Health Promotion
in Primary Health Care:
General Practice

Country Report - Germany

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Practice/Family Medicine

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### Content

#### Part A: Collection of national models or initiatives for patient/user-oriented health promotion in General Practice

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Part A: Collection of national models or initiatives for patient/user-oriented health promotion in General Practice

For the report we have tried to present projects which differ in the extent of community involvement, the target group and the setting. This collection is not a representative selection of health promotion projects in Germany, but it shows some very efficient and well-accepted initiatives. Overall, these models either focus on behavioural modification, integration of care and support and the attention and provision of health-relevant information.

Models

1. Arbeitsgemeinschaft Gesundheitsförderung Östringen
   „Community-Based Behavioural Medicine“ Programme
2. Wremer Frühjahrskur - Modell einer Herz-Kreislaufrävention in einem Dorf
   Springtime cure in Wremen
   Model of prevention of cardiovascular diseases in a village
3. Promotio - Zentrum für Prävention und Rehabilitation
   Promotion - center for prevention and rehabilitation
4. Ärztliche Gesellschaft zur Gesundheitsförderung der Frau e. V.
   Physicians Association of Health Promotion for Women
5. Schule und Gesundheit - Ein gesundheitsförderndes Schulprojekt
   School and Health - A Health Promoting School Project
6. PAGT
   Projekt Ambulantes Gerontologisches Team
   Project ambulatory gerontological team
7. Verbund gesundheitsorientierter Praxen
   Cooperation health orientated surgeries
Arbeitsgemeinschaft Gesundheitsförderung Östringen
„Community-Based Behavioural Medicine“ Programme

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Who has commissioned the initiative?
Östringen area participated in the CINDI-Study (Countrywide Integrated Non-Communicable Disease Intervention Programme of the WHO) in 1985-1992. Because of the success and general acceptance of these interventions, local GPs founded a study group for health promotion „Arbeitsgemeinschaft Gesundheitsförderung Östringen“ in 1991. This study group was strongly supported by local community services and local industry, especially DuPont, which is one of the main employers in this region.

Who has coordinated the initiative?
The programme was mainly coordinated by Dr. Wiesemann (address see above).

What is running time of the initiative?
The study group was founded 1991. The group is still active and runs several health promoting activities within the community.

What is the current state of the initiative?
The „Arbeitsgemeinschaft Gesundheitsförderung Östringen (is now) has become an integral part of everyday practice in this area and is supported by several local GPs and specialists, the community and local industries.
Short description of the initiative:
The project was initially strongly related to the CINDI-programme, which focuses on chronic non-communicable diseases. The centres of attention for health promotion are the reduction of cardiovascular risk factors as well as other diseases like diabetes and musculoskeletal problems within the population of the small provincial town of Östringen.

The study group addressed the following main objectives:
- Is it possible for GPs to establish a local health programme without considerable costs that is accepted on a long-term basis by the population?
- Can any notable reduction of behaviour-related CVD risk factors be achieved?
- Can exercise-based groups support community-related behavioural medicine and lead to significant motivation towards a health promoting life-style?

The study group contributed significantly to the development of the “three-level-strategy” which was adopted by the German Association of Physicians and recommended as an efficient strategy for health promotion in ambulatory care. It focuses on behavioural modification towards a health promoting life-style.

The study group implemented this strategy into the community of Östringen.
- At the first level, health advice was given to the patient during consultation, e.g. information about cardiovascular risks.
- At the second level, the GP works with patient groups in his/her surgery using special group education programmes, e.g. about non-smoking, nutrition etc.
- At the third level, health promoting activities by the local GP in kindergartens, work places, sport clubs are included.

The core parts of this model are:
- Study group on community-based behavioural medicine, which ensures cooperation amongst all local health professionals, contributes to the development and assessment of health promoting activities.
- Coordinating GP surgery, which organize the health-related activities, provide and analyze data, provide literature and training, and publish the “local health guide”.

Within the programme, physical exercise activities on a community level are offered to the general population. The exercise-based groups consist of 8-20 participants and meet at least once or twice a week over a period of 16 weeks. The exercise instructors keep in close contact with the local GPs. These groups focus on specific health problems like stress management, special training for the back, osteoarthritis, heart groups and groups for quitting smoking. Part of these group activities often also covers nutrition counselling and information about relaxation techniques.

GPs in this area can directly refer their patients to one of the exercise-based groups. Patients receive a special prescription for behaviour-related activities (instead of a drug prescription). Health insurances and municipal
institutions support the “community-based behavioural medicine” programme by covering the costs of the instructors and the sports halls. The medical entry examination, special individual advice and follow-up were done by the participating GPs.

Has any systematic project evaluation been conducted on the model/initiative?
The overall acceptance of the programme in the community was very high amongst GPs as well as amongst participants. The whole community was very much dedicated to the programme, health as such became an issue and there were many contributions to health topics in the local newspaper (at least one per week).

Participants of the "community-based behavioural medicine" programme underwent a medical entry examination and a follow-up. Data about these examinations were collected and analyzed by the coordination GP surgery during the research period. The Local Health Information System was used to collect, analyze and manage the health-related data. Data were collected about biomedical indicators (e.g. Age, sex, BMI, blood pressure, cholesterol) and behavioural indicators (smoking). To evaluate the occurrence of risk factors, four cross-sectional random samples (over 4,800 examinations) were recorded from 1992 to 1995.

A considerable effect on the reduction of risk factors was achieved during the study period. Smoking was significantly reduced; the level of the average blood pressure was also significantly reduced. There were no significant effects on cholesterol or BMI during the study period.

On a community level, 23 different exercise-based groups were established and assessed by a standardized questionnaire. Participants of the exercise groups (600 persons) were asked about their exercise habits, acceptance of the exercise groups, musculoskeletal health problems, diet and discomfort caused by stress. The participants considerably improved their health-related behaviour. They discussed their health within their family, they changed their diet and started to integrate exercise into their daily routine.

If information available: What is the knowledge about project results so far?
The acceptability of the programme was widely considered to be very high. The programme provided a continuous preventive care for the community very efficiently. Risk assessment, exercise-based groups and a local health information system were established and became an integral part of the primary care in this area. There was no further economic evaluation of the programme, but so far, the additional financial costs have been very moderate.

If information available: Which were the most important factors supporting the development and implementation?
Key factors for the success of the programme were the dedication and enthusiasm of local GPs for health promotion and the support of the local community. The local conditions (a small provincial town with a very good infrastructure) were favourable for the implementation. There was a strong interest within the community in protection of the environment and environmental medicine. A local company, DuPont, which is a member of
“Responsible Care” an initiative of chemical industries for the continuous improvement of safety, health and environmental protection, also supported the programme.

If information available: Which were the most important barriers concerning development and implementation?
Not known

Which specific aspects of the model would you consider especially well developed or otherwise instructive and thus relevant for transfer to other EU member states?
I consider this project to be a very significant model for health promotion in primary care because:
- It focuses on non-communicable diseases, which have an increasing impact on the overall health of the population
- The concentration of community-based behavioural medicine, which highlights the importance of favourable conditions and public support for any significant change in the life-style of people at risk.
- It provided an easy access to health promoting activities
- It provided the continuous care and involvement of family doctors with their reinforcing effect toward a healthier life style.
- Sport and physical activity were considered as a permanent “pro-drug”. Especially the prescription of health promoting exercise-based groups emphasized the importance of the improvement and maintenance of health.

Publications, reports, self-descriptions:


Wiesemann, W., Nüssel, E., Scheuermann, W., Topf, G. Improving Cardiovascular Health in the German CINDI Area: Methods and Results of the Practice-Based “Three-Level Strategy” Eur. J.Gen Practice 2 (1996) 117-125


Broschüre „Gesundheit und Umwelt in der Region Östringen“ herausgegeben von der Arbeitsgemeinschaft Gesundheitsförderung Östringen
Wremer Frühjahrskur

Springtime cure in Wremen

Modell einer Herz-Kreislaufprävention in einem Dorf

Model of prevention of cardiovascular diseases in a village

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Who has commissioned the initiative?
Dr. Samsel started the initiative in 1985 while he was working as a General Practitioner in a single-handed GP surgery in a small rural place in North Germany. There was no official commission of this initiative.

Who has coordinated the initiative?
See above

What is running time of the initiative?
The initiative called Wremer Frühjahrskur started in 1985 and was run by Dr. Samsel until 1990, after which the initiative was taken over by the local sports and exercise club, which was very much involved in the initiative from the very beginning. Dr. Samsel has left the GP surgery by now. There is no information available about the current state of the initiative.

What is the current state of the initiative?
No information available

Short description of the initiative model:
Cardiovascular mortality is very high in Germany and was increasing for many years in spite of the progress in diagnostics and treatments. The main risk factors are very well known, like smoking, high cholesterol, hypertension, obesity and lack of regular exercise. Dr. Samsel noticed this situation in his daily work as a GP. He presumed that these problems could not be handled by GP consultation. He especially regretted the total lack of any prevention measures or health-related information given to the population in rural areas.

The general aim of the initiative was the improvement of the overall quality of life by the adoption of a healthy life-style. A general idea was the total awareness of health as an issue of the population. The promotion of physical, mental and psychosocial welfare of the general population was the main target.
Central to the development of this initiative is the claim by Dr. Samsel that health promotion should meet the people where they actually stand concerning their individual situation, health and health beliefs. Especially in a small community, the local living conditions, structure of the community and the available infrastructure should be taken into account for health promoting measures.

According to the initiative, prerequisites for health promotion, which are available in many small communities, are:

- A GP with enthusiasm about prevention and health promotion who is willing to leave the GP surgery and meet people in their everyday life.
- A local sports club which has got some interest in health promotion
- An umbrella organization as technical support
- Sports fields, simple sports equipment, perhaps a swimming pool
- A meeting room.

The initiative can be divided in the following steps:

- Information
To draw the attention of the population towards health and passing on health-related information, a series of lectures were organized for the general population throughout the winter 1985. This was sponsored by an adult education centre “Work and life in lower Saxony”. All households received leaflets about these lectures. More and more people attended these lectures, the average age of the attendees decreased significantly and over the time, discussions about health issues became very lively and the meetings were very much like a social event in this community.

- Information and self-perception
A new series of courses were launched in the springtime that involved some practical advice. One part of the course consisted of nutrition counselling, which was partly done by the chef of the local pub who, by chance, was trained as a dietician and gave instructions about low-fat cooking. The second part was development of a simple sports programme, with gymnastics, walking, jogging and swimming. This programme, called „Wremer Frühjahrskur“ was a big success. Many more participants than expected subscribed to it. Local people became very enthusiastic about sports and a healthy diet. At the end, a big party was organized by the community to celebrate the success. Slowly changes within the community were noticed:
  - Formation of a jogging group, which met twice a week
  - A gymnastic group for elderly ladies was founded and very well accepted.
  - Significant increase of members in the local sport club
  - The local baker increased his supply of organic wholemeal products
  - Health became a constant issue in the consultations with the GP.
- Stabilization by repetition of information and action
During the next winter, all active participants held regular meetings to improve and professionalize the next course. The number of active participants increased. Within the second „Wremer Frühjahrskur“ another seminar about healthy slow jogging was launched. Two physiotherapists joined the group and started a seminar about prevention of back problems. Two participants with counselling training offered a stop-smoking course. A special group for teenagers was founded to increase their interest in health and a health promoting lifestyle.
The overall acceptance of the second spring course was even greater. The main impression for the population of the initiative was that all participants enjoyed themselves in exercising and meeting the other participants.

- Consolidation of preventive subjects
During the third winter, the concept of prevention of cardiovascular diseases was presented to the general population by another series of lectures. The physiotherapists established a “Back School”, following a Scandinavian model, which was eventually called „Wremer Back School“. The demand for these courses was extremely high, indicating back problems as a significant and very common health problem within the population. The dietician offered a practical seminar about wholefood and cooking in the local school, which also was very popular. The third course was a success, but some active participants felt, that the next course had to concentrate on the integration of beginners and advanced people to offer actions for different needs.

- Adjustment to changed conditions, integration of beginners and advanced participants
Over the years, the sports club became very much involved in the initiative. To establish the initiative within the community, the overall organization was transferred to the sports club, which changed the name to „TUS-Aktiv“. The mixture of information and exercise was maintained. The jogging school for children and teenagers was especially well accepted, nearly all of the children in this age group participated. People involved in the organization became more experienced and things continued very smoothly.

The village has changed over the time. Reports in local, regional and national media about the initiative were published, which produced a strong sense of coherence and self-esteem within the population. Healthy nutrition and regular exercise became a well accepted part of the everyday life and the perception of the population of a well-functioning community in control of their living conditions was one of the greatest achievements of the initiative.

Has any systematic project evaluation been conducted on the model/initiative?
There was no systematic evaluation conducted. The noticeable changes within the population were described above. A report of the initiative was written by Dr. Samsel, who received the “Hufeland Preis”, one of the most significant awards for Prevention in Germany.
If information available: What is the knowledge about project results so far?
The overall acceptability within the population was very high. The initiative was later transferred to the local sports club to increase the chances of a sustainable action within the community. No data about any economic evaluation is available, but the initiative did not involve any significant financial support. Participants paid 15 DM (7.67 euros) per course to cover insurance and material. Instructors and other active participants worked honorarily and did not ask for any remuneration.

If information available: Which were the most important factors supporting the development and implementation

This initiative was shaped by very favourable conditions for health promotion in this village. First of all by the local GP, who dedicated his energy and spare time to the idea of prevention and health promotion on a community level. He was well supported by local organisations like the sports club and the adult education centre as well as by other members of the community with some relevant training background, like a dietician or physiotherapists. The main factor in the success was a rather united community with an intact social structure, which was willing to integrate health promotion into their social life.

If information available: Which were the most important barriers concerning development and implementation?
No information available.

Which specific aspects of the model would you consider especially well developed or otherwise instructive and thus relevant for transfer to other EU member states?

I consider this project as a very significant model for health promotion in primary care because:
- It was an effective, acceptable initiative of health promotion within a rural small community.
- It made the best use of available resources and infrastructure without the need for significant financial support.
- The initiative in itself supported and used the social structure of the community to promote a healthy lifestyle.
- It involved the community, which eventually formed health-promoting actions suiting the needs and situation of this village.
- It resisted from any form of paternalism and tried to meet the population in their specific conditions.
- It demonstrated that a few medical professions with enthusiasm could achieve a sustainable change in people’s life-style and health-awareness through simple actions and with limited resources.

Publications, reports, self-descriptions:

Samsel, Walter: Von der Wremer Frühjahrskur zur TUS-Aktiv – Modell einer Herz-Kreislaufprävention in einem Dorf
Promotio
Zentrum für Prävention und Rehabilitation

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Who has commissioned the initiative?
There has been no official commissioning of this initiative

Who has co-ordinated the initiative:
Dr. Susanne Ehrhardt-Schmelzer, a General Practitioner, started her own surgery in 1985, where she introduced prevention and health promotion methods into her everyday work with patients. Main focuses were behavioural changes for patients with hypertension, smoking cessation, relaxation, coping with pain and improvement of sleeping pattern. Prof. Dr. Dr. H.-D. Basler, Head of the Department of Medical Psychology of the University of Marburg, supported her. Many programmes, which she introduced into her surgery, were developed and evaluated by Professor Basler. In 1991, she founded a centre for prevention and rehabilitation, which has increased significantly in size since then. This centre offers quality assured programmes of prevention and health promotion.

What is running time of the initiative?
Promotio was founded in 1991. It has expanded significantly in Göttingen. Other health professionals, who have started two other centres in Witten/Nordrhein-Westfalen and Neubrandenburg, also used the concept.

What is the current state of the initiative?
Promotio is now an established prevention centre in the Göttingen region.

Short description of the initiative model:
The Promotio concept was first developed within the setting of General practice to deal with major health risks such as smoking, obesity, lack of exercise and stress. It focuses mainly on behavioural change through individual advice and group work. It tries to address persons in different stages of change according to the Transtheoretical Model of Change. It received support and scientific advice from the department of Medical Psychology, University of Marburg and was the first locus of several newly-developed prevention intervention programmes.
Promotio offers individually tailored programmes for health problems like obesity, smoking, stress and lower back problems. It now works independently of any General Practice and offers its service to the general population of that area. Prevention programmes are generally not covered by health insurance, so patients and clients have to pay for the service. Promotio has received no financial support from any organisation so far.

Since 1998, Promotion started to cooperate with a pharmaceutical company, Knoll, who has used concepts, developed by Promotio to support weight-loss of patients. Promotion also works within the field of ambulant rehabilitation, for which it has contracts with social insurance companies to cover the costs of the programmes. A main strategy of Promotio is to change health-damaging behaviour and life-style through several methods. Patients should learn:
- Self-observation
- Behaviour modification
- Stabilization and maintenance of the behavioural changes achieved

Important parts are:
- Health-relevant information
- Group meeting for mutual support and motivation
- Relaxation techniques
- Promoting of a healthy, active life-style
A main focus of Promotio is obesity, which remains a major health problem in Germany. Central to this programme are strategies for a change of life-style with special emphasis on physical exercise. Patients should learn to enjoy their physical activity within a group, also using group dynamic processes. The level of training is individually adapted to the patient’s fitness and previous experience. Changes in diet, coping with stress and well-being are additional topics within the programme.

The concept of Promotio
- has an integral idea about health and well-being
- increases self-responsibility of participants for maintaining their health
- helps to promote a healthy life-style and reduce health-hazarding behaviour
- tries to change attitudes towards health risks and practise a health-promoting life-style
- is self-financing and has proven to be financially efficient
- follows scientific principles and is quality assured

Has any systematic project evaluation been conducted on the model/initiative?
Promotio has done extensive evaluation of the effect of its programmes for patient with chronic back problems. These programmes include cognitive training and pain management strategies. Participants in these programmes have shown significant improvements in many variables like pain, attitudes, functional capacity and muscular strength, compared to a control group. Other programmes like weight reduction have been also systematically evaluated.
Promotio was founded in 1991 and has been very successful since then. The concept has been well accepted amongst the population of this area. It does not receive any financial public support, but has been able to finance itself through its own means and course fees. The idea has even been financially so successful, that similar centres were founded in other parts of Germany.

Dr. Ehrhardt-Schmelzer has extensive experiences in health promotion in a primary care setting. She received strong support in her work from the department of Medical psychology of the University in Marburg.

I consider this project to be a very significant model for health promotion in primary care because:
- Promotio is an independent and self-financing initiative, which offers its health promoting services to the population
- focuses on long-term behaviour changes and attitudes towards health
- has an integral idea about health
- supports coping of participants with stress, pain and adverse events
- puts emphasis on self-responsibility

Publications, reports, self-descriptions

Extensive information and several brochures for patients about Promotion
ÄGGF
Ärztliche Gesellschaft zur Gesundheitsförderung der Frau e. V.
Physicians Association of Health Promotion for Women

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Who has commissioned the initiative?
The ÄGGF (Ärztliche Gesellschaft zur Gesundheitsförderung der Frau e. V., Physicians Association of Health Promotion for Women) was founded in 1952 and has been a registered charity since 1956. It was originally founded to face the very special health problems for women after the war, where sex education and information about menstrual hygiene, contraception and pregnancy was not easily available for many women, especially in low socio-economic classes, such as many of the refugee women. Since then, the ÄGGF has adapted the scope and targets of their work according to the changed needs of contemporary women and living conditions.

The ÄGGF works under the auspices of German Association of Gynaecology and Obstetrics and the German Association of Paediatrics. It cooperates with the German Physician Association and several local Public Health departments.

Who has coordinated the initiative?
Its active members headed by the first chairperson, Dr. Gisela Gille, coordinate the initiative. ÄGGF has 39 active members (all female doctors), who work in different regions throughout Germany.

What is running time of the initiative?
The ÄGGF has worked continuously since 1952 with some changes in its structure, targets and strategies. It has increased significantly in size and scope since them and now covers large areas of Germany with its services.

What is the current state of the initiative?
The ÄGGF has now established health-promoting services for its target groups in many areas of Germany. They have established very good working relationships with several communities and health authorities and are in some parts an integral part of everyday practice.
Short description of the initiative model:
The aim of the ÄGGF is to inform and raise self-responsibility for, and awareness towards, health, especially amongst women in vulnerable age groups like female teenagers and women during menopause. This report, therefore, focuses on the work with female adolescents, who are the main target groups of the ÄGGF today.
To have access to them, ÄGGF has built up connections with local health authorities and schools. Doctors working with ÄGGF participate in school lessons and support teachers when they talk about health-related issues like, for example, sexual education and other important health-related areas for this age group. ÄGGF tries to raise self-responsibility and health awareness amongst teenagers. Vocational and secondary modern schools are more frequented by the ÄGGF than grammar schools.
An area of concern is also the vaccination rate amongst teenagers, especially of German measles and Hepatitis B infection. ÄGGF supports the local health authorities with vaccination programmes, and in this field in particular, some very effective cooperation between the health authorities and the ÄGGF has been established to increase the acceptance and transfer of relevant information about vaccination. German measles is a very important matter in the talks with premenarchal girls, whereas Hepatitis B infection is more an issue with older teenagers, who are more likely to contract a sexually transmitted disease and suffer from drug addiction, both of which are areas of high significance in health promotion.
Health is promoted within this age group by
- Information
- Motivation
- Competence support
- Raised awareness of body functions and health

Teenagers should develop a positive attitude towards their own body to be able to protect themselves from adverse influences and conditions. ÄGGF supports teenagers in discovering their creativity and ability to enjoy their body while they take responsibility for their own health. Sessions focus on dialogue. Sessions are conducted as consultations with teenagers within their relevant peer group and not as a school lesson. Doctors are open to any suggestions by the participants during the session and they try to adapt the main issues to the developmental phase of the group and their specific needs.
Topics for health promoting sessions for adolescents and teenagers are:
- Physical and mental changes in puberty
- Anatomy and physiology of reproductive organs
- Personal hygiene and menstrual hygiene
- Acceptance of the body
- Potential health damaging behaviour
- Vaccination
- Conception, pregnancy and birth
- Contraception
- Prevention of sexual transmitted diseases
- Termination of pregnancy
Methods of the ÄGGF are:
- Communication about health – dialogue instead of lecture.
- Meeting the teenagers halfway, accommodate their specific needs and questions.
- Example from real life are always employed, information given is of practical relevance.
- Adaptation to the age, sex, specific living conditions and cultural and religious background of the participants.
- Focussing on teenagers from lower socio-economic classes who have often poor access to the health care system to compensate for social disadvantage.

Has any systematic project evaluation been conducted on the model/initiative?
During the long period of health promotion for women and female teenagers, several evaluations of the acceptance and effectiveness of the initiative have been performed. The acceptance of the initiative is very high amongst the participants. Teenagers view the initiative very positively. Reports have shown that many female teenagers suffer irritations about their physical, mental and affective changes during that period and appreciate open communication and discussion with a medical expert in these issues. Rubella vaccination especially seemed to be a very good starting point for health discussions.

If information is available: What is the knowledge about project results so far?
Acceptability, feasibility and sustainability of this initiative, which has been working now for nearly fifty years is very high. ÄGGF is a registered charity and is sponsored by some pharmaceutical companies and private donations. ÄGGF received the Helmut-Stickl-Awards by the German Academy of Pediatrics for its support of vaccination programmes.

If information available: Which were the most important factors supporting the development and implementation?
A female gynaecologist, Dr. Med. Judith Esser Mittag, founded ÄGGF in the post-war era. Since then, several female doctors with a strong interest in health promotion have dedicated their experience towards the initiative. ÄGGF always tried to hold a good working relationship with the local health authorities and have supported them in their preventive work in schools and their vaccination programmes.

If information available: Which were the most important barriers concerning development and implementation?
No information available.
Which specific aspects of the model would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?

I consider this project as a very significant model for health promotion in primary care because:

- It focuses on a target group, which are vulnerable to health damaging behaviour and life-style related health hazards (female adolescents).
- It works together closely with and supports local health authorities.
- It concentrates health-promoting actions on groups with poor access to preventive measures to compensate socio-economic disadvantages.
- It emphasizes the importance of dialogue in the transfer of health-related information.
- It adapts the topics and subjects of any health promoting activity to the needs of the group.

Publications, reports, self-descriptions


ÄGGF

Broschüre zur Information
Schule und Gesundheit
Ein gesundheitsförderndes Schulprojekt
School and Health
A Health Promoting School Project

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Who has commissioned the initiative?
The initiative was initiated by a cooperation of the Medusana foundation, a registered charity, which works mainly in the field of health promotion for children, and the Physician Association of the Westphalia-Lippe region. The initiative is funded by Johnson & Johnson Medical Care.

Who has coordinated the initiative?
The initiative is coordinated by Medusana (for details see above).

What is running time of the initiative?
The pilot phase started in 1989 and was completed in 1995. This phase was coordinated by the Brendan/Schmittmann Stiftung in Freiburg, Germany and founded by the German Ministry of Health. By 1995, the project was taken over by the Medusana foundation, a registered charity, which is still in charge of the project. Since 1997, a cooperation was set up between the Medusana foundation and the physician association of Westphalia-Lippe. The project has expanded significantly since 1997 in the region of Westphalia-Lippe. Recently another team has started to work in Leipzig, Saxony.

What is the current state of the initiative?
Within the region of Westphalia-Lippe, 24 teams (GP and teacher) have started to introduce this project as an integral part of education in their schools. Some of these teams are already very experienced, so the project is definitely not in a pilot phase any longer. But there is still a long way to go to integrate these activities into everyday practice within the region. The physicians association aims to expand the initiative to cover all of Nordrhein-Westphalia.
Short description of the initiative model:

Health promotion for schoolchildren and teenagers faces totally different challenges than for adults. They have different needs and health problems. Individual advice given to them through the paediatrician or GP will hardly be effective, especially if the advice contradicts peer pressure. Health advice and information are best given within their relevant groups, which are often classmates. This situation explains why health promotion for this group is best given via school education. GPs have very little contact with this age group within any medical setting; nevertheless they might be a very competent partners for teenagers for health advice. The central idea of the project was to combine teaching experience and medical expertise for health promotion in school.

A medical doctor (often a local GP) and a teacher form a team, which teaches health relevant issues within a certain period. This education is called cooperative health classes. It will either consist of three full days or one full day and three double periods. Both models will include an information evening for the parents. The doctor/teacher team has some preparation time beforehand and receives additional mandatory training twice a year by the Medusana foundation.

The doctor/teacher team will work continuously for an extended period. They will share the preparation for the teaching session. A special strategy is the helix teaching method, where a certain health issue will be repeated every school year suitable for the age and capabilities of the pupils by the same doctor/teacher team over 4 years (optimum) Pupils from the age of 11 to 15 years (the age group which is most susceptible for any health damaging behaviour) receive consistent health information within a very motivating atmosphere. Dialogue and partnership between the doctor and teacher, and between the team and the parents are vital for the success of the initiative.

The doctor/teacher team will decide on their main focus for the teaching session. Medusana foundation offers materials for several health issues, like exercise, skin-environment, nutrition, puberty, addiction, alcohol, AIDS, smoking etc. The general intention is to raise awareness of their body and well-being and give them expertise and competence to promote their health.

Essential to the concept of this initiative is a salutogenic approach to health promotion. Learning about health means the experience of the physical, mental, cognitive and social being. This project does not focus on risk factors, but on available health promoting resources of the participants. Deterrent has not been proven to be effective to detain teenagers from health damaging behaviour. Instead, schoolchildren and teenager should experience that they enjoy health promoting activities. A big issue within the project is “help for self-help”. Pupils should gain autonomy and competence. Instructions for self-help with minor health problems like a cold and proper skin care are given to them.
Has any systematic project evaluation been conducted on the model/initiative?
The central institute of the physicians sick fund association has done accompanying research of the project.
Targets of the research were:
- Stepwise investigation about the supporting and hindering factors
  - of the cooperation between doctors and teachers and
  - their shared responsibility in teaching.
- Continuous support of the project coordination
  - to optimise the applied measures and
  - to increase the overall acceptance of the model.

This research project focus on the participating doctors and teachers. No research has been done so far about
the acceptance of the pupils or the overall outcomes.

Within this research project, doctors and teachers were asked by standardized questionnaires. Overall, the
results indicate a positive experience of the project. Teachers and doctors assessed the acceptance and
effectiveness of the model as high and pupils enjoy the activities. More than half of the teams saw some
behavioural change in the pupils after the teaching session.

If information available: What is the knowledge about project results so far?
Doctors and teachers, as well as pupils and their parents, have strongly accepted this project. Over 10 years of
experience has led to a structure which is easily applicable within different schools. Continuity has high priority
within the initiative, which has been able to induce a stable cooperation between several doctor/teachers
teams. There is no information available about the overall effectiveness about the programme or any economic
evaluation. The financing of the initiative is balanced. The initiative is sponsored by the pharmaceutical industry,
but is independent in the choice of their subjects and the structuring of their projects.

If information available: Which were the most important factors supporting the development and
implementation
One main factor for the success of the initiative so far is the efficient cooperation between doctors and
teachers, who contribute their medical and educational expertise. Key actors are the founders of Medusana, a
medical doctor dedicated to health promotion and a trained pedagogue, who have structured this model using
both their expertise. They got significant support through a strong cooperation with the regional physicians
association and a pharmaceutical company.

If information available: Which were the most important barriers concerning development and implementation?
In 1996, health promotion was deleted from the area of responsibility for medical service (Leistungskatalog) of
the social health insurances. Since them, cooperation between schools and social health insurances has
decreased significantly, which also means that initiatives like the Medusana foundation do not receive financial
support from health insurance companies and rely on sponsorship or support from other organizations. Fortunately, the Medusana foundation was able to find other financial support. There is no other information about barriers.

Which specific aspects of the model would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?

I consider this project as a very significant model for health promotion in primary care because:

- It combines the medical expertise of the GP (or other medical doctor) with the educational experience of a teacher for the maximum effect of health promoting measures.
- It highlights cooperation, team-work and dialogue between all those who work on this project.
- It tries to meet pupils in their daily environment (school) and uses peer effects for behavioural changes.
- It focuses on a salutogenic approach to health promotion and supports autonomy and competence of the participants.
- It focuses not only on behavioural changes, but also on organizational and environmental changes in this specific settings (schools).
- The structure of the project is very flexible to meet the needs of different age groups and schools.

Publications, reports, self-descriptions

52 Seiten Vorträge, Arbeitsgruppen, Wettbewerbe Bündner Empfehlungen für die schulische Gesundheitsförderung

Brochure: Schule und Gesundheit Ärzte und Lehrer für Prävention

Meye, R.M.: Gesundheitsförderung in der Schule: Ärzte und Lehrer für Prävention Ergebnisse der Begleitforschung
Zentralinstitut für die kassenärztliche Versorgung in der Bundesrepublik Deutschland
Köln, März 2000
PAGT
Projekt Ambulantes Gerontologisches Team

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Who has commissioned the initiative?
Within the framework of the project “Healthy cities” initiated by the WHO, a working group “Self-determined Ageing” has been set up in Hamburg. The working party, which was very heterogeneous in its age range as well as its professional backgrounds, highlighted the fact that the concept of health promotion is not only directed at those who are still in good health, but is equally important for elderly people.
PAGT was financed by the Federal Ministry for Family, Senior Citizens, Women and Young People (intervention project and research) and Johanna and Fritz Buch Memorial Fund (intervention project only)

Who has co-coordinated the initiative?
Official responsibility of the intervention project lies within the association „Sozialwissenschaften und Gesundheit e.V."
Research responsibility: Institute of Medical Sociology, Working Group Social Gerontology, University of Hamburg

What is running time of the initiative?

What is the current state of the initiative?
The intervention part of the project was finished in March 1996. The research period is also finished. It was not possible to implement it in everyday practice.
Short description of the initiative model:
The Project "Ambulant Gerontological Team" (PAGT) has as its goal the improvement of the quality of life both of those older people who are in need of help and of their relatives. With the help of new organizational structures in health promotion and in health care, the following situations are to be avoided or to be delayed: progression to a chronic stage of the patient’s condition; admittance to hospital on the grounds of social factors; long periods of hospitalisation; need for long-term care and undesired admittance to a nursing home.

The project works with following principles:
- self-determination enabled by utilization of available help
- continuity in the provision of care
- cooperation of all those concerned in the provision of care
- coordination of help
- helping people to help themselves and to maintain their independence

In the Ambulant Gerontological Team (AGT), the family doctor is supported by a patient support person and a co-coordinator in the planning and in the realization of a health care and health promotion programme which is oriented to the patient's individual needs (Case and Care Management). The basic team tasks are:
- the planning of medical, care, therapeutic and psycho-social intervention and the assessment of health-promoting, preventive, and rehabilitative measures - in individual cases with the assistance of a specialist (planning)
- regular case conferences and implementation of the intervention programme in association with the services which are involved in the provision of the care (monitoring)
- assessment of the success of the intervention programme (evaluation)
- planning, and when appropriate, establishment of groups for patients with particular needs, monitoring of measures taken and the exchange of information and experience with other services, with those bodies which finance the health and social services, and with bodies represented in the larger health policy framework

The project worked on a local scope within two small inner-city areas of Hamburg in Germany

The Department of Medical Sociology provided the framework for the organization and the accompanying scientific research. Local GPs were recruited to participate. The PAGT team was involved and co-coordinated the local social services and other supporting agencies as much as possible, but there was no further official cooperation with professional organizations or health policy actors.

Has any systematic project evaluation been conducted on the model/initiative?
In the accompanying scientific research, the individual patient's progress was evaluated, as was the organization of the project and the background conditions to the project. The opportunities for the practical realization of the tasks of the team-members in the context of normal care provision were examined, particularly from the point of view of their feasibility.
The basis for the evaluation of the individual patient’s progress is formed by the results of:
- the multi-dimensional geriatric assessment (a translated and modified version of the OARS Multidimensional Functional Assessment Questionnaire)
- the screening procedure (brief interview of older patients, a risk-assessment list to be completed by the family doctor and a clinical overview of the need for care)
- the documentation of the patient support person

The results, which are thus gained for the organization of the model, are based on the experience of the members of the Ambulant Gerontological Team (AGT) in multidisciplinary team work and the assessments of the project’s work by the social and health care services in the district. The data collection was performed by means of expert-interviews with those involved in the project and on the basis of group discussion with those working in the services in the district. The basis for the results presented is a qualitative evaluation based on grounded theory (Glaser & Strauss) and qualitative content analysis (Mayring).

The team members were unanimous in their evaluation that the model project makes a significant contribution to quality control in the provision of care for older people and therefore would not now wish to dispense with teamwork. This is justified by the following experience:
- the observation of an improvement in the domestic and psychosocial situation of elderly people
- feeling of greater stability and a greater feeling of security on the part of the elderly people
- broader perspective in the sense of an holistic treatment of patients
- increase in the geriatric and gerontological qualifications

A good atmosphere of co-operation has been developed with the health and social services in the district under examination. A prerequisite for this was the establishment of personal contact to those already offering care in the district. The following problems and demands/desires emerged:
- lack of transparency and a deficit of information gives rise to feelings of competition and hinders cooperation
- participation in local activities and discussions encourages acceptance and integration
- the need for a co-ordination office in the district as an advice and support centre for older people, their relatives and their professional helpers

If information available: What is the knowledge about project results so far?
All participants, including the elderly patients, accepted the project very well. During the project, the cooperation between social and medical services was significantly improved and a good working atmosphere was established. The project was scientifically evaluated and was proven to improve the quality of life of the elderly patients and delay the need of nursing care.

This project especially showed that the coordination of individual GP care and community support is a very effective means for health promotion among vulnerable groups.
Unfortunately, the project was not sustainable for a longer period due to lack of financial resources. In Germany, financial responsibilities for social services are very fragmented, which has led to the situation where no agency or insurance company feels responsible for the financial support of the integration of services. Public and private sponsors funded the research project, but after this period, no funding was found in spite of the successful implementation and very promising outcomes.

If information available: Which were the most important factors supporting the development and implementation?

The project was an intervention project with accompanying scientific research. There was no support by health policy or health professional organization from the beginning, but during the project time, many services got involved and the project group succeeded in establishing a very good rapport with many health organizations.

If information available: Which were the most important barriers concerning development and implementation?

At the beginning, the recruitment of participating GPs was very difficult for this project. Most were afraid of the additional workload.

One of the central ideas of the project is the integration of care and support for elderly, vulnerable citizen. Within the German Health Care System, the integration of services and sharing of information is often poor, due to the overall structure and financing. Integration of ambulatory and hospital care, sharing of information between GPs and specialists has long been known as a weak point in Germany. The project had to deal with these barriers in the implementation of the model structure and the co-ordination of care.

Which specific aspects of the model would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?

I consider this project as a very significant model for health promotion in primary care because:

- Health promotion is especially important (and possible) for vulnerable groups, who are already in poor health.
- For vulnerable groups, health promotion means often the integration and co-ordination of available resources
- Integration and co-ordination has to involve the community

Especially with a growing part of the elderly population, the maintenance of independence in this age group, the delay of chronic diseases and the improvement of their quality of life must be a high priority in the delivery of health promoting services. This model aims towards precisely these goals and was very successful. It highlighted the autonomy, independence and enabling of the elderly population, an idea which is closely related to the Ottawa Charter.
Publications, reports, self-descriptions


Verbund gesundheitsorientierter Praxen
Cooperation health orientated surgeries

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Who has commissioned the initiative?
There is no official commissioning so far. At the moment, Professor Schüffel is negotiating the financing of the project with a German social health insurance company.

Who has coordinated the initiative?
Professor Schüffel from Marburg, who is supported by two colleagues, Dr. Ursula Brucks and Wulf-Bodo Wahl, coordinates this project.

What is running time of the initiative?
In 1992, a circle of medical doctors and other health professional with interest in salutogenesis inaugurated an annual meeting (Wartburggespräche, Wartburg Talks) to discuss the concept of salutogenesis and develop the implementation of the concept into the health care system. These meetings have led to several publications in the field of salutogenesis and medical care. Participants began to rethink the role of medical professionals in the field of health promotion. It is now planned to use this conceptual thinking to set up a cooperation of health-orientated surgeries within several regions of Hesse.

What is the current state of the initiative?
This initiative is still in the stage of a concept development. Considerable conceptual work and publication has been done over the last 8 years to prepare the participants for this project.
Short description of the initiative model:
Schüffel and his colleagues have highlighted two situations within the health care system, where resources and opportunities for health promotion are wasted:
- There is no systematic support for people to cope with their health problems and take a self-determined and independent part within the patient-doctor relationship.
- There is no systematic support for patient’s needs for self-reflection on their physical, mental and psychosocial condition, which lead to the loss of essential information about the patient. Treatments tend to focus on symptoms rather than on problems. Psychosocial problems are often misinterpreted in the terms of sickness and disease.

In General practice, psychosomatic complaints and psychosocial problems are very prevalent reasons for encounters (about one third). GPs and specialists alike need special communication skills to deal appropriately with these problems and to avoid inadequate and expensive diagnostic procedures and treatments. Many other patients see their GP regularly because of chronic diseases like diabetes or CHD. Studies have proven that these patients benefit significantly from patient training programmes which give them competence and autonomy and reduce costs and subsequent adverse results. These demands emphasize the importance of psychosocial and communicative training (and subsequent competence) of doctors to provide efficient health promoting management and care.

Schüffel and his colleagues highlight the fact that the current German remuneration system does not support adequate consultations for these problems (information, training for self-management, supporting self-responsibility) nor for any other health promoting measures which lead to autonomy and competence of the patients. Neither GPs nor specialists get proper payment for these services; in fact they would even sustain financial losses because of a lower consultation rate.

The overall target of the project is the implementation of a cooperation of GP surgeries and office-based specialists, who orientate their services toward health as a positive concept. All participants would have received a theoretical introduction into the salutogenic approach and focus on the origin of health, the formation of well-being, positive attitude to life and available resources.

A special budget for the participating surgeries will be set up to cover the remuneration (rather a capitation scheme and not fee-for-service) for all delivered services (treatment of sick patients and health promoting activities). All surgeries will receive a budget to prevent any loss of income.

During the first two years (preliminary project), all participants of the project will reshape and reorganize their practice in order to achieve the essential prerequisites for a health-orientated service. They will receive constant support, feedback and supervision by the project management. A continuous teamwork will be established for theoretical assistance and interchange.
The project realization (preliminary project) will happen on three levels:

- Health orientation of the surgery organisation: organisational and administrative demands on the doctor should be reduced to give him/her maximum time for patient care and consultation.

- Health orientation of consultation and management: Available health-promoting resources and capabilities should be emphasized during the consultation. Patients with difficult and complex health and psychosocial problems will receive special attention (a method, developed by Professor Schüffel and colleagues, which is called „epikritische Fallbetrachtung“ and review the history of the patient) in order that they are able to discover new scopes of action and potentials for health and well-being.

- Support of process change: the re-organization and remodelling of the surgery and the delivering of services, as well as significant changes of attitude might cause considerable problems and doubts for the participating doctors. During this phase, a continuous circle for social support and reflection will be established amongst the doctors.

In case of a positive outcome of the preliminary project, cooperation will be set up to implement health orientated medical service for an entire region or at least larger parts of the region. This cooperation will test and develop a model of integrated care within the salutogenic approach.

Preliminary talks with GPs and specialists from different regions, who are willing and prepared to participate, have been taken place so far. The selected regions are very different in their socio-economic structure (Hessisch Lichtenau / Kassel, Kassel city, Marburg, Hofheim/Taunus and Frankfurt city centre), which will increase the reliability of any study result.

A detailed evaluation is planned by means of interventional research to analyse organizational and procedural changes. Main targets are the optimisation of patient management by using all available resources and the satisfaction of doctors and patients. Other outcome parameters under observation will be the extent and quality of the delivered medical service and the preventive, therapeutic and rehabilitative effects of the overall care.

Curbing cost expansion is not a target of this project. In the long-term, a reduced rate of consultation due to higher patient autonomy, competence and satisfaction might lead to financial consolidation of health care expenditures.

Has any systematic project evaluation been conducted on the model/initiative?
No evaluation so far.

If information available: What is the knowledge about project results so far?
No results so far.
Which were the most important factors supporting the development and implementation?

Which were the most important barriers concerning development and implementation?
“The doctors’ very own fear of ambiguity”, quotation by Professor Schüffel

Which specific aspects of the model would you consider especially well-developed or otherwise instructive, and thus relevant for transfer to other EU member states?
I consider this project to be a very significant model for health promotion in primary care because:
- It highlights the effect of the remuneration system and process organization for the implementation of health promoting services in general practice
- It emphasizes the potentials of autonomy, competence and self-management of patients to look after their own health.
- It consistently pursues the salutogenic approach within the health care system.
- It aims toward the integration of care and the positive effects on the health of patients.
- It highlights the positive effects of the doctor’s satisfaction on the care and management of patients.

Publications, reports, self-descriptions:

U. Brucks, W.-B. Wahl, W. Schüffel (2000); "Lernen Sie mit Ihren Patienten!"
MMW-Fortschr. Med 49 Nr. 6 / 2000
Part B: Health Promotion in General Practice in Germany

General overview of the Health Care System

The German Health Care system is predominantly financed through social security insurance. Membership of one of the social health insurance companies (Gesetzliche Krankenversicherung, GKV) is mandatory for all employees (below a certain income), while their spouse and their children under the age of 18 can hold free membership. 90% of all Germans have social health insurance, while the rest of the population are mainly insured by private health insurance companies. Only 0.9% of all Germans have no health insurance at all.

Employees and employers share the financing of social health insurance (GKV). The GKV finances the main part of all expenditure in health care and determines the scope of medical service (Leistungskatalog). This includes prevention, diagnostics, treatment of diseases, maternity service, sick benefits and other benefits, as well as health promotion. Health promotion covers special disease prevention programmes (nutrition counselling, anti-smoking counselling, relaxation), financial support of self-help groups and special provisional spa treatments.

Ambulatory care is provided by General Practitioners and office-based specialist. Patients can be referred to a specialist by their GP, but are also entitled to direct access to a specialist. Patients in Germany are not enlisted in a General Practice as they are in the UK. Even if they tend to see the same GP, there is much more fluctuation in the doctor-patient relationship in Germany than in health care systems with a greater emphasis on primary care. That also means that patients cannot be followed up through the GP surgery.

Doctors are remunerated through a fee-for-service scheme within a global budget for different medical services. General Practitioners have a contract with the Association of Panel Doctors (Kassenärztliche Vereinigung) of their area. These associations receive money from the social health insurances and distribute the money between the doctors of that area every three months. Doctors are remunerated according to the services delivered during that period of time within a certain budget.
Health promotion within the German health care system - Laws, regulations and guidelines

Traditionally, health promotion and prevention has been a main task of the public health service (Öffentlicher Gesundheitsdienst). Under the law of public health service (Gesetz über den öffentlichen Gesundheitsdienst Nordrhein-Westfalen, ÖGDG, Artikel 3, Kapitel 1, §2) Aims and task of the public health service are:
- Protection and promotion of the health of the population.
- Participation in prevention of diseases and information and health education of the population.
Further on (Chapter 2, §7):
- The local public health service has to coordinate planning and translation of health promotion, and prevention and support organizations and groups, working in that area.

In Germany, the public health service is not entitled to be involved in any treatment of patients. Even if recently, more and more health professionals working in the public health service are becoming more interested in health promotion, their influence is very limited, especially because the cooperation between the health care service and the public health service is very poor. The main task of the public health service is still very much restricted to the surveillance and monitoring of transmittable diseases and potential public health hazards. The medical profession and the social health insurance companies share the responsibility for prevention and health promotion through the Reformation of Health Policy Act (Gesundheitsreformgesetz, 1988). Within the increasing competitive market of social health insurance, health promotion became rather a marketing tool, which later (in 1996) had to be restricted.

The 99end National Conference of German Doctors stated:
“...Health promotion is a sensible and indispensible part of medical care. Instead of rejecting any publicly financed health promotion, we recommend to assure the quality, as well as improve and evaluate all health promotion activities. It must be ensured that health promotion fulfills scientific criteria. The expertise of the medical profession is at the disposal to support health promotion and we recommend a legal regulation in which the medical profession and the social health insurance coordinate health promoting measures.”

A new reform of the health care system (Gesundheitsreform 2000) was launched in 2000. The following quotation is from the website of the German Ministry of Health:
“More precaution. Better future. More future-oriented. These are challenges for our health care system. Health promotion, prevention and reduction of health risks is always better than the relief of symptoms later on. And that is modern health policy. In the past, this strategy was sacrificed for a short-sighted cost-cutting policy. We are trying to change this mistake by:
- The extension of health promotion, prevention and rehabilitation
- The support of self-help groups
- The support of your own efforts to promote your health by your social health insurance”
Social health insurances have a vital interest in health promotion and prevention. Several health insurance companies do support pilot projects or run their own projects. For example, health insurance companies run breast cancer screening projects in some areas in Germany or have initiated projects for the prevention of addiction and violence in schools. Some offer financial support for courses like relaxation therapies (Autogenes Training, Muskelentspannung nach Jacobson), physical fitness and exercise groups, losing weight or giving up smoking.

Politically, health promotion is a strong issue in the discussion about the health care system. Politicians, Health Care providers and doctors association expressed their strong commitment for the re-orientation of the health care system towards health promotion. During the 102nd National Conference of German Doctors, a resolution about health promotion was passed:

“...health policy has to provide the essential prerequisites for health promotion, such as:
- The development of a health promoting policy.
- The structuring of health-promoting living conditions.
- The support of health promotion community activities.
- The re-orientation of health care service toward health promotion.

Prevention and screening programmes in Germany

Since 1989, those of the age of 35 years with social health insurance are entitled to a medical check-up every two years for screening of heart, circulation, kidney problems and diabetes. Patients were also screened for obesity, smoking, exercise pattern, stress and appropriate advice are given. The check-up includes:
- Medical history
- Physical examination (especially cardiovascular system)
- Blood pressure, cholesterol, uric acid, creatinine, blood glucose, urine analysis
- ECG (if necessary)
- Health related advice

Women of 25 and older and men of 45 and older are entitled to special cancer screening every year. Regular check-ups for children are also part of the medical cover provided by the GKV. These preventive services get rewarded outside the general budget, which makes them, especially in times of a very tight budget, financially very attractive. In spite of the strong financial incentives for preventive services for doctors (vaccination and screening are well paid by fee-for-service on a fixed rate and do not count for the overall budget), the overall participation rates in screening and check-up programmes are moderate with lower participation rates among patients of low socio-economic status. In the German National Health Interview and Examination Survey 1998, respondents were asked for their individual participation in health check-ups, health-related medical advice and health promotion measures. The utilization rates differed significantly according to age, gender, social status and health insurance type.
Specific situation and organization of General Practice in Germany

Germany, one of the nations with the highest health care expenditure per capita, has a rather weak orientation towards primary health care. Entrepreneurial-orientated private surgeries, fee-for-service reimbursement and a strong alignment with the technical potential of medicine are important characteristics of the German health care system. Most of the German GPs work still in a single-handed surgery. General practitioners in Germany compete with office-based specialists in the outpatient sector. Communication between the GPs, the specialists, the hospital-based doctors and the community is often poor.

Because of the wide availability of office-based specialists, General practitioners have lost many areas of treatment and medical care. Antenatal and gynaecological care is nowadays rarely provided through General Practice in Germany, because there are many office-based gynaecologists who offer these services. As a result, only a very few General Practitioners have some training in obstetrics and gynaecology because it is rarely required. Especially in urban areas, office-based specialist paediatricians provide paediatric care and very few small children are seen by a GP. This situation might be different in rural areas. Furthermore, many office-based specialists of internal medicine offer their services as a family doctor to their patients, which some patients prefer. This situation shows that General Practice in Germany is difficult to define and to delimit from other areas of medicine. In addition, over recent decades, General Practice has lost credibility. An emphasis on high technological medicine does not support the integral approach of General Practice towards medicine.

Recent health policy in Germany now strongly supports General Practice, especially General Practitioners preventive as well as health promoting activities. General Practice, in turn, claims the main competence in these activities. Even if General Practice is still very much based on the biomedical model of medicine, a psychosocial approach to the care of patient is an important part of General Practice because of the long-lasting relationship with the patient and the insight into their living conditions and family life.

General Practice at Universities and postgraduate training

Nowadays, because of the rising costs and financial strain on the health care system, a stronger orientation towards primary care is seen as a mean of curbing cost expansion. This has lead to some changes in the remuneration system, which is causing a great deal of tension between General Practitioners and office-based specialists. There are also some efforts to improve the training of General Practitioners. Newly qualified doctors, who want to train as GPs, have to complete a 5-years training scheme, with a minimum time in General Medicine, Surgery and at least 18 months in General Practice.

The situation of General Practice within the university setting is still not comparable to other countries like the Netherlands, Scandinavian countries or the UK. Out of 36 Medical Schools, only 3 have a full professor of General Practice, in many universities teaching in General Practice is provided by associate professors or local General Practitioners with some teaching experience. Within the academic training, prevention and health
promotion is a very minor issue. These subjects are, if any, only presented to students by the departments of General Practice or Social Medicine.

Health promotion in student and postgraduate training

Subjects and Aims of postgraduate training in General Practice, according to the regulation of postgraduate training for General Practice⁹ (Weiterbildungsordnung der Ärztekammer Nordrhein, 30.04.1999) are:
- Consultation about health, screening of health problems, prevention including vaccination strategies,
- Integration of health-promoting activities within the community as well as exposing and monitoring of environmental or occupational health hazards.

The theoretical postgraduate training, which is mandatory for all trainees, includes an 8 hours course about prevention, health promotion and cooperation. Apart from that, no further structured training is included in the 5-years training scheme.

General Practice and Health Promotion

The German Doctor’s Association (Bundesärztekammer) has developed a curriculum¹⁰ for medical health promotion, in which individual health counselling is highlighted as the main health-promoting activity provided by the doctor. This reflects the situation of health promotion in General Practice in Germany in which the service is provided to an individual, while the engagement of doctors on a community level is often poor.

The German Doctor’s Association has also given a statement of health promotion¹¹ as a task of the medical profession (1993).

"...Health promotion is the basis of any patient’s care. Effective and efficient treatment and rehabilitation is only possible through constant observation of the individual life-styles and living conditions of patients. Especially the current challenges of the health care system and society require new ideas and ways of action with a strong approach towards health promotion far beyond curative care."

Within this statement, a three step scheme of medical health promotion was presented:
1. Individual consultation
   e. g. Information, advice and motivation concerning a health-promoting life-style.
2. Group work with persons at risk
   e. g. planing, instruction and supervision of group work, support of self-help groups.
3. Cooperation with public health programmes
   e. g. working on a public level (often within the community) on behalf of health interests of the population.
The German doctors association (Bundesärztekammer) has published a health policy paper (Gesundheitspolitisches Programm der deutschen Ärzteschaft) in which they express:

“The strengthening of the individual's capability to maintain health and to cope with health problems is one of the main focus of health promotion. The consultation is the centre of any health promotion, because it supports the competence of a patient for a health-promoting life-style in giving information about health risks, in changing attitudes towards health promotion as a way of life and in supporting behavioural change.”

In 1995, the German Doctor's Association Bundesärztekammer) and the Association of Sickness Fund Doctors (Kassenärztliche Bundesvereinigung) started a project called “Ärztliche Präventionswoche; Medical prevention week”. The main focus was smoking, nutrition and vaccination. The acceptance amongst doctors was high. A similar project was repeated in 1998 which focused on health promotion for children and adolescents.

General Practitioners have been questioned by the Society of Panel Doctors of Bavaria about the status, deficiencies and the future focus of prevention. Preventive care plays an important part in General practice. However, doctors think that the status of prevention still has a lower importance, because of unsatisfactory remuneration, lack of further education and inadequate time for appropriate consultation. Doctors expressed the desire that the medical self/administration offered more education about preventive medicine, especially about nutrition, withdrawal from smoking and protection from infection.

The main focus of health promotion in General Practice is the individual health counselling of patients. Since 1989, patients over the age of 35 years are entitled for a regular check-up every two years which include health-promoting advice for areas like weight loss, smoking, coping with stress and regular exercise. Many General Practitioners in Germany give regular health advice to their patients and are doubtless the first and most important partners of patients in any questions concerning their health. In this context, health is an important issue in the consultation. Especially in a familiar and friendly relationship between a patient and his or her family doctor, very efficient and active health promotion can take place, by talking about a healthy life-style and possible risk factors considering the individual situation and living condition of the patient.

Many General Practitioners in Germany offer special services to patients at risk. They use behaviour modification and cognition therapy techniques for obese patients and smokers. Many General Practitioners also run groups for patients who suffer from diabetes mellitus or hypertension, where they present information about life-style, exercise and nutrition to them. Training materials for doctors, practice nurses and patients (brochures, information boards, etc.) for hypertension and diabetes have been developed by the Association of Panel Doctors (Zentralinstitut für kassenärztliche Versorgung in der BRD, Projektbüro für Schulungsprogramme) and are available throughout Germany.

Some Associations of Panel Doctors (Kassenärztliche Vereinigung, KV) have organized special projects to improve the care of high-risk patients. For example, the KV Mecklenburg-Vorpommern runs a model project of
Structured training and care of patients with hypertension. Similar projects take place for patients with diabetes. Some doctor’s associations offer special contracts to their general practitioners for high quality care of diabetic patients. These GPs receive special training in diabetes and have to monitor and treat (and refer) their diabetic patients according to a fixed scheme to ensure good quality care. GPs are paid separately for every patient. This scheme is funded from a separate budget.

Overall, health promotion within the setting of General Practice focuses very much on individual counselling and on risk modification. Special programmes are available to reduce the risk and improve the care of vulnerable groups, such as patients with hypertension and diabetes. Apart from a few projects, the cooperation between General Practice and the community is rather poor, partly due to the structure of the German health system with privately-owned single surgeries. In spite of these situations, there are some General Practitioners who have crossed these boarders and have very successfully initiated health promotion activities within the community. Within the last few years, the definition of health promotion (in health policy statements) has shifted from prevention towards health as a positive integral concept, according to the Ottawa Charter. It probably needs more time to implement this new approach of health promotion into the German health care system.
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