatively scarce – but there seems a large extent of variation between facilities. Comparisons with other settings of care concerning health risks are made possible e.g. by data from the European NEXT study (quoted by Brause/Horn/Schaeffer et al. 2010). Staff from residential LTC seems to be especially burdened on four dimensions in comparison with four other settings (see Simon et al. 2005, see Table 2 below).

Table 2: Job strain on care workers in different setting in the German NEXT study: Values indicate amount of strain experiences on a scale between 0 und 100, with 100 as maximum (Simon et al. 2005)

<table>
<thead>
<tr>
<th></th>
<th>Residential Care</th>
<th>Home Care</th>
<th>Intensive Care</th>
<th>Normal hospital</th>
<th>Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>quantitative Challenges</td>
<td>65,4</td>
<td>55,2</td>
<td>61,8</td>
<td>62,1</td>
<td>49,3</td>
</tr>
<tr>
<td>physical strain</td>
<td>49,7</td>
<td>23,4</td>
<td>24,0</td>
<td>40,6</td>
<td>17,7</td>
</tr>
<tr>
<td>emotional challenges</td>
<td>79,1</td>
<td>74,2</td>
<td>75,7</td>
<td>70,9</td>
<td>59,0</td>
</tr>
<tr>
<td>contact with unfriendly and aggressive users</td>
<td>69,1</td>
<td>52,8</td>
<td>56,0</td>
<td>56,8</td>
<td>70,3</td>
</tr>
</tbody>
</table>

3.1.3 Relatives

Health status of relatives of LTC users has become an issue in the last years especially in home care, where relatives as informal carers carry most of the burden of work and responsibility. A systematic analysis of the literature is still outstanding. Attention for this group seems especially important as personal network of residents – mainly the relatives – could be of crucial influence on residents’ health. There are good arguments that this group should be treated not only as potentially vulnerable (many of them after long periods of hard work as informal carers) but also as important co-producers of quality of life for the residents (e.g. Friedemann/Köhler 2010).
3.2 Operative Performance - Core- and support processes as factors influencing health (VOHIM Box C)

There are many indications to consider operative performance (core- and support processes of LTC organisations) to be relevant for health of the residents – with intended outcomes and unintended impacts. Considering the impacts, we already mentioned that residential LTC seems to have a lot of the characteristics of a „total institution“ (Goffman6). Users are often rather dependent and vulnerable. Following the data presented above, we can also expect considerable health impact on staff. Concerning relatives, we do not have systematic data for residential care, but can expect health impacts.

Re-constructing potential health impacts of the operative performance of residential care facilities has to start out with an analysis of what is central in operative performance. We follow here propositions from process management and start with a description of core processes of residential LTC. A paper by Grün 1998 presents a manifold picture:

- Admittance (including Assessment) and termination of residence;
- Habitation, alimentation, housekeeping (cleaning, washing, hygiene etc.);
- Professional nursing services (nursing process referring to ADL);
- Medical procedures (drugs, catheterisation, infusions); services for specific needs
- Special services (e.g. animation, organising leisure)
- Administration, organisation (e.g. documentation, service handover, ordering of supplies)
- Support for relatives
- Co-operation, communication (e.g. with suppliers, physicians)

This list makes residential care facilities appear as multi-functional systems similar to households. They seem to be lacking a dominant function – a major difference to modern acute hospitals. But as household type of system, the primary focus seems to be the support function for everyday life, with decreasing health status extended to include more and more aspects of life – as residents lose mobility and get more and more “totally included” into the world of the facility.

Creation of health impact by the organisations’ operative performance (in the VOHIM: Arrow 5 from box C, mediated by individual processes) means: Role behaviour of staff is relevant (e.g. how standardised or individualised are the users handled?), but also role behaviour of residents and relatives, interaction between these actors, opportunities and limits defined by spatial and technical characteristics of the physical setting etc.

So far, scientific research on the health impact of specific programs of residential care seems scarce; nevertheless we find some plausible propositions. E.g. in a paper on „Prevention for the very old“, (Garms-Homolova 2008, p. 273) asserts that a lack of preventive orientation in residential care could constitute a major determinant of low quality of care and quality of life. The author underlines that nursing theory in principle is very supportive for prevention and health promotion – but there seems a long way to go to

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6 This is said understanding that most of today’s residential care – at least in developed countries - seems rather far away from the original model developed by Goffman following research on psychiatric care in the US in the 1950’s
realise this potential in everyday practice of care. In everyday practice, nursing care often seems very much focussed on disease (perhaps with some orientation at the model „convalescence“). In this context, it is difficult to argue for time and resources for prevention or even health promotion. The author argues that vagueness and lack of concrete might be one of the reasons, so she proposes to start out to systematically monitor and correct for the potentially destructive potential of care routines: Nursing care must become more reflexive, monitoring its own operation for unintended (negative) health impacts and correcting for them (p. 273).

In a recent paper on options for health promotion in LTC, Schaeffer/Büscher (2009) name a number of aspects that can be tackled to optimise LTC in a health promoting direction:

- Establishment of health monitoring (e.g. around the issues of sensory perception, gait, pain...)
- Adaptation of physical setting – reducing risks
- Sufficient and healthy (attractive, wanted, normal) nutrition
- Concerning professional performance of staff
  - avoid de-stabilising the residents – make use of concepts like trajectory management, case management
  - systematically include well-being among the targets (comforting)
  - organise care in a way that allows for experiences of trust, continuity, meaningfulness, esteem, respect, coherence
  - sustain social networks
  - support mobility/ exercise in an appropriate manner
  - health education/ behavioural modification to enhance Health Literacy
  - enhancement of psychological resilience (e.g. by psycho-education)
- The authors also point at the need for changes in LTC on the organisational level, but also concerning qualifications, in legal and financial frameworks as necessary preconditions for the changes in physical settings, focus and quality of services they demand to become effective and sustainable.

This leads us to discuss to further aspects of health impact of LTC organisations in the next two sections. 3.3 deals with issues of internal governance, while 3.4 addresses societal and social preconditions for developing LTC settings into health promoting settings.

**3.3 Premises and Governance in LTC (Box B und A)**

In the perspective of the VOHIM, individuals are acting in organisations in roles, observing the organisations’ expectations concerning their behaviour as (structural) premises of their actions. Part of these premises is decided upon by those parts of the organisation responsible for governance, another part refers to expectations in the organisations’ relevant environments: Legal regulations or professional standards usually are valid across the borders of organisational systems, just like principles of accounting etc. These internal and external rules, regulations, standards can be regarded as providing orientation for individuals’ actions – what behaviour is expected from them and what not.

Hospitals and schools are both organisations with a strong, primary relationship to a function system of modern society, with well established professions at their centre. Thus, concerning orientation of their members in professional or complementary roles
and also concerning assertion of legitimacy of their performance they can rely upon many external resources. It seems as if “professionalisation” is not (yet?) developed to the same degree in long-term care for the elderly.

A second important aspect is the capacity for LTC organisations for innovation. The Canadian organisational theorist Mintzberg has developed a typology of structural characteristics of organisations relevant for the way they can deal with innovation (e.g. Mintzberg 1992). Applying Mintzberg’s model on residential care facilities is interesting – though difficult: These organisations often seem to operate in very bureaucratic ways – but they do not fit the picture of the „machine bureaucracy“. Professionals play an important role in their operation – but by far not as dominantly as in acute hospitals. Some of these organisations might resemble „missionary organisations“, some might show traits of an innovative „adhocracies“. Mintzberg asserts that each of these organisational types deal with innovation in a different way (e.g. innovation in the direction of health promotion). For each organisational type, different types of actors have to make relevant contributions. There can be huge variations concerning the relative importance of different factors: Charismatic leadership (on different levels), a strong „ techno structure“ that develops elaborated SOPs, well qualified, rather independent professionals (with a strong footing in scientific knowledge, professional standards and experience) etc. Systematic knowledge on LTC organisations in this direction seems rather weak – which implies that the LBIHPR will be on rather experimental grounds when attempting to implement health promotion innovations in an effective and sustainable way.

3.4 Relevant societal/ social environments of residential care facilities

Recent attempts to argue for the emergence of a specific, autonomous function system of „care“ have not yet yielded very convincing proposals. So at this point, it seems useful for describing the relationship of LTC organisations to their relevant societal environment (see arrows 11, 12 in the VOHIM, Figure 1 above) to follow Schroeter (2006) to understand „care“ (understood as long-term care) as a “figurative” social field in terms of Bourdieu. The image of a contested field, of an area in which a multitude of actors try to develop their sphere of influence, where stable priorities or hierarchies are difficult to establish seems to provide more orientation than the assumption of a new function system.

Figure 2 (below) provides a tentative description on the relevant environments of long-term care facilities in the form of a graph (see below). There seem to be some well established strong relationships (probably structural couplings in terms of the VOHIM) exist to the political and the legal system, to social support/ social work (in discussion as a secondary function system, emergent from the political or legal system), to medicine/health care, to the economic system and to religion. Of course there are also strong relationships with (the many individual) families. In addition, there are also other relationships that might become more relevant in the future – the relationship to science, education, to the media and perhaps also to health promotion – following Pelikan, an emergent function system (Pelikan 2007b; and Pelikan 2009). In addition, the figure contains indi-

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7 As evolutionary solution that combines orientation at scientific knowledge with orientation at the individual case; for this conceptualization see Oevermann 1997 (in German).
cations on specific structures developed in the function systems with reference to the specific needs/demands of LTC and its populations.

**Figure 2: LTC organisations in their relevant societal environments**

Looking at the diversity and the non-hierarchical order of these relationships, there is an open question what the implications are for self-observation by the organisations and their members and also for external observation.

A first assumption: Orientation in such a complex field is difficult. In comparison with health care, the scientific grounding and professionalisation seems much weaker – no relief for uncertainties concerning quality criteria and further development of the field. It will be an interesting scientific and practical question if health promotion as a complex, but structured suggestion for innovation can act in an orienting way.

### 4 Some preliminary conclusions for settings-oriented health promotion in LTC facilities

Why focus on a health promotion approach that is especially interested in development of organisational settings to become “health promoting environments”? Another option for health promotion practice and research would be to rather focus on specific health promotion interventions for populations affected by LTC (especially users/residents)\(^8\)

This preference for the settings approach of course was promoted by the integration of the program line in the overall program of LBIHPR -which focuses on health promotion in organisational settings. But there are also good arguments why the specific “context is very relevant for effectiveness and sustainability of health promotion interventions in general. An „ecological model of health promotion”, a “systems perspective” and a

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\(^8\) For the distinction between health promoting settings and health promotion in settings see e.g. Baric 1998.
“whole system organisation development and change focus” are argued by some authors to be essential for effective health promotion in general. (e.g. Dooris/Poland/Kolbe et al. 2007).

Concerning health promotion for users of residential LTC, specific attention on these organisational aspects seems especially important, given ongoing discussions on a quasi-total character of some or many of these institutions (at least in the German speaking context; e.g. Heinzelmann 2004, Hettlage 2008,).

Settings-oriented health promotion in this understanding attempts to co-develop the context, in addition to specific problem-, person- or targetgroup-oriented interventions. That means: Utilise established structures and processes, including hierarchies, power structures etc. and connect to already established perspectives concerning development and reform. Such a strategic orientation seems especially useful in a rather difficult environment like LTC, where connectivity and the potential added value of health promotion is not self evident and resources generally seem scarce.

Of course there are also arguments against a settings approach: It is a complex and demanding endeavour for the practice field – and also for political actors, which are rather relevant in this area. The practice field (especially owners, management and professional staff) must be prepared to look at potential problems and decide if investment in change processes is possible – or not.

And there is also a challenge for science: It is difficult to evaluate this approach in a systematic and convincing way (Dooris/Poland/Kolbe et al. 2007). One classical solution for this is to clarify in advance which kind of evidence is needed for which stakeholders/ target groups – which argument will increase likelihood that stakeholders invest in health promotion in LTC facilities? But it is important to remember that for scientific stakeholders and for the scientific quality of research in general, a clear management of theoretical and empirical complexity of the settings approach is much needed. The VOHIM - as developed so far - seems a promising developmental line to answer to these challenges – for health promotion in organisational settings in general as well as in LTC settings in particular.
5 Presentation at the Vienna Symposium on Health and Health Promotion in Organizations

Long term care as organizational setting for health and health promotion

Symposium on Health and Health Promotion in Organizations, Vienna June 2-4, 2010

Krajic, K., Schmidt, C., Schüssler, S.

Overview

• Health and health promotion in long-term care
• How do LTC organisations produce their health impact?
• How can LTC organisations optimise their health impact?
• Preconditions for implementing health promotion
  – Internal: Governance issues
  – External: Relationship to relevant social environments
• A pilot project, planned as next step

Health and health promotion in long-term care

• What is long-term care?
• What do we know about health in LTC?
  – Theoretical issues
  – Empirical evidence
• State of development of HP in LTC

Definition of long-term care (LTC)

• “A wide range of health and health-related support services provided on an informal or formal basis to people who have functional disabilities over an extended period of time with the goal of maximizing their independence” (Evashwick 2005, p. 4)
• Comment by Schaeffer/ Büscher 2009: A significant evolution from the former understanding of LTC as a mix of basic support and custody of the patient/ client – a last option, when there were no more therapeutic nor preventive, nor health promoting options available.
• Focus of the LBIHPR on LTC for the elderly, starting out with residential care
What do we know about health in LTC? Theoretical issues: Illness and Positive Health

- An illness is an experience that can be described and (partly) measured as a deviation from the normal state.
- Since health is mostly inconspicuous and often taken for granted, it only becomes visible when a problem occurs.
- Positive Health is distinct from the absence of illness and can be understood as a prerequisite for living and it may vary from a minimum to a maximum state.
- Positive Health may be made the subject of health promotion when an ideal state is defined and proactively aimed at (Pelikan 2007).

Dimensions of Positive Health (Pelikan 2009)

<table>
<thead>
<tr>
<th>Body</th>
<th>Mind</th>
<th>Social Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional capacity (judged by experts)</td>
<td>Sensory/nervous system, musculoskeletal apparatus, metabolism, immunocompetence</td>
<td>Mental capacity, Emotional, Evaluative</td>
</tr>
<tr>
<td>(Subjective) feeling well with...</td>
<td>The physical situation (e.g. no pain)</td>
<td>The mental situation</td>
</tr>
<tr>
<td>Attractiveness of the individual (perceived by others on the basis of...)</td>
<td>Beauty, physical performance, neatness</td>
<td>Cognitive ability, empathy, judgment, capacity to act</td>
</tr>
</tbody>
</table>

Dimensions of Positive Health - Examples

<table>
<thead>
<tr>
<th>Body</th>
<th>Mind</th>
<th>Social Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal hearing capacity/ hearing problems</td>
<td>Oriented/not oriented not depressed/depressed</td>
<td>Having friends, relatives, being known, having no friends, relatives, enough/not enough money available</td>
</tr>
<tr>
<td>Normal eyesight/ poor eyesight</td>
<td>Feeling happy/sad</td>
<td>Feeling well-supported lonely</td>
</tr>
<tr>
<td>Mobility/immobility</td>
<td>Feeling self-confident/insecure</td>
<td>Feeling needed/ useless</td>
</tr>
<tr>
<td>No pain/pain</td>
<td>Feeling strong/ weak</td>
<td></td>
</tr>
<tr>
<td>(Subjective) feeling well with...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others perceive my body as attractive/ugly</td>
<td>Others perceive me as intelligent/ “old and dumb”</td>
<td>Others perceive me as commanding social resources/ a poor welfare recipient</td>
</tr>
</tbody>
</table>

Health of Staff: Job strain on care workers in different setting in the German NEXT study (Simon et al. 2005)

<table>
<thead>
<tr>
<th>Residential Care</th>
<th>Home Care</th>
<th>Intensive Care</th>
<th>Normal Hospital</th>
<th>Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative challenges</td>
<td>65,4</td>
<td>55,2</td>
<td>61,8</td>
<td>62,1</td>
</tr>
<tr>
<td>Physical strain</td>
<td>49,7</td>
<td>23,4</td>
<td>24,0</td>
<td>40,6</td>
</tr>
<tr>
<td>Emotional challenges</td>
<td>79,1</td>
<td>74,2</td>
<td>75,7</td>
<td>70,9</td>
</tr>
<tr>
<td>Contact with unfriendly and aggressive users</td>
<td>69,1</td>
<td>52,8</td>
<td>56,0</td>
<td>56,8</td>
</tr>
</tbody>
</table>

Health Promotion in LTC?

- In the last 25 years, there have been only a few studies about health promotion in long-term care (Minkler 1984; Caserta 1995; Kayser-Jones 2009). It has not yet been given the appropriate attention on an international or a national level (SVR 2009, Krajic et al. 2010).
- At least in German-speaking country’s health promotion activities focus on staff members (Brause et al. 2010, Krajic et al. 2010).
- Doubts about the usefulness of targeting old and very old people for health-promoting measures (Kuhlmeier & Schaeffer 2008).
- In recent years, however, there has been some new thinking, especially since empirical findings have shown that health promoting and preventative measures can be effective even in old age (Kuhlmeier & Schaeffer 2009; Foster et al. 2009).
- Relatios as informal carers an important target group gaining relevance a) concerning their own vulnerability b) as co-producers of the resident’s health – but usually not under the heading of health promotion.
- So far no overall approaches under the heading of “health promotion” (other headings: “Böhm”, Eden Alternative etc.).
Health Promotion: How can LTC organisations improve/ optimise their health impact? 1

- By avoiding negative impact of their standard procedures
- By organising their core processes in a health promoting way
- By offering new specific (additional) services directly addressing specific aspects of (positive) health

Core processes in residential care (Grün 1998): A multifunctional, household type of organisation

- Admission (including Assessment) and termination of residence;
- Habituation, alimentation, housekeeping (cleaning, washing, hygiene etc.);
- Professional nursing services (nursing process referring to ADL), medical procedures (drugs, catheterisation, infusions), services for specific needs
- Special services (e.g. animation, organising leisure)
- Administration, organisation (e.g. documentation, service handover, ordering of supplies)
- Support for relatives
- Co-operation, communication (e.g. with suppliers, physicians)

What are the implications of multifunctionality for governance/ quality development/ chances for health promotion?

How can LTC organisations optimise their health impact? 2

By avoiding harmful practice - Garms-Homolova 2008

- Lack of preventive orientation in residential care could constitute a major determinant of low quality of care and quality of life
- Nursing theory in principle is very supportive for prevention and health promotion, yet a long way to go to realise this potential
- In everyday practice, care/ nursing often seems very much focussed on disease
- Difficult to argue for time and resources for prevention or even health promotion – especially if vague and unconcrete
- Destructive potential of care routines to be monitored for unintended (negative) health impacts

How can LTC organisations optimise their health impact? 3

Schaeffer/Büscher 2009 name a number of aspects that can be tackled to optimise LTC in a health promoting direction

- Establishment of health monitoring (e.g. around the issues of sensory perception, pain)
- Adaptation of physical setting – reducing risks
- Sufficient and healthy (attractive, wanted, normal) nutrition
- Concerning professional performance of staff
  - Avoid de-stabilising the residents – make use of concepts like trajectory management, case management
  - Systematically include well being among the targets (comforting)
  - Organise care in a way that allows for experiences of trust, continuity, meaningfulness, esteem, respect, coherence
  - Support social networks
  - Support mobility/ exercise in an appropriate manner
  - Health education/ behavioural modification to enhance health literacy
  - Enhance of psychological resilience (e.g. by psycho-education)
- Conditions for successful implementation: changes in organisation, qualification, frameworks
- Systematic research and development much needed – especially for the group of very old persons, many specifications are still lacking

How can LTC organisations optimise their health impact? 4

By monitoring/ adapting their core processes using quality dimensions that were found to be relevant for quality of life of users

...and develop operative performance to allow residents to experience

- Empathy
- Autonomy
- Privacy
- Safety
- Acceptance

(5 core dimensions relevant for positive quality of life according to Amann et al.2010)
Long term care as organizational setting for health and health promotion

LTC organisations in their societal environments

Organisations offering residential care for the elderly

Planned Pilot Project

- Scientific support/evaluation of a 2-year pilot project, developed in collaboration with practice partners of LBIHPR: National and regional health promotion agencies and the Austrian social insurance agency.
- Planned start in the end of 2010 till August 2012
- 4 residential care facilities
  - Initiating an overall developmental process in the 4 participating residential homes by...
    - establishing a project structure (health promotion co-ordinator and project group)
    - conducting a systematic needs assessment
    - carrying out strategy development process with management (using benchmarking in the overall project structure)
    - carry out 2 specific interventions (residents/ staff)
    - re-assessment

Project Objectives

- Residents: Implementing a specific common intervention – strengthening mobility by investing in physical activity
  - Intervention: as a criteria for the institutions’ participation; Intervention will be adapted to residents capacities after needs assessment
  - Design: intervention study
  - Target group: residents
  - Sample: 30 IG/30 CG in each residential home
  - Outcome: functional status, quality of living
- Staff
  - Intervention: Health Circles in each facility

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6 Commentaries to the presentation at the Vienna Symposium on Health and Health Promotion in Organization

6.1 Comments from Georg Bauer

Thank you very much for your presentations, you could outline the complexity of the issues to be addressed in the particular settings. However, I was surprised that most of you actually did not use the VOHIM model itself to map the key issues you raised. That could have facilitated first conclusions, how the key themes are inter-related across settings and also how to set priorities for research and actions around these. Just an observation - since the symposium is about this model and how these different program lines could relate to this model.

Considering the large number of issues you raised, I cannot address them in detail. But there is one key aspect: You may be quite right by mentioning that it is particularly important in a long term care setting to specify how to assess the health of the users in this particular context. As a matter of fact I think this applies to all settings, because also for example in a regular business environment, which is my own area of research, we have to consider what health really means within this business context. It is difficult to approach companies to implement health promotion just to create wellbeing for the employees. So we have to explain that health is both wellbeing and well functioning. Further I liked the three by three table of health you propose - and generating ideas how these boxes could be related.

For now I will focus on the critical issue about how health could be mapped within the VOHIM model. Based on the saying “nothing is as practical as good theory” - my interest is to make your theory practical for organizations: that it is comprehensible, that it relates to organizations in a meaningful way and that it is manageable.

I think that your model very much implies the interactivity between the individual and the environment in producing health, which is in line with a general sociological model of health. But, as you have pointed out, we still don’t find health explicitly depicted in the model. Also, I have some difficulties with the term health status as we already discussed yesterday. And finally there seems an overemphasis on the behaviour of the individual. The term behaviour might imply that people by themselves can decide and that development of individual health is primarily an intentional process. Instead the main label of the box might be named action and reaction, because in large part health is produced unconsciously - for example much of the stress response cannot be influenced. Acknowledging both unconscious reactions and intentional behaviour is important to avoid old struggles in the health promotion field about the relative importance of individual behaviour vs. the environment in the health development process.

Regarding next steps, I think you have well developed the upper part of your model. Although you did not yet explicitly incorporate all the models and concepts you mentioned yesterday as a conceptual basis of VOHIM, I believe this can be done in the future. But even more important will be to relate the VOHIM to key health promotion principles and methods. Regarding for example the principle of empower-
ment, I suggest to introduce a power box into the model which shows that different environments, but also different individuals vary in their degrees of power to couple to and influence the organization.

Besides this conceptual linkage work, in a next step the model should be linked to and tested in regard to the broad empirical evidence about key determinants of health in organizations. How would you fit in key concepts you mentioned in your presentation: the quantitative challenges, physical stress, emotional challenges, contact with users, demand for control of people?

Health is a consequence of living an active life, but also a precondition for acting upon our lives and health opportunities. Regarding health status, it is often defined from the outside, particularly by the medical field, insurance systems or within life domains e. g. by employers. Thus, I would suggest to assign the health status to the social environment box. In this case, our aim would be to assure that the health status of the members of an organization would be an additional result considered in the decision making process of organizations.

Another challenge is that you would like to couple the VOHIM to organizations. Not organizations in the abstract Luhmannian sense, but real organizations as we perceive them in everyday life. For example members of a hospital probably would consider the social system, the members, and the physical environment as part of their organisation. Also, the single box of the individual contains diverse users and members of organizations – which interact with in the organizational box and share a social and material environment. It will be difficult to show these subsystems and their interactions.

Another critical issue to be considered is that for now, the sequence of the boxes A through H and the numbering of arrows 1 through 10 of the of the model suggest that the organization and its initial decisions come first. However, the story of the founding of the Ludwig Boltzmann Institute for health promotion is a nice example showing the opposite: First there were some dedicated people who were in need for a new organization to meet their desires and needs for research. Only then the new organization Ludwig Boltzman Institute for Health Promotion Research emerged around them and their individual needs.
6.2 Comments from Marie Louise Friedemann

I´m going to begin with a theoretical discussion but my main topic is related to family and how the family fits in the long-term care process. Next, I shall ask about the needs of residents and families. This is an important question. Then, I will talk about organizations and staff, and the family, how they interact or should interact with each other, and how organizational change may take place. Most of the time, such change is difficult, I agree. Finally, I have a few suggestions concerning nursing homes. I want to include my own empirical data since it may be useful to illustrate the long-term care process.

You know that I have developed my own theoretical framework, and obviously, this makes me biased. It feels as if I wore special glasses through which I see the world. That is why, when I view your VOHIM, the first that comes to my mind is its relationship to the four dimensions of my family framework, that constitute the main organizing dimensions:

- System Maintenance (SM)
- Coherence (C)
- Individuation (I)
- System Change (SC)

So I´m looking at systems (residents, families, organizations) the way they maintain themselves. Coherence describes how they are in tune within and among themselves. Individuation signifies the openness to learn and make connections with other individuals or organizations. The last is system change, which is obviously the flexibility to make changes. So you see, what I´m talking about is how long-term care systems, individuals and families may maintain their integrity while adapting to change. Your definition of health is a little bit confusing since so many different concepts have been incorporated. I wonder if it is a process or the outcome of one, namely health promotion. But right now, let me talk about your dimensions of positive health and how I think they might relate to the four dimensions of my family framework.

- Three aspects of positive health: Function (SM), well-being (C), attractiveness (I) – capacity for change (SC)
- Three systems: Body (SM), mind (C+SM), social status (I) – spirit (C + SC)
- Positive health: Health resources, subjective quality of life (empathy, autonomy (C), privacy, safety (SM), acceptance(I). Depends on staff behaviors – individual care (vs standardized care)

I see that function relates to system maintenance and well-being to perception of coherence, or being in harmony within. Attractiveness is individuation or the system’s relationship with its environment. Then I wonder, shouldn’t there be a concept like capacity for change or flexibility added, the reason being that my fourth dimension of system change is missing in your concept of positive health. I can observe with nursing home residents, for example, that without such flexibility, residents don’t adjust to the institution and we see regression in their mental and functional status.
Looking at your three systems (body, mind and social status), I wonder what happened to spirituality. Let’s agree that religion is not a priority of the institution, but is this true with the residents? Are we considering their spirituality or how they make sense of their life?

In health promotion, there is a positive health aspect developed that consists of health resources and subjective quality of life. For this, residents need empathy and autonomy, (both of which signify coherence), the premises of safety (system maintenance) and acceptance of the residents’ physical, psychological, social, and spiritual being (individuation). One point I try to make here is that these things that need to be provided to the residents depend on staff behaviour. Whether or not staff actually gives such care may make the difference between individual care or standardized care. Only if we consider these aspects individually for each resident can we meet the residents’ needs or begin talking about health promotion.

To answer the question of what health promotion actually means, you have suggested 4 strategies.

4 strategies:

- Illness prevention (tertiary care)
- Treatment of illness (secondary care)
- Safety provision (primary care)
- Promotion of positive health (primary care)

The last two affect subjective quality of life. They promote health and protect from or fight against illness. Long term care maximizes autonomy, I like that very much. Positive health of individuals and the strategies are summarized. Illness prevention needs to go in there; it is tertiary care in patients with chronic illness; treatment of illness is secondary care; and safety provision is primary care. The promotion of positive health would be primary care type of interventions. Success in all three types of prevention depends on how the nursing home and its staff perceive their situation. If we follow these strategies, they will in turn protect the stakeholders from illness.

Now where do the families fit in? The family is mentioned in the graph on societal environments of LTC organizations, not as a function system, but as this lonely environment over here, sort of lost. And we all don’t know what to do with families - maybe the family should be considered a function system, I’m not sure. It seems to be the case in the actual situation of nursing homes. Staff does not know what to do with families. Then, there is the question of how the family relates social support marked on the left side. The family contributes the majority of social support. It provides informal support, whereas the social worker or other professionals offer formal supports. Family support is and should be an organizational function. The other functions mentioned in the graph are mainly system maintenance related, but family support would be rather something related to coherence of the resident.

So, in order to see how the family needs to enter the nursing home system to fulfil the function of providing coherence to the resident, it needs to be granted a role of a partner with the staff. I have interviewed 45 nursing homes and over 200 families, and found out that those family members feel welcome in nursing homes who are respected and are given the opportunity to do the things in the home that they
want to do. And, in the ideal case, they function together with the staff as an expanded family in the nursing home. The staff of the nursing home becomes part of the family in the family members’ perception. If that happens, the staff can work together with family members as partners in the care of the residents for the benefit of the resident. This seems to function in well-run nursing homes. In many other homes, however, such a partnership is not possible. Instead, the staff gets upset with relatives because they are controlling and get in their way. Nevertheless, for individualized care we need a partnership of staff and the families, through which needs can be met mutually, including the needs of the patient.

- For individualized care, needs of staff and residents have to be considered (needs assessment). Needs met = well-being, positive health.
- Family needs are not mentioned. Families want to be respected as resource and experts in the facility.
- Staff needs are not mentioned but are crucial for resident health.

Let us talk about needs. We should find a place in the model for needs, we need to mention them somewhere. Nursing homes usually function without considering the needs of families, or even of their staff. They have a structure and fixed processes, and usually, nobody asks what anybody’s needs are. Patients have to somehow fit it in and if they don’t, they are not happy. The point is: The families have needs too and they want to be respected, as I found in my study, and the staff has needs too. I think recognizing this is crucial in terms of providing good care to the residents. So, in terms of the organization, policies should allow time to be spent on needs of residents, family, and staff.

We have talked about the model and have seen that the organization gets shocked into action and moved to change more through irritation than through positive feedback. I’m wondering whether the feedback loop, should entail an additional arrow going from the individual system down here instead of to box C, directly to box A. And that would be a positive way of moving the system, rather than a negative one through irritation. That is just an ideal; staff will do assessments and the organization responds accordingly, and the family is included as an interactional system in the model. So, I was wondering, whether it wouldn’t make sense to use that left lower box and include the family environment in that, not just the individual. We could then look at how the environments interact with each other and the staff. This way, individuals are subsystems of the organization and as subsystems, they have a legitimate way of functioning. You might have a look at that.

For organizational change to happen, system change needs to occur. What is System Change (SC) needed for? First, to prevent decline of the residents and to prevent risks, also to support their needs, and I would say, to keep the organization healthy. System change should address the needs of the residents, including spiritual needs. These are not necessarily religion, but it may be that religious services are the only way organizations can attend to spiritual needs. Changes are not possible unless organization structures and processes are changed and since they are complex, this is not an easy thing to do.

In summary, these are my suggested strategies:

- Start change with structural, procedural, and attitude changes (from top down or bottom up)
- Change “individual system” in model into “interactional subsystem” (staff, family, and residents)
- Determine how all three subsystems can form a “family” with interdependent roles.
- Seek evidence (needs assessments) from staff, families, and residents (if able).

My suggestion is to start the change with a structured procedure and attitude changes, through top down and bottom up processes. In the model, we could change the individual system into an interactional subsystem, that was the other suggestion I had before. Determine all three subsystems control the family with interdependent roles.

So they work together as with family and who is doing what. And the staff will have to change their roles too in relation to the families’ needs. And most important of all is to see the evidence. So they need assessment as a first step toward gaining evidence. That needs to be changed. And it happens from staff, families and residents. The staff needs to do a needs assessment, too. And change happens really by training the staff. It doesn´t need to be professional nursing staff, in the residences we have a lot of non-professionals working with the residents. And tell them to treat the residents with respect or to talk with them. Like family members, talk with them. So they can feel like people who are working together.
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