Strengthening health promotion in hospitals with capacity building: a Taiwanese case study

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SUMMARY
Organizational capacity building for health promotion (HP) is beneficial to the effective implementation of HP in organizational settings. The World Health Organization (WHO) Health Promoting Hospitals’ (HPHs) initiative encourages hospitals to promote the health of their stakeholders by developing organizational capacity. This study analyzes an application case of one hospital of the HPH initiative in Taiwan, characterizes actions aiming at building organizational support to strengthen health gains and identifies facilitators of and barriers to the implementation of the HP in this hospital. Case study methodology was used with a triangulation of various sources; thematic analysis was used to analyze qualitative information. This study found a positive impact of the HPH initiative on the case hospital, such as more support from leadership, a fine-tuned HP mission and strategy, cultivated pro-HP habits of physical activities, a supportive intramural structure, an HP-inclusive system, improved management practices and enhanced staff participation. Transformational and transactional enablers are of equal importance in implementing HPH. However, it was also found that the case hospital encountered more transactional barriers than transformational ones. This hospital was hindered by insufficient support from external environments, leadership with limited autonomy and authority, a preference for ideals over professionalism, insufficient participation by physicians, a lack of manpower and time, a merit system with limited stimulating effect, ineffective management practices in weak central project management, a lack of integration, insufficient communication and an inability to inculcate the staff on the importance of HP, and inadequate staff participation. Several implications for other hospitals are suggested.

Key words: organizational change; capacity building; Health Promoting Hospitals; qualitative methods

INTRODUCTION
The World Health Organization (WHO) has proposed that health services be integrated with health promotion (HP) to better promote population health (WHO, 1978, 1986, 2009; WHO-EURO, 2009). The WHO accordingly launched the Health Promoting Hospitals (HPH) project in 1988, as a network in 1990, which is continuing to expand and develop across the world (Pelikan et al., 2011). Taiwan’s HPH Network founded in 2006 rapidly developed with the third
highest membership in the International HPH Network by May 2011 (Pelikan et al., 2011). By July 2013, Taiwan’s network was number one as a region and was second only to Italy as a nation (The International HPH Network, 2013). This achievement is rather impressive given that the network was established rather late in the history of HPH.

The HPH initiative and movement is a specific form of the settings approach to HP. An HPH aims to ‘improve health gain for its stakeholders by developing structure, cultures, decisions and process’ [(WHO-EURO, 2007), p. 6]. For hospitals to fulfill the potential role of HP, these organizations can follow two alternative models for implementation: the Addition Model, which combines project management and organizational development or other organizational change management strategies with particular HPH subsystems, or the Integration Model, which integrates HP into existing quality management, such as application of the combined European Foundation for Quality Management (EFQM) Excellence Model and the balanced scorecard (BSC) (Pelikan et al., 1998, 2005; Brandt et al., 2005).

Previous studies have suggested that organizational capacity building for HP could multiply health gains (Hawe et al., 1997), achieve program sustainability (Yeatsman and Nove, 2002) and carry out more HP activities or strategies (Lin and Lin, 2010; Pelikan et al., 2012). That is, organizational change in building the capacity for HP is key to effective re-orientation toward HPHs (Johnson and Paton, 2007). The Effective reorientation of health services requires the commitment of hospitals to changing into health promoting settings with corresponding organizational inputs (Johnson and Baum, 2001; Röthlin, 2013). Therefore, this study aimed to explore the impact of the HPH initiative on a hospital that was committed to this cause in the early stage of the HPH movement in Taiwan, with an emphasis on organizational change, as well as to identify the factors that had enabled or hindered its implementation of the HPH endeavor.

METHODS

From a group of organizational change models, this study has drawn heavily on the Burke–Litwin model (Burke, 2002) because this model is comprehensive, practical and applicable to health service research (Burke and Litwin, 1992; Johnson and Paton, 2007; Filej et al., 2009; Martins and Coetzee, 2009). To set the frame for our analysis, we began by constructing seven or eight dimensions of the diagnostic framework for change in organizational capacity to implement HPH: external environments, leadership, mission and strategy, organization culture, structure, system, management practice and staff participation. The last dimension of staff participation is composed of the organizational factors of ‘work-unit climate’, ‘task requirements and individual skills/abilities’, ‘motivation’, ‘individual needs and values’ and ‘individual and organizational performance’. The factor of external environment was excluded from ‘achievement’ because this

BACKGROUND

Affiliated to the Tzu Chi Foundation, an influential Buddhist philanthropic organization (Huang, 2009), Tzu Chi Dalin General Hospital (Dalin hereafter) was established in 2000 in a rural area in southern Taiwan. Dalin is equipped with approximately 900 beds and is staffed by 1200 medical professionals and 500 non-medical professionals, such as social workers and administrators. Dalin committed itself to the HPH initiative at the end of 2005, and has been accredited as a member of the WHO HPH Network since 2007. A hospital official asserted that Dalin ‘was cut out for an HPH’ because it was established under one of the core missions of the Tzu Chi Foundation: the pursuit of life-respecting and humanity-oriented medical services. Consequently, Dalin has been devoted to HP activities since its establishment, with or without external funding. The hospital implemented the HPH initiative because this program was in line with the hospital’s goal of holistic care and also would improve the hospital’s image. Dalin decided to join the International HPH Network for the above two reasons and to secure public recognition of the hospital’s role as a champion of HP. In addition, Dalin is well known for its enthusiastic volunteer service and extensive efforts in environmental protection, which are also in line with the other core values of the Tzu Chi Foundation and the HPH mission, as far as environmental protection is concerned. As such, Dalin is arguably one of the hospitals that would be most likely welcome, adopt and implement the HPH initiative; for that reason, we chose Dalin for this case study.
study particularly focused on organizational capacity within hospitals.

The case-selecting strategy in this study was information-orientated, as suggested by Flyvbjerg (2011). *Dalin* was selected for its relative maturity in the development of the HPH initiative, which helped the researchers to better apprehend the process of formation of HP hospitals. The first author established a cordial and trustful relationship with this case hospital through an internship in her college days. One of the other authors is a faculty member at Tzu Chi University, which is part of the Tzu Chi Foundation, as is the case hospital. These connections, along with the fact that the then superintendent was keen on implementing the HPH initiative, made it easy for the first author to visit the case hospital, to attend the intramural meetings, to conduct interviews, to be granted the access to the archives and to be provided with the documents necessary for this research. Ethical reviews were submitted to the Human Research Ethics Committee of Griffith University and the institutional review board of *Dalin* before the fieldwork to ensure that the research procedure complied with the relevant ethical principles.

This study applied the triangulation of data sources, including document review of the hospital’s meeting minutes, newsletters, magazines and journals; in-depth interviews with the key informants who were involved in or familiar with the HPH project; and participant observation. In total, 20 hospital staff members were interviewed, including superintendents, the chief secretary, project managers and the directors of task forces.

Participant observation was conducted in this case study to acquant the researcher with the culture and dynamics within *Dalin*, thus allowing the researchers to understand the complex phenomena and background that led to the implementation of HPH. The first author took a 3-month stint in *Dalin* as an observer. During the stint, the researcher was placed in the Department of Community Medicine on weekdays and followed the working schedule of the hospital. The main occasions observed with note taking included HPH-related meetings, HP activities, the hospital environments, management styles and the working culture.

To analyze the data collected through document review, in-depth interviews and participant observation, we used thematic analysis with a hybrid approach of inductive and deductive coding and theme development. The method combined the theory-driven, prior-research-driven and data-driven code development as illustrated in Boyatzis (1998). In light of the work of Boyatzis (1998) and Fereday and Muir-Cochrane (2006), the study followed four steps for data analysis: developing the initial code manual, using a template of codes to gauge the data and to update the code, grouping the information based on the domains under research, connecting the codes and identifying the emerging themes. The data were analyzed using N-vivo software of QSR 8.0 and Mindjet MindManager 8.0. We first developed the initial code manual based on a literature review and then applied the template of codes and additional codes that were extracted by coding the interview transcripts line by line. We then grouped codes as subthemes and themes and further conjugated the themes to the Burke–Litwin model.

The final results, as reported in this article, were obtained through triangulation by collating the preliminary results of archive reviews, participant observation and in-depth interviews. The conclusion was reinforced and confirmed when those methods indicated consistent facts, and when an inconsistency arose, cross-examinations were checked to resolve the inconsistency.

**RESULTS**

The implementation of the HPH initiative at *Dalin* was initially driven and supported by the hospital’s high-ranking leadership and subsequently sustained by its organizational inputs. In 2006, *Dalin* adopted the Addition Model and instituted an HPH subsystem, including the HPH committee, in addition to the hospital’s regular structure. Later in 2008, *Dalin* used the Integration Model to a moderate degree to integrate HP into its quality management system to strengthen integration of the hospital’s core missions. An example of this endeavor is the BSC. The HPH committee meeting was integrated with the existing meeting of the Department of Community Medicine and convened once per month. The superintendent would chair the meeting, and other high-ranking leaders, including all directors of administrative departments and a small number of directors of medical departments, participated. Generally, the administrative departments assumed the major role in this implementation. The HPH committee...
integrated items stipulated in the WHO HPH self-assessment tool with those items in the *Hospital Accreditation Guidelines* to justify the necessity of implementing HPH and to reduce resistance to the HPH proposal. On the HPH committee, the task leadership group, led by its superintendent and facilitated by the Department of Community Medicine, aimed to support the other four task groups.

**Achievements**

In line with the Burke–Litwin model, achievements, similar to enablers and barriers, are categorized as transformational and transactional (Table 1). The former term refers to foundational changes in organization, represented by more support from leadership, a fine-tuned HP mission and strategy and cultivated pro-HP habits of physical activities. Transactional achievements signify the accomplishment of day-to-day operations conducive to the implementation of HP and refer to supportive intramural structures, HP inclusive systems, improved management practices and enhanced staff participation.

In terms of the transformational achievements, HPH at *Dalin* earned strong support from the high-ranking leadership, particularly its superintendent, and the support trickled down over time to the middle-level managers of administrative departments (A-I). Regarding the leadership, a middle-level manager who works in public relations said that ‘the superintendent is very supportive [of HPH] and accordingly mobilized administrative departments and offered corresponding funding and resources. The best advantage for us is to have an administrative hospital officer who is very supportive’. The supportive attitude of the superintendent was validated by the triangulation, as the result of the above-mentioned interviews was repeatedly confirmed by participant observation. Inspired by the HPH initiative and under the supportive leadership, *Dalin* developed an HP-embracing mission and related strategies (A-II-i) by incorporating HP into its overall development plans and annual action plans (A-II-ii) and by extending HP target groups to include the major targeted areas of staff, patients, communities and environment (A-II-iii). In addition, the habit of being physically active was gradually cultivated due to the promotion of a series of physical activities (A-III). The hospital made space available for physical activities, which appeared to have changed exercise habits: ‘I somehow started to feel an impulse to exercise, as I saw people in the hallway wearing an athletic outfit’.

Regarding transactional achievements, *Dalin* established supportive intramural structures such as the HPH committee (A-IV-i). The committee was further differentiated into taskforces of leadership, staff, patients, communities and environments. Through this platform, various departments worked together to achieve common objectives (A-IV-ii). A high-level manager stated that ‘before the HPH initiative, we were guided by a belief in our values to implement HP activities, but not in a systematic way. We now do it in a systematic way’.

HP-inclusive systems facilitating the implementation of HPH were identified in the case hospital. The hospital invested extra resources, including funding, information systems, physical activity space for staff, manpower and HP-related education and training (A-V-i). The hospital also formulated additional healthy policies, such as staff HP measures (A-V-ii), to build supportive environments for HP. HP was integrated into the hospital’s operational procedures, such as patient needs assessment and patient information and intervention (A-V-iii). HP was also incorporated into Dalin’s subsystems including the employee benefit program, the merit program, the education and training program for new employees, the case management program and the hospital canteen (A-V-iv). The efforts supporting the HPH initiative were also integrated into the preparation of hospital accreditation and into the hospital’s strategic planning system, namely, the BSC (A-V-iv).

Improved management practices were evident following the HPH implementation. The hospital raised the visibility of HP within *Dalin* through the HP-embracing mission statement, the HPH committee and task forces, staff HP programs and a regular series of promulgations to show its aspiration for HP (A-VI-i). *Dalin* found the International HPH Network to be an appropriate forum to share the hospital’s experience and to be a showcase to present the hospital’s achievements. Since the adoption of HPH, the hospital has keenly participated in HP-related conferences, at home and abroad, to present its work by sending teams of impressive size to these conferences. Participation in the international conferences had windfall effects on the evaluation. Possibly due to *Dalin*’s ‘just-do-it’ culture, far more emphasis was placed on
Table 1: Matrix of achievements, enablers and barriers in the implementation of HPH at Dalin

<table>
<thead>
<tr>
<th>A. Achievements</th>
<th>B. Enablers</th>
<th>C. Barriers</th>
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<tbody>
<tr>
<td><strong>Transformational factors</strong></td>
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<tr>
<td><strong>External environments</strong></td>
<td>(I) Supportive external context for HPH</td>
<td>(I) Insufficient support from external environment</td>
</tr>
<tr>
<td></td>
<td>(i) Supportive policy contexts</td>
<td>(i) Insufficient resource input from external environment</td>
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<tr>
<td></td>
<td>(ii) Bandwagon effect</td>
<td>(ii) Invalid public conception of HPH</td>
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<td></td>
<td>(iii) Link to external operational support</td>
<td>(iii) Lack of references</td>
</tr>
<tr>
<td></td>
<td>(iv) Participation platforms</td>
<td>(iv) Unsustainability of funding projects</td>
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<tr>
<td><strong>Leadership</strong></td>
<td>(II) Supportive leadership</td>
<td>(II) Leadership with limited authority</td>
</tr>
<tr>
<td>(I) More support from leadership</td>
<td></td>
<td></td>
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<tr>
<td>(II) Fine-tuned HP mission and strategy</td>
<td>(III) Pro-HP mission and strategy</td>
<td>(III) None</td>
</tr>
<tr>
<td>(i) HPH explicitly incorporated into mission statement</td>
<td>(i) Existing conducive missions</td>
<td></td>
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<tr>
<td>(ii) HP integrated into development policies</td>
<td>(ii) HPH embracing written mission statement</td>
<td></td>
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<tr>
<td>(iii) Hospital staff extended as HP target group</td>
<td>(iii) HP embracing development policies</td>
<td></td>
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<tr>
<td><strong>Culture</strong></td>
<td>(IV) Religious culture embeddedness</td>
<td>(IV) Ideals favored over professionalism</td>
</tr>
<tr>
<td>(III) Cultivated habits of physical activities</td>
<td></td>
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<tr>
<td><strong>Transactional factors</strong></td>
<td></td>
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<tr>
<td><strong>Structure</strong></td>
<td>(V) Supportive intramural structure</td>
<td>(V) Under representation of medical professionals</td>
</tr>
<tr>
<td>(IV) Supportive intramural structure</td>
<td>(i) Established inter-professional committee</td>
<td>(VI) Insufficient systemic support</td>
</tr>
<tr>
<td>(i) Established communication structures</td>
<td>(ii) Established multidisciplinary project groups</td>
<td>(i) Lacks of resources</td>
</tr>
<tr>
<td>(ii) Multi-sectoral cooperation</td>
<td>(iii) Identification of people to coordinate or lead</td>
<td>(ii) Performance system with limited stimulating effect</td>
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<td></td>
<td>(iv) Active and supportive secretariat of HPH committee</td>
<td></td>
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<td></td>
<td>(v) Effective coordination by high-ranking leaders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(vi) Existing conducive structures</td>
<td></td>
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<tr>
<td><strong>System</strong></td>
<td>(V) HP-inclusive system</td>
<td>(VI) Insufficient systemic support</td>
</tr>
<tr>
<td>(V) HP-inclusive system</td>
<td>(i) Healthy policies in place</td>
<td>(i) Lacks of resources</td>
</tr>
<tr>
<td>(i) More resource inputs</td>
<td>(ii) Available resources</td>
<td>(ii) Performance system with limited stimulating effect</td>
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<tr>
<td>(ii) More healthy policies</td>
<td>(iii) HP-embracing subsystems</td>
<td></td>
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<tr>
<td>(iii) Incorporation into operational procedures</td>
<td>(iv) HP-embracing operational procedures</td>
<td></td>
</tr>
<tr>
<td>(iv) Incorporation into subsystems</td>
<td>(v) Integration into systems</td>
<td></td>
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<tr>
<td><strong>Management practices</strong></td>
<td>(VI) Improved management practices</td>
<td>(VII) Less-than-effective management practices</td>
</tr>
<tr>
<td>(VI) Improved management practices</td>
<td>(i) Effective project management</td>
<td>(i) Loose central project management</td>
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<tr>
<td>(i) Increased visibility of HP</td>
<td>(ii) Increased visibility of HP</td>
<td>(ii) Lack of integration</td>
</tr>
<tr>
<td>(ii) Improved project management</td>
<td>(iii) Use of quality management tools</td>
<td>(iii) Insufficient communication</td>
</tr>
<tr>
<td>(iii) Use of local resources</td>
<td>(iv) Use of local resources</td>
<td>(iv) Staff inculcation on importance of HP</td>
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Staff participation

Continued
rather than on evaluation. At the conferences, Dalin had to demonstrate the outcome along with evidence and a rationale, evaluation, which is indispensable for demonstrating achievements, therefore edged itself into the center of the agenda. The emphasis on evaluation may be considered as the deepening of the HPH implementation (A-VI-ii), as this emphasis forced the people in charge of the implementation to reflect on what they had done, as a key coordinator reflected:

Before, [we] just worked hard without thinking. You just do it! In fact, we did not have a protocol for the process of thinking and rethinking. But, now, we will think how we can do a task better and more efficiently. With limited resources, we should focus on which task we think about.

Heightened attention to patients’ health was one of the windfall effects. As patients’ health was linked to the hospital accreditation scheme, the hospital made additional efforts to improve systems for patient needs assessment and patient information and intervention (A-VI-ii).

The HPH initiative encouraged confidence in HP among non-medical professionals in the hospital (A-VI-ii). Furthermore, the HPH initiative facilitated latent learning in project management, such as community diagnosis, program planning and evaluation, although the hospital could not fully put these plans into practice immediately due to limited manpower and professional personnel (A-VI-ii).

The hospital made efforts regarding enhanced staff participation. The hospital established a friendly work-unit climate through increased social interaction among staff by making staff HP programs available (A-VII-i). The most effective impetus may have been the pressure to pass hospital accreditation: because every staff member is keenly aware of the importance of passing hospital accreditation, of which HPH is an integral part, the potential resistance was greatly reduced (A-VII-ii). Furthermore, the hospital provided rewards to the staffers for making additional efforts for HPH, although the incentives may not have met expectations (A-VII-ii). Dalin fine-tuned the job–person match by improving staff awareness and the skills and ability required for implementing HPH through HP-related education and training and on-the-job-training schemes (A-VII-iii).

The implementation of HPH increased interaction between the units through cross-sectoral

Table 1: Continued

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<thead>
<tr>
<th>A. Achievements</th>
<th>B. Enablers</th>
<th>C. Barriers</th>
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<tbody>
<tr>
<td>(VII) Enhanced staff participation</td>
<td>(i) Friendly work-unit climate</td>
<td>(i) Inadequate staff participation</td>
</tr>
<tr>
<td>(ii) Link to individual and departmental professional development</td>
<td>(ii) Job–person mismatch</td>
<td>(ii) Low motivation</td>
</tr>
<tr>
<td>(iii) Enhanced job–person match</td>
<td>(iii) Subscripton to notion of HP</td>
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<tr>
<td>(iv) More interaction between units</td>
<td>(iv) Increased motivation</td>
<td></td>
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<tr>
<td>(v) Domestic and international links</td>
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communication structures and staff HP activities (A-VII-iv). After adopting the HPH initiative, Dalin’s efforts in environmental protection and healthy environments moved from individual centeredness to collective centeredness and went beyond the business of the single department (A-VII-iv). The hospital’s concerns extended from environmental protection and occupational risk-free environments to healthy environments, such as a smoke-free environment and physical activity space. A middle-level manager described the multi-sectoral work model as follows:

Before [HPH], efforts in environmental protection were more individually oriented. HPH emphasizes collective efforts through the organization. All reached a consensus and worked together to achieve the common objective. We did not feel that we were the only unit working on it, which enhanced collective effectiveness.

The hospital enhanced staff participation by fostering stronger links between domestic and international entities (A-VII-v). The staff was strongly encouraged to participate in domestic and international conferences, with the provision of subsidy, to present their work outcomes.

Enablers

Regarding transformational enablers, supportive external contexts for HPH and particularly supportive extramural policies/regulations have paved the way for the implementation of HPH (B-I-i). The government-funded projects for HP and the National Health Insurance (NHI) cover costs for case management and health education for patients with certain diseases. HP was already a part of the existing hospital accreditation scheme, which provided strong incentives for the case hospital to adopt HPH. To a certain extent, the bandwagon effect also helped Dalin to adopt HPH because the initiative was regarded as an international trend (B-I-ii). To enhance its research capacity, the case hospital maintained a successive record of collaborating with several academic institutes, which lent intellectual resources for adopting and implementing the HPH initiative, although more academic resources were desired (B-I-iii). Coordination by high-ranking leaders was conducive to conflict resolution and smoother implementation (B-V-v). The implementation of HPH at Dalin was supported by its leadership, with an emphasis on systemic implementation and an interest in international networking (B-II). Pro-HP missions and strategies were identified as important factors in the adoption of HPH. The community-oriented core missions of Dalin and its original mandates, which favored HP, were the precursors of the adoption and implementation of HPH (B-III-i). The hospital’s written mission statement and hospital development policies manifested its aspiration to become an HP hospital (B-III-ii/iii). Religious ideals such as holistic care, concerns for humanity and environmental protection were mutually reinforcing with the goals of HPH (B-IV).

Dalin’s HPH implementation was also facilitated by several transactional enablers. First, the implementation of HPH in the hospital was assisted by supportive intramural structures, which were evident in the inter-professional HPH committee (B-V-i), multidisciplinary project groups (B-V-ii), specific people coordinating or leading (B-V-iii) and an active and supportive secretariat of the HPH committee (B-V-iv). Coordination by high-ranking leaders was conducive to conflict resolution and smoother implementation (B-V-v). The implementation of HPH was also facilitated by existing structures, such as the Department of Community Medicine for community HP and the Department of TV Station for multimedia health education and promotion (B-V-vi).

A middle-level manager described a conflict that was resolved by the mediation of a high-level administrator as follows: ‘Often, we may have problems with other units in the prioritization of the projects; this is a benign conflict that can be easily settled through the mediation of the Superintendent’s Office’.

Pro-HP systems are identified as a critical facilitating factor. Healthy policies were incorporated from experts and other health institutes. The Taiwan Society of HPH (TSHPH) provided opportunities to participate in the society’s operation and access to relevant information. A key coordinator described why he was enthusiastic about participating in the TSHPH as follows:

I am an education committee member [of the TSHPH]. I attend [the meeting] whenever I am available. I participate in the committee as much as I can in order to push our hospital to continue [implementing HPH], acquire external information and interact with the society and other hospitals.
into staff HP measures, such as prohibiting the use of trans fats within the hospital and implementing patient needs guidelines (B-VI-i). Available resources included funding, the existing information system, manpower, a committed staff, education and training, time allocated to HP, skill support and volunteers (B-VI-ii). One middle-level senior administrator described how much he appreciated his colleagues who were interested in HP and were willing to help with the project:

I really appreciated X (a physical therapist). Earlier, he said that the team must count him in if there was something he could do to help. I cannot imagine that someone would offer such a big help if I were at another institute. He made me feel that this institute has many talents. So did Dr Y (a family practitioner). They have paid a great deal of attention to some tasks that were not their duties. What a surprising phenomenon it is.

Support for HP was demonstrated in the hospital’s subsystems in many ways (B-VI-iii): the reward system; the on-the-job-training scheme; the information system; the employee benefits; the case management system, which the staff supported strongly; and the hospital canteen, which provided healthy food. The hospital paid a cash reward to the hospital staff who had earned awards related to HP. In addition, the introduction of HPH was incorporated into the new staff orientation, and HP credits, which were categorized into practice and lecture, were created and incorporated into the hospital’s on-the-job-training scheme. As elaborated earlier, operational procedures supporting HP were established in the systems related to patient needs assessment and patient information and intervention (B-VI-iv). The integration of the HPH initiative into the existing hospital system was demonstrated by the hospital accreditation procedure and the quality management system, such as quality control circles and plan-do-check-act cycles (B-VI-v).

As one of the key enablers, effective management practices encompass improved project management (B-VII-i), an increased visibility of HP (B-VII-ii), the use of quality management tools (B-VII-iii) and the use of local resources (B-VII-iv). Effective project management was manifested in needs assessment and evidence-based strategies. The increased visibility of HP made the hospital staff aware of the policy of HPH and prompted them to participate in the program.

The implementation of HPH at Dalin was also boosted by the aspirations of the staff through their professional development (B-VIII-i), their commitment to the notion of HPH (B-VIII-ii) and increased staff motivation (B-VIII-iii).

**Barriers**

Insufficient resource input from external environments was perceived as one of the important external barriers to performing HP. Dalin was particularly concerned with the inadequate NHI coverage, the lack of resources in its rural locality and difficulties in recruiting professional personnel because of the hospital’s rural neighborhood (C-I-i). The community had only a vague notion of HPH, so it was hard to garner concerted action from the community for the sake of HPH (C-I-ii). A lack of precedents to follow or successful experiences to learn from was regarded as another barrier to implementing HPH (C-I-iii). Furthermore, many HP-related programs in Taiwan came from government project funding, which normally offered only short-term financing and underestimated the labor cost (C-I-iv). Long-term planning for HP was therefore a challenge. A middle-level medical director described the limitation of project funding as follows:

Projects have a predetermined time frame for implementation. It is hard to do long-term planning. You might only have half a year for implementation after organizing, reporting and claiming funding, even though it claims to be a one-year project. After spending the funding, maybe funding is available next year; maybe it is not available anymore. Maybe you do not want to do it anymore, so the project stops. It becomes short-lived. You are not able to do long-term development.

Another external barrier is that hospital leadership has only limited autonomy and authority because of the stringent governing Tzu Chi Foundation, especially in the accounting and recruitment policies (C-II). As a result, the superintendent has a very limited authority and often failed to deploy necessary resources or human power as he saw fit: ‘The superintendent only has the authority to approve spending less than NT$100 000 (approximately US$3000). It is really hard to do anything’, said a middle-level administrator of an administrative department. Although Dalin and the Tzu Chi Foundation may wholeheartedly subscribe to the ideals of HPH,
the professionalism needed to perform HPH has not yet received comparable attention (C-IV).

The implementation of HPH at Dalin was also hindered by transactional barriers. Firstly, medical professionals were underrepresented on the HPH committee (C-V). Only a small number of physicians participated in the HPH committee; most of the medical representatives on the committee were family practitioners. The taskforce for patient HP was coordinated by a high-ranking nursing director, but there was no intersectional medical task group in place for further action. Secondly, insufficient systemic support was also a significant transactional barrier. Dalin was short of regular staff supportive of HPH, professionals and personnel specifically appointed to supervise the integration process (C-VI-i). Furthermore, the incentives were too meager to effectively encourage better performance (C-VI-ii). A high-level administrator reflected that ‘Once, the former vice superintendent was shocked by the scanty amount of incentives. He yelled, ‘You call this incentive?!’ Obviously, the incentives were not enough to get people going!’

Less-than-effective project management was identified as the third impediment. This issue manifested itself in weak project management (C-VII-i), a lack of integration of similar tasks (C-VII-ii), insufficient communication (C-VII-iii) and an inability to inculcate the staff on the importance of HP (C-VII-iv). The high-ranking leaders have set up the overall policy direction but have not provided any concrete objectives at the second level to achieve the goals. This finding is an example of how triangulation can come to resolve inconsistencies: the high-ranking leaders maintained that the overall policy had been spelled out, yet the participant observation failed to substantiate this claim. Therefore, each department created its own system. A key coordinator described how she accumulated data as follows:

I often had to work in an inductive way. Because everyone was working on his/her own, I needed to pull all small pieces of work together. I just could not see the whole picture at the beginning, but only many small fragmented pieces.

Loose central project management was evident in the priority-setting (C-VII-i). The priorities, which were often not explicitly spelled out, may occasionally have competed with or even contravened each other. There was a lack of concrete objective setting and an inability to integrate HP into daily practices. Moreover, the implementation of HPH was disorganized, and there was a lack of program evaluation. The lack of program evaluation was associated with overburdened staff, a lack of specialist personnel to perform the evaluations, inadequate know-how regarding evaluation, limited access to experts and a culture dominated by ideals rather than pragmatism.

Fourthly, inadequate staff participation was mainly caused by job–person mismatch and low motivation. The former issue was the result of an inadequate understanding and insufficient skills of HP, an inadequate understanding and insufficient skills of quality management tools and insufficient proficiency in English and research methodology (C-VIII-i). Low motivation could be related to insufficient feedback, overburdened staff, few incentives, an effort–reward imbalance and medical professionals not regarding HP as part of their jobs (C-VIII-ii). A middle-level administrative manager who worked on healthy stairs described the effect of receiving no feedback as follows: ‘What was the effect of the healthy stairs? In fact, I did not see any report on its impact. I have no idea about it. It of course affects my intention to develop healthy-stairs building’. A doctor commented that ‘the incentive is just your Giving’. Furthermore, he described the effort–reward imbalance as follows: ‘The reward given by the hospital was not for the individual but for the department. But, within the department, some people made more effort, and some people made less. So inequity occurred. How to make those who made efforts feel more satisfied is something that the hospital needs to work on’.

DISCUSSION

The HPH initiative strengthened the legitimacy and desirability of HP in Dalin’s missions and offered referential approaches to implementing HP in an effective and efficient way. Through the HPH movement, Dalin built both transformational and transactional organizational capacity for HP while a certain measure of organizational support was in want, and particularly those gaps identified as barriers in this study. There was once a doubt whether the HPH initiative was simply old wine in a new bottle (Johnson and Baum, 2001). However, it is inspiring that this study found a positive impact of the HPH initiative on Dalin’s case.
The method of this case study is not without problems. The idiosyncratic feature of being a religious hospital may constitute a warning that caution must be exercised when generalizing our findings to other hospitals. Other hospitals, and especially proprietary hospitals, may operate on an incentive structure that is more in line with economic logic. A stint of 3 months may seem short; however, the generosity in granting access to the necessary research sources, the richness of the archived documents and the research-friendly milieu made the 3-month stay very rewarding. Furthermore, the authors have maintained regular interaction with the case hospital for various academic activities and have therefore extended the contact for further inquiry.

This case study showed that transformational and transactional enablers are of equal importance in the process of implementing HPH. However, the study also found that Dalin encountered more transactional barriers than transformational barriers. To sustain the effective and efficient implementation of HPH, Dalin needs to increase representation of medical professionals on the HPH committee, to provide more systemic supports, to improve on management practices and to encourage staff participation. The religious root, however, might have certain unintended effects on the HPH implementation. As commented by Professor Herman B. Leonard of Harvard Business School in a case study featuring the Tzu Chi Foundation, ‘It uses “value” and “faith” as key concepts of management and leadership, which is very different from the “strategies” and “incentives” used by western management (TZU CHI USA, 2011)’. This courteous comment cuts both ways. On the one hand, an ideal, as long as it is in line with the core value of the Foundation, can be pushed to the fore through corporate support; on the other hand, the strategies and incentives may receive less attention than they deserve, as manifested in the HPH implementation at Dalin. Moreover, the creation of a position for a full-time hospital HP coordinator is highly recommended, which is also particularly highlighted by recent international research (Röthlin et al., 2015).

This case study also demonstrated the significance of networks in supporting HPH development. Participation in international and domestic HPH conferences and in the TSHPH played a particularly stimulating role in the implementation of HPH at Dalin, a theme highlighted by Broesskamp-Stone (Broesskamp-Stone, 2005), Dietscher et al. (Dietscher et al., 2011).

While both the Addition Model and the Integration Model were embodied in Dalin, the former model took precedence over the latter. Dalin mainly adopted the Addition Model through a specific structure, including the HPH committee, project groups, coordinators and a secretary, to create a health-promoting setting. The significance of the HP structure was also demonstrated by recent research (Lee et al., 2012; Röthlin et al., 2015). One year later, the hospital appeared to try the Integration Model through the integration of development policies and quality management tools, such as the BSC, to incorporate HP into individual departmental tasks. This integration strengthened priorities in HPH and reduced job conflicts, although this application required further delicate efforts. Dalin adopted HPH and the BSC nearly at the same time, making it difficult to adopt the Integration Model alone at the beginning. Therefore, the Addition Model brought organizational forces into full play in this case. Furthermore, on the HPH committee, coordination by the high-ranking leader was apparently conducive to conflict resolution and smoother implementation.

According to recent research (Lee et al., 2014), most HP hospitals in Taiwan have adopted the Addition Model in putting the HPH initiative into practice. In terms of selection between the Addition Model and the Integration Model, we suggest that hospitals that do not have a well-developed quality management system should adopt the Addition Model; otherwise, hospitals should integrate quality management with HP by adopting the Integration Model.

Implications

Several implications can be drawn from this study. The first lesson for other hospitals is that the HPH enterprise can be sustained only when supported by both the leadership and a devoted ground force; the former provides vision and aspiration, whereas the latter provides ways and means to ensure a successful implementation. Secondly, the integration of hospital accreditation and HPH might effectively reduce resistance if the existing hospital accreditation scheme encompasses components of HP. Thirdly, this study suggests that hospital leaders encourage staff to participate in international and domestic HPH conferences,
through which the staff feels recognized and motivated. Lastly, a hospital with good credentials of quality management can adopt the Integration Model and seamlessly assimilate the HP component into the original quality management framework; otherwise, the Addition Model is more appropriate, as the particular HPH structure is relatively concrete, allowing relevant resources to be relatively easily organized and HP issues and action to be more visible.

ETHICAL ADHERENCE

Ethical reviews were submitted to Human Research Ethics Committee, Griffith University and the institutional review board of Dalin, before the fieldwork to ensure that the research procedure complied with the relevant ethical principles. The Griffith Protocol Number of the ethical clearance certificate is ENV/11/08/HREC and one of Dalin is B09703002.

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No conflicts of interests in this paper.

REFERENCES


