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Titel

„Two professions in two different health systems in the focus – or can the work of a School Physician be done by a School Nurse?“

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Abstract

Two health-care professions in two different health care systems, which couldn't be more different from each other- Austria and the United Kingdom. Can the health care system in Austria be modified in the long-term in a way that a School Nurse takes over what is currently done by a School Physician?

In the focus of interest in this thesis is whether the field of activity of an Austrian School Physician and a School Nurse in the United Kingdom can be considered as equal and therefore gives room for further, careful considerations regarding the broadening of the nursing profession in Austria.

As a result a significant difference in the educational pathway for both professions as well as their different scope of activities can be identified. Summing up, both job profiles have their eligibility; the job profile of a School Nurse in the United Kingdom seems to efficiently do justice to modern public health needs though.

Kurzzusammenfassung

Zwei Gesundheitsberufe in zwei verschiedenen Gesundheitssystemen, die nicht unterschiedlicher sein könnten- Österreich und das Vereinigte Königreich. Kann die Arbeit eines/r Schularztes/ärztin zukünftig von einer/m Schulkrankenschwester/pfleger getan werden? Fokus dieser Diplomarbeit ist es einen Vergleich zwischen zwei Berufsbildern; dem/der Schularzt/ärztin in Österreich und der/m Schulkrankenschwester/pfleger im Vereinigten Königreich, anzustellen.

Signifikantes Ergebnis der Recherche ist der große Unterschied des Ausbildungsweges für beide Professionen; ebenso unterscheidet sich der Tätigkeitsbereich deutlich. Zusammenfassend kann gesagt werden, dass beide Professionen ihre Berechtigung zu haben scheinen; jedoch nähert sich die Rolle der/s Schulkrankenschwester/pfleger eindeutig mehr an die Anforderungen, die Public Health- Strategien an ein Gesundheitssystem haben, an.

Statement

This thesis is written under consideration of linguistic leveling of gender. The term School Physician (Schularzt) and School Nurse (Schulkrankenschwester) shall be used due to its appearance in international literature, and is supposed to address to women and men equally.

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A Introduction

1 Problem

Health systems are ready for reform. Widespread diseases are caused by excess nutrition, smoking, a contaminative environment, unhealthy housing conditions, a lack of physical activity or poor nutrition...; these are only the big issues, modern societies are confronted with.

The starting point of this work has been given from my interest in public health promotion with a focus on children and children's health. Since I have started to be active in sports myself, I have realized how much this activity contributes to a healthy growing up, mainly taking preventive action for later on in life. Due to the fact that I have been working many years with children in sports, schools and other communities; I feel driven to contribute to the discussion in regards to health promotion for the youngest in our society.

Thanks to a high level of cultivation, people know about the risks, they also know about the consequences of their action, but they still tend to do what obviously can harm them. Some are convinced that the only strategy which might have a positive impact on this behavior, is a system that rewards a healthy lifestyle. But until any kind of action will be implemented, politics and health specialists have to be initiative and focus on preventative measurements.

To compare the health care system of one country with one of another country shall support the insight and awareness about different roles, tasks and consequences in diverse systems. The information that can be gathered shall be beneficial for new strategies and implementations in order to improve an existing system. To be considered has the fact that there are a variety of factors that can have a positive or negative impact on implementations, due to social, cultural or historical factors.

In other words; what is working well in one country doesn’t not necessarily work well in another country.

The keyword in this context is definitely **health promotion** and **prevention**. Prevention can most effectively put into practice when it is done at an early stage. This is a fact which determines at the same time the target group, prevention has to aim at; that is to say: **children**. It goes without saying that the place where children are easily met and can be worked with, is: **schools**.

At schools, children spend usually five days a week for at least four to five hours a day. A fact that has to be taken advantage of, as using this huge amount of time can help to have a positive impact on the children's lifestyle.

As the setting is defined where to work with the target group in order to take initiatives that will bring long-term benefits; it also has to be clarified who takes over the responsibility of delivering health and health promotion.

This thesis aims at continuing the question about the efficacy of the position of the School Physician in relation to a modern public health approach. It takes into account another perspective, that is to say the position of the School Nurse in the United Kingdom whose scope of tasks seems to exceed the ones of an Austrian School Physician impressively at first glance. By comparing the field of activity of two professions that are dedicated to the same target group and its maintenance of a healthy lifestyle, the question of research shall be answered.

1.2 Purpose/ question of research

If we assume that the knowledge and expertise of a School Nurse is sufficient and therefore he or she can substitute a School Physician in his daily work; this assumption goes along with the fact that we consider both professions to be able to equally contribute to health promotion for children. Both professions operate within the same setting and can be an integral element of children's school life. Can the nursing profession in Austria be reformed in a way that new job positions in schools will be created, as it is common in the United Kingdom? Is it possible to transform the Austrian law in order to make this happen?

The question of research "*Can the work of a School Physician be done by a School Nurse?"* shall be present throughout all chapters.

By focusing on the organisation of both health care systems, the positions of both professions within the system shall be identified. Which role do the School Physician and the School Nurse play in the health care system and how did the professions develop over the years? What is their contribution in regards to health promotion and maintenance of a healthy lifestyle of their pupils? How is the relationship between the pupils and the School Physician, the School Nurse and their pupils; how close and frequent their contact? In the focus of interest shall also be the legal embedment and in the following the requirements that have to be fulfilled in order to be able to perform well in the job. What educational path has to be undergone before being able to work in the setting of school in public health promotion?

If these questions bring along answers that implement a significant matching between the position of a School Physician and a School Nurse, the question needs to be raised whether it might be possible that School Nurses will substitute School Physicians one day in Austria. Of course one has to be aware of the fact that this represents a complicated topic, as the role of a School Physician in Austria has a very long tradition and is highly respected. As a student of science of nursing without any nursing background, I have a different approach to science of nursing and I am of the opinion that reform of the profession of nursing is overdue.

This thesis shall represent an attempt to find out, whether this reforms can start with implementing the role of a School Nurse, deduced from the example in the United Kingdom, also in Austrian schools in future times, as a completely new approach towards public health and public health promotion. English as a writing language was chosen, as this topic represents a challenge to modern societies in Europe and shall therefore be addressed in English. In addition it thereby is accessible to a broader audience.

1.3 Methods

1.3.1 Literature review

Primarily it was decided to focus on literature on public health promotion in general, in order to point out the importance health promotion takes over in specific communities of modern societies. As public health promotion shall just be the rough framework of this thesis, literature review was shortened.

To be followed was the literature review on the organisation of the health care system in Austria as well as in the United Kingdom, to understand their structure better and also the health care professions who are responsible for public health promotion among children. Additionally it was in the focus of interest to review all available literature in regards to the profession of a School Physician as well as of a School Nurse. Main focus was put on their educational pathway, scope of activity, their cooperation with other partners in the school setting, as well as their involvement in class.

In the following, the systematic approach to review available literature and the research for it shall be described:

- The internet was considerated to be the best possible option to access all databases of universitary libraries and therefore it was searched in the OPAC (database of the University of Vienna and its institutions) as well as in the VAN SWIETEN BLOG (database of the Medical University of Vienna) for following keywords:
  - public health promotion *or* health promotion *or* public health promotion for children;
  - health care system of Austria *or* health care system in the United Kingdom *or* organisation of the health care system of Austria *or* organisation of the health care system in the United Kingdom;
  - school Physician *or* Schularzt *or* activities of a School Physician *or* Tätigkeitsfeld eines Schularztes *or* School Physician in Austria *or* Schularzt in Österreich *or* education of a School Physician *or* Ausbildung Schularzt;
  - school nurse *or* activities of school nurse *or* education of a School Nurse;
  - health risks for children and young people *or* health risks;
  - school *or* school setting *or* health promotion in the setting of school *or* health promotion in schools;

- Literature review was done by searching in separate databases like PubMed, Google Books, ProQuest, Österreichische Dissertationsdatenbank and Google by using the above mentioned keywords
- Literature review was performed by searching on the web pages of notable international development organizations like WHO, UNICEF, World Bank
- Literature review was performed by searching on the web pages of the ministries of health of the respective countries, and other web pages of national agencies like the NHS for the United Kingdom and the Ärztekammer or Fond Gesundes Österreich for Austria

Direct contact was searched for with experts from *Ärztlicher Dienst der Stadt Graz*, *Donau Universität Krems* or *Coordinator Schulärztlicher Dienst Wien* who conduct either research or work within the field of interest in regards to the School Physician in Austria.

The intention to find as many publications as possible and then after exclude after the only criteria of being most recently published, could not be realized as the amount of available sources was rather meagre.

This is why the references and sources that have been chosen are a mix of scientific papers, reports of several organizations or agencies, as well as discussion papers of conferences or meetings and books.

1.3.2 Comparison of professions

What was selected as being a suitable reference was carefully examined in the following in order to form categories that would later on give the possibility to finally compare the profession of a School Physician in Austria with a School Nurse in the United Kingdom. To gain a clear and detailed picture of both professions, following topics are in the centre of interest:

1) To understand the scope of activity a School Physician or a School Nurse is performing in, the *educational pathway* has to be understood equally.
2) The *scope of activity* needs to be scrutinized in order to get a clear picture about the dedication of the profession- is it dedicated to mainly provide medical services or are more tasks involved?
3) The question arises whether the definition of their *role* is clear to a School Physician or a School Nurse and is well identified?
4) The setting of schools consists of a variety of different players. The *cooperation* between the School Physician and the School Nurse with other partners is in the focus of interest. Who are these partners?
5) *Involvement* in *class education* can represent a valuable contribution to public health promotion.

1.3.3 Design and structure

The paper shall be considered as theoretical study which is structured in two main parts. Part A consists of 5 chapters and shall give an insight into the health care system of Austria and the United Kingdom, its major structure and characteristics. As far as the health care system of Austria is concerned there shall be a focus on the school system and the maintenance of health at school ("*Schulgesundheitspflege*").

Embracing 7 chapters, part B focuses in depth on the two health care professions in both countries. Their legal embedment, their educational pathway, their satisfaction within the job, as well as the interaction and cooperation with other individuals in the setting of school shall be addressed to. In addition the biggest health risks for children and adolescents shall be identified and in the following it shall be questioned, if and in what way the School Physician assesses theses risks and how he or she addresses to them.

Bringing the topic down, the information gathered together shall be debated within the discussion; followed by a short conclusion and German summary.

1.4 Expected results

As diverse as the Austrian health care system and the health care system in the United Kingdom might be in regards to their organisation and their structure; both roles- physicians and nurses who have their work place in schools have one common target: to maintain a good health condition of pupils as well as to protect them within the environment of school. What is expected by doing research in the field of the position of a School Physician and a School Nurse is that both roles have an equal intention; to promote health in the setting of school and to provide medical services by various tasks. Therefor I expect the field of activity and their services to be very similar.

It can be assumed that both professions have a long tradition and are equally eligible to be authorized with one of the most important responsibilities within the health care system: to promote health among the youngest in our societies.

Differentiation can be expected in the training of a School Physician and a School Nurse, either initial training which entitles both professions to perform, or training on ongoing basis. This personal expectation is founded on the fact that there is a huge gap in between the education of nursing and the education of becoming a physician in Austria. Both educational pathways are hard and long, but differ strongly from each other.

Differences are also assumed in the contact with the pupils from both professions. How much time does a School Physician spend in the school- is he/she performing in line with a full time position; how does this work for School Nurses in the United Kingdom? How much time do both professions actually really spend effectively with the pupils? From my personal experience with a School Physician as a pupil; I am personally convinced that School Nurses most probably have a much closer contact to their pupils; as I hardly ever had contact with the School Physician in my school career.

In connection to the question of the frequency of contact to the pupils is also the question whether a School Physician or a School Nurse is representing an integral part of the curriculum of the pupils, which means in other words: does he or she teach? And if so, what subjects? From previous browsing through literature it is obvious that a School Nurse in the United Kingdom does; but as far as the Austrian School Physicians are concerned, no answer has been found yet. This question shall be complied with in this thesis.

Last but not least, the satisfaction from the School Physician and School Nurse' side is from great interest for this work. Hardly anything is known about their self-assessment; do they believe that their work is beneficial? What brings satisfaction, what frustration? Where is space to improve which tasks or conditions? In my opinion this shall be in the focus, as only happy professions, who see a sense and appreciate what they do; perform well and bring benefit to the target group. In connection to this question, the expected result is quite porous; therefore it needs in-depth clarification.

However the outcome of all these questions might be; it will give further insight in the operational field of two professions in two different health care systems who carry heavy stocks, as both are responsible to arrange and maintain a healthy environment for pupils in cooperation with teachers, school staff, parents and of course pupils. Furthermore they have to also provide medical services and observe predominant diseases. Not to forget their important role in health promotion and prevention.

1.5 Status quo & sources

On first sight the position of the School Physician in Austria seems to be a very up-to date topic nowadays, which was brought up only recently. On the one hand it has strong supporters, who are convinced that the work of the School Physician is essential and cannot be done by anyone else. On the other hand, criticism from public health experts is coming up. If one has a closer look though, it becomes obvious that critical voices were becoming louder already many years ago. Whereas in former times the School Physician was seen as an integral part in schools who was mainly dedicated to hygienic tasks and medical check-ups, the question was raised in the late fifties whether the tasks performed would make sense.

Neither before the fifties nor after was Austria characterized by a unitary and standardized school health system. There might be a general legal embedment at federal level in regards to the scope and the structure of the service of a School Physician, but in fact this law is realised differently by all federal states. Indeed, it depends on the type of school that determines the responsible authority.

In the *Schulorganisationsgesetz* from 1962 designations concerning the Austrian school system, the type of schools which are responsible in the following for the scope of activity and tasks performed by the School Physician. Furthermore the *Schulpflichtgesetz* determines school visits by pupils, pupils readiness for school, but also the inability to visit school.

This pictures clearly the variety of laws concerning the Austrian school system and mainly the service of the School Physician, but also it represents the diversity of authorities responsible for structure and organisation of the services by School Physicians.

Interestingly to mention is also the fact that additionally competences on a federal level were also split; not only was the ministry of health and women in charge of, but also the ministry for education, science and culture.

As far as documentation is concerned, a similar picture becomes apparent. Not too much information is accessible; in 1980 until the year 1995, all results of the medical examination of specific and beforehand determined age-groups of pupils would be entered on a so-called health paper and forwarded to a statistical institution. Out of the blue, and due to unknown reasons, this standardized analysis was cancelled and fundamental work and epidemiological data was lost. Today electronic documentation is not obliged to be part of the service of a School Physician; in general there is no standardization.

To sum it up; the position of the Austrian School Physician is characterized by a long and strong tradition and mainly a high diversity in the legal embedment. It is neither determined what a School Physician has to be trained in before performing in schools, neither is there broad knowledge about the actual scope of activity of a School Physician. What is definitely unknown is how School Physicians actually feel in their position, if they are satisfied with what they do and if in their opinion they bring a long-term benefit to the health condition of their pupils.

Due to a very limited number of existing, actual sources, it was necessary to revert to several sources. In order to provide better readability the sources shall be divided into two parts; one referring to the Austrian sources, the other on the English’.

The number of actual publications is quite straightforward for both countries. In the following the very frequently quoted publications shall be written by Haupt (1963), Gamper (2002), Weber (2005), Kogler (2007), Dür (1998, 2008), Gartlehner and Kaminski (2009), Ball and Pike (2009), Fendt (2010); whereas, as already mentioned, publications by ministries, universities, the National Health System (NHS) and the World Health Organization (WHO) played an important role within this work.

1.5.1 Literature concerning Austria

As far as the description of the scope of activity of a School Physician is concerned, the contemporary literature proved to be quite poor. Sporadically books appear in the databanks of various libraries whose authors had more or less the same intention: to picture the position and field of activity of School Physicians. In 1963, Haupt (see Haupt, 1963) wrote about the problems and challenges within the scope of activities of the physicians operating in schools. Basis for information about the Austrian School Physician on an operational level formed a questionnaire from 1998, conducted by Wolfgang Dür from the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie* (since 2008 named as *Ludwig Boltzmann Institut Health Promotion and Research*) Publications concerning the health care system was challenging in a way that it was simply too numerous and voluminous in order to be able to include all these publications within this work. The web pages of the ministry of health in Austria (see Ministerium für Gesundheit, 2011) (with all its connected agencies as for instance the social insurance institution) formed a good foundation in regards to information about the health care system and its organisation.

1.5.2 Literature concerning the United Kingdom

The profession of the School Nurse in the United Kingdom can be traced back to decades that have passed long ago. As old as the profession itself, is also the literature that can be found when performing research in libraries. In consideration of this fact as well as the numerous amounts of publications that one is confronted with; the selection of publication was carried out in dependence of the authors' professional competency.

Due to this fact, the selection of publications was carried out in dependence of the authors' professional competency and the information provided. Surprisingly most of the relevant information could be found at training posts, as the Royal College of Nursing. On behalf of this well-known college, *employment.ltd* conducted a study among School Nurses in the United Kingdom in 2005. (see Ball and Pike, 2005) By questioning the School Nurses in detail, the study was dedicated to the comprehensive understanding of the role of School Nurses in the United Kingdom.

As far as the health care system is concerned, the most up-to date information could be gained from the webpage of the department of health (see department of health, 2011), as well as from the webpage of the NHS (see national health system, 2011) and many more related agencies, as for instance the NHS direct.

1.5.3 Main sources

Within his dissertation in 1963, Martin Haupt gave a clear picture about the problems and challenges which School Physicians had to face at that time already. Due to its focus on the years before the 18th century, it cannot be considered as contemporary work, but interestingly to mention at this point is that there can be certain analogies identified between the challenges of former times as well as from today.

Within her medical-historic work, Martina Gamper works up on the development of the School Physician in Austria and provides a in-depth foundational work for future research. In her publication the transformation of the School Physician; who was dedicated to hygienic inspections within schools and who was mainly responsible for hygienic conditions in school buildings; to the School Physician who was dedicated to the well-being of his/her pupils; is clearly depicted.

Gudrun Weber, an Austrian physician, published in 2005 a book in which she summarizes together with other experts from different disciplines an abridgment of the various domains the work of a School Physician is anchored in. This broad work embraces the legal foundation of School Physicians, dental hygiene, nutrition, infectious diseases and many more topics. In regards to the role of the School Physician, very little is described and the book can be seen more a guideline than an actual snap shot of the field of activity of School Physicians in Austria.

Kathrine Elisabeth Kogler dedicated her dissertation to the historical follow-up of the debate of physicians' tasks in schools and the growing governmental responsibility to care for health promotion in schools. Kogler follows the various congresses and scientific discussion boards and eases the understanding of medical infrastructure, the introduction of medical professionals in schools as well as the big variety of legislation that resulted of a very diverse development within different regions.

In 1998, Wolfgang Dür, sociologist within the *Ludwig Boltzmann Institut für Medizinsoziologie* intended to define the position of the School Physician in order to highlight the spectrum of tasks which were performed by the School Physician. In the focus of interest was furthermore the cooperation between not only School Physicians and pupils, but also between School Physicians and teachers, as well as between School Physicians and parents. A significant amount of teachers, school directors and School Physicians has been questioned in order to receive perspectives and opinions from their side; followed by a workshop with selected participants to further develop outcomes of the survey. Since then, no further research of the same volume has been conducted and this publication turned out to be very supportive in picturing the operational field as well as the self-assessment of Austrian School Physicians.

The importance of empowerment in health related topics for those who have very limited possibilities to design circumstances of life; is discussed in Wolfgang Dür's book in 2008. This essential work which is dedicated to health promotion in schools strongly supports empowerment as the concept to reach the ability to improve social living environments. Some might be of the opinion that empowerment is connected to demoralization. Dür understands it as a service from schools which has to be taken as granted.

Gartlehner and Kaminski; two physicians who are working for the department for evidence-based medicine at the Danube University; add fuel to the issues around the School Physician when they published their paper that was questioning whether the screening measurements performed by School Physicians nowadays would bring the expected benefit. The outcome of their work was that many off the performed interventions were neither beneficial, nor harmful. The results were addressed by various journals and even the print media picked it up, but again very soon the interest was damped.

The Royal College of Nursing in the United Kingdom is very well known and has an excellent reputation among professionals in the field of medicine and nursing. The College is also known for its consistent interest in School Nurses and nurses' fields of activity. In 2005 the College instructed Jane Ball and Geoff Pike to conduct a survey among numerous School Nurses in order to identify their self-assessment, their satisfaction and frustration within the job as well as their personal opinion whether their job would be beneficial to the pupils or not. This publication turned out to be essential for this thesis as it provides a very deep insight into the daily life of School Nurses in the United Kingdom.

Christian Fendt provides important basic information in regards to the development of the Austrian health care system as well it organisation and structure. Together with publications of the ministry of health a good foundation was given in order to identify the main characteristics of the system, public health strategies and their implementations as well as prevention programs.

2 When is health care system a good health care system?

What most of the systems have in common, is the fact that all their Departments of Health traditionally focus on how to manage illness rather than focusing on achieving health. In the late 70ies it was the *Alma-Ata Declaration*, which for the very first time highlighted health promotion and primary health care as an inevitable step towards modern thinking.[1]

In the Alma-Ata Declaration, the World Health Organization states: “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close to where people live and work, and constitutes the first element of a continuous health care process.” (Declaration of Alma-Ata, WHO, 1978, p.1)

Public Health became more than only a byword and governments started to be aware of the fact, that primary health care as its most important method is the only way to guarantee functional health care systems in the long-term. (see Gillies, 2003)

Traditionally health has been considered as the absence of disease. A modern, medical view has now taken over which sees health care as the treatment and increasingly preventing disease. In general, health is being considered to be more positive and in a holistic sense. (see Gillies, 2003)

[1] For further information follow: Alma Ata declaration

There are plenty of different health care systems in different nations worldwide, but they have something in common: they are defined as a collection of encounters between individuals. The interaction happens between a patient, client, or care recipient and a professional or a care -giver. (see Gillies, 2003)

Each position brings with him\her, his\her own perspective and individual needs which makes the whole process very complex.

As all systems share also the fact that their resources are coming to an end, prioritization has to be made, and focus on certain target groups has to be put on. Only few politicians are ready to speak about the rationing of healthcare, but are certainly aware of the fact that making decisions as well as facing challenges, is due.

2.1 Healthcare

In the Alma-Ata Declaration from 1978, the World Health Organisation describes primary health care as following: (Declaration of Alma-Ata, WHO, 1978, p.2)

- "reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities, and is based on the application of the relevant results of social, biomedical and health services research and Public Health experience" (Declaration of Alma-Ata, WHO, 1978, p.2)
- "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly" (Declaration of Alma-Ata, WHO, 1978, p.2)
- "includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promoting of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child healthcare, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs."[2] (Declaration of Alma-Ata, WHO, 1978, p.2)

On first sight, some of the above mentioned topics let us easily connect them to developing countries and it might be correct that most of the listed objectives are not yet implemented there, but overall they can still be seen as necessities which have to be implemented in Europe and beyond its borders. Promoting health and a healthy overall lifestyle as well as focus on preventing diseases and illness will always be a win-win situation for all parties involved. (see Gillies, 2003)

Financial resources will be saved by preventing diseases rather than by treating them and also for each person it has an overall benefit to stay healthy as long as possible than to sicken and recover afterwards. (see Gillies, 2003)

[2] For further information follow: Alma Ata declaration

Theoretically this seems to be very logical and self-evident, but there are two main factors which allegorize an obstacle: (see Gillies, 2003)

- **separate budget**

Costs for primary care are often sidelined by savings in secondary care and the budget for promotion is kept separately from primary care. (see Gillies, 2003) A very good example is prescribing medication for asthma patients. Some inhalers which are proven to be highly efficient are rather not prescribed easily as the costs are relatively high. Compared to the costs, that would come up when facing an emergency situation in relation with the disease; the costs of prescribing more expensive medication are lower in the long-term.

- **recognition and awareness among the public**

Good work is mostly overseen. What is highly paid attention to is when a system does not work properly. Allocate this fact to a health care system, the quality and availability of care when individuals are ill is a much more visible indicator of quality for the public, thus the voter. (see Gillies, 2003)

2.1.1 Achievements of Public Health

What can be seen as the biggest historical achievements of Public Health in the last century should be mentioned as well: (see Borsoi, Meduni Wien, 2008)

- Vaccination
- Control of infectious diseases
- Safety in the means of transport
- Safety within working environments
- Decrease of the mortality in relation to cardiovascular diseases
- Reduction of maternal and infant mortality
- Safety in the means of food
- Family-planning
- Fluoridation
- Cognition of the danger and threat of tobacco

These achievements are of great importance for the good health conditions we are living under in Europe. A good health care system is helping individuals having easy access to care whenever they need it. A better health care system is setting up actions to prevent the necessity of needing any care and keeping individuals healthy. (see Borsoi, Meduni Wien, 2008)

Times, in which a health care system was responsible to keep individuals simply alive, are not acceptable any longer. Nowadays it can be expected from health care systems to maintain a specific quality of life in the way that care is theoretically provided but basically not needed.

But we do not have to forget that all these achievements can only be reached when its users\customers are acting responsibly regarding to their lifestyle too.

The basic needs of individuals while interacting with the health care system are quickly listed: (see Gillies, 2003)

- Individuals expect from the health care system to keep them healthy as long as possible
- If this is not possible, individuals want the health care system to provide them health care services as best as possible
- Individuals want the health care system to do this as cheap as possible

Connected to these expectations of the population, medicalization has reached such a tremendous level of importance in our health care systems nowadays, which involves the fact that people seem to forget how to treat trivial infections, like a cold or a cough.

We are definitely on the way to extravagate between financial benefit and harm. In the short-term medicalization might be beneficial, as it gives the option of a quick recovery but if considered in the long-term, harm is outweighing. Not only, that unnecessary prescribing of medication represents danger of resistance to specific substances; a fact that simply destroys all their wondrous benefits; but it also pushes the raising inability of patient's self-help.

It is easier for patients to ask the doctor for advice and to swallow some pills, then to basically take preventive measurements and prevent themselves of even being in need to see the doctor, apart from vital and strongly recommended physical examinations as a preventative action.

The source of the problem is a lack of education and knowledge, empowerment as a strategy has to be in the centre of interest. (see Dür, 2008)

2.1.2 Methods of Public Health

Public Health works with four major methods: (see Borsoi, Meduni Wien, 2008)

- Health promotion
- Primary prevention
- Secondary prevention
- Tertiary prevention

Health promotion, as the first method of Public Health has the main significance in this thesis. This is pictured in the following table:

Table 1: Public Health Methods

Method / *Scenario*	Health Promotion	Primary Prevention	Secondary Prevention	Tertiary Prevention
Starting Point	Enhancement of potentials	Risk reduction before disease's onset	In the actual stage of disease	After acute treatment
Health Concept	Comprehensive (bio-psycho-social)	• Comprehensive • Biomedical	Biomedical	Biomedical
Target Group	Social targets (population group)	• Individuals • Population group	Individuals (patients)	Individuals (rehabilitants)
Orientation of activities	Enhancing resources change in environment change of behaviour	• Reduction of risks • Change in environment • Change of behaviour	Curative	• Recurrent-prophylactic • Rehabilitative • Palliative

Source: own illustration based on Borsoi, 2008

Commemorating the title and hypotheses being under examination in this work, and taking a look at the above listed table, it is very easy to identify that *health promotion* is the method to work with regards to prevention at a very early stage.

Each country in the European Union has a health system that differs in a way from others. Two of them will be under strong review, in order to highlight their key factors and to identify the main function within the system responsible for Public Health and *health promotion* aiming at an identified target group.

3 The Austrian Health Care System

Austria is democratic republic, located in the middle of Central Europe. It is separated in nine provinces, with its capital Vienna as one of them. In 1995 Austria joined the European Union and implemented the EURO as its currency in 2002. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The prospect of a long life has never been that promising in Austria like today. “Since the 1970ies the life expectancy has increased by more than 8 years whereas infant mortality has decreased by more than 75%”. (The Austrian Health Care System, Bundesministerium f. Gesundheit, 2010, p.2)

The challenge of an aging population is confronting Austria as many other industrialized countries. In 2008 a 60-year old man had approximately still 21.3 years to live, while a 60-year old woman would very probably live still for 25.1 years. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Austria is known to have one of the most generous and well-working social security services.[3] The density of physicians shall be pointed out with the remarkable number of 5 physicians (including dentists) were counted per 1 000 inhabitants. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

[3] For further information follow: Bundesministerium für Gesundheit

3.1 Organization

Austria is a state that consists of nine federal states with their own political structures and competences. (see Fendt, 2010) Besides the federation and the federal states, also the communities are representing independent organisations that are involved in decisions concerning the health care system. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The key players in the Austrian health care system at federal level are the Austrian Parliament, the Federal Ministry of Health (*Bundesministerium für Gesundheit*), the Federal Ministry of Labour, Social Affairs and other social-security institutions. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The Federal Ministry of Health is responsible to enact legislation and ensure the health of the public and furthermore represents the authority and decision maker between all parties involved into the health care system. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Health services are provided by federal authorities, whereas provinces are responsible for *health promotion* and prevention services. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

It is the state that is delegating specific competences within health care politics to insurance communities. The legal social insurance institution and the association of the Austrian social insurance institutions play a very important role within the system and form an organised public mains supply. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Competences are within the federation in regards to most of the areas of health policy. Whereas the federation is taking over basic legislation, the completion is taken over by the different federal states. One of the major problems, the Austrian health care system has to fight with, is the overlap of the competences; a fact which makes the system very hard to be properly organised. (see Fendt, 2010)

At federal level the major actors are the National Council, the Federal Council, the Ministry of Health and the social insurances. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Primarily the Ministry of Health initiates a legislative proposal, which is examined by several experts in regards to feasibility and then after it is being forwarded to the National Council in order to receive a consensus. (see Fendt, 2010)

The health minister is supported by many experts and organisations. The most important ones in Austria are the "*Oberste Sanitaetsrat*", the "*Fonds Gesundes Österreich*" and the "*Bundesgesundheitsagentur*". These organisations consist of various experts from the area of health planning, financing, care, quality assurance, as well as general medicine. The experts of the "*Obere Sanitaetsrat*" are mostly busy with topics like the "*Mutter-Kind-Pass*" ("mother-child-pass"), vaccination and AIDS; and are selected by the ministry of health for a period of three years. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

As health is such a complex field of policies, also other ministries are involved in any decisions regarding the health care system in Austria. The ministry of finance for instance is responsible among other things for the allocation of budgets for hospitals. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

On regional level politics has a great influence on the implementation and financing of the health care system. Each federal state government of the nine federal states of Austria has its own department dealing with health related topics. Head of each of these departments is always represented by a general physician, who is responsible for delegation. Furthermore each district authority has its own health care department which is regulating health care issues as well it takes over the function of information and assistance centre for the public. (see Fendt, 2010)

Special responsibilities as assistance for HIV-infected persons, advisory service for pregnant women and any kind of information regarding vaccination are taken over by these departments. Each federal state is responsible for the extent and complexity of this informational service which is provided to the citizens. Other key players within the organisational structure on the regional level are the social welfare organisations. They are controlled by the federal states and the communities, while the federation is only responsible for supervision. This is caused by the simple fact, that the federal states have a much better overview about the situations in regards to social welfare and are able to make more efficient decisions. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

3.1.1 Social Insurance

The principle of the Austrian social insurance system is built on a statutory basement. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Kreutzer (2007) defined the Austrian social insurance system as shown in figure 1. (see Kreutzer, 2007)

Figure 1: The Austrian Social Insurance System

Source: Kreutzer, 2007

Health insurance is obligatory in Austria, membership cannot be chosen randomly; it depends on the business/job of the insured person. Furthermore there is also a connection between the insurance and the place of work, or the place of residence. Dependents can be insured without additional costs until the age of 27 in case of secondary education. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

By the transmission of the competences to the social insurances as self-administrative bodies, the federation aimed at the efficiency of the health care system, as they have a

direct interest. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The social insurances are corporate bodies of the public law and are financed by the mandatory contributions. As self-administrative bodies, the social insurances are acting independently and are not dependent from the governmental authorities in any way. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Major contribution to the health care system in regards to health care promotion is done by the fact that the social insurances are taking over the costs for the so-called preventive medical examination, which every person with place of residence in Austria is entitled to undergo once a year, when the age of eighteen years is reached. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

To be highlighted in this case is that even persons who are not insured are granted access to this yearly health check-up. The main guidelines of the Austrian health care system are solidarity, affordability and universality. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Access to the variety of services is assured to everyone who is insured; it is basically a person's right. The main services, provided to insured persons, are: (The Austrian Health Care System, Key Facts, Bundesministerium f. Gesundheit, 2010, p.10, 11)

- Primary health care services provided by contract
- Specialized in-patient and out-patient care
- Emergency care
- Maternity services
- Psychotherapy
- Health technology (X-ray and laboratory tests)
- Physiotherapy, ergo therapy, speech therapy, curative massage, provided by other health professionals than physicians
- Dental services
- Prescription medicines
- Medical devices such as walking aids, wheelchairs or blood glucose strips
- Ambulance services
- Mobile care and home care
- Preventive and health promotion services (vaccinations, screening examinations)
- Rehabilitation and long-term care services
- Care for people with disabilities

3.1.2 Development of the Austrian Health Care System

Before going into detail of the organisation and statistical facts of the Austrian health care system, a short overview of the latest development shall be given at this point.

The Austrian health care system shows a long and diversified history of many different political forms of rules. The basic principle behind all the different models of health care systems is the *Bismarck*-model. The health care system which we know today is the result of very many reformations and adaptations, but as well also the result of social regression. (see Fendt, 2010)

The Austrian health care system underwent a lot of reformations in different periods, but this would go beyond the interest of the subject of this work.

It seems to be reasonable to start with the development during the Second Republic. After the end of the Second World War, Austria and also Germany were discussing about implementing a new health care system. In the centre of interest was the health care system of the United Kingdom and it was thought about to adapt the Austrian one to the, at that time newly founded NHS (National Health System). (see Fendt, 2010)

In 1956 it was however decided to maintain the old system and to keep up the connection between employment and social security. After harmonizing the system for labourers and employees, it was decided to also integrate family members, retirees, unemployed persons and welfare recipients in the social security protection. In 1966, almost 72% of the Austrian population were insured within the social system. (see Fendt, 2010)

Even if the Austrian health care system is not comparable to the health care system of the United Kingdom, the high coverage of insured individuals is a very close approach to it. (see Fendt, 2010)

3.1.3 Health reform 2005

Crucial for the health reform in 2005 was the identification of the major problems of the Austrian health care system. On the one hand, a general, overall objective for all regions and sectors was missing, while on the other hand, a financial plan without the possibility of financial adjustment was representing a challenge for the government. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Two major objectives were drawn up. The first objective was to raise the awareness of the population about cost-intensive, widespread diseases, which could be easy avoided by leading a healthy lifestyle, as coronary diseases, lung cancer or diabetes. (see Fendt, 2010)

The second objective of the reform in 2005, was the closer networking of the stationary and ambulant area in order to co-ordinate, control and finance the health care system in a more efficient and sustainable way. The overall objective was to focus on a very close co-ordination between federation, region and social insurances. (see Fendt, 2010)

So what has been the result of this reform in 2005? Critics literally say that nothing has happened so far; Austrian politics tend to discuss instead of operating. (see Kraßnitzer, 2008)

The quality of the Austrian Health Care System is indisputable. Compared to other countries the expenses are nevertheless much higher. The reason for this ascent of expenses is seen mainly in the high density of hospital beds. Regarding to the OECD 2009, Austria is leading the ranking of hospital beds per inhabitants (6, 1 beds on 1000 inhabitants) within Europe. (see Health at a Glance: Europe 2010, OECD, 2010) Kraßnitzer complains in his article that services may have been transferred to the extramural areas, but without adequate financial resources. Furthermore he criticises the lack of modernisation of the services offered to the patients. Last but not least, Kraßnitzer highlights, that only 0.16% of the gross domestic product is spent in prevention, which in the light of Public Health challenges of today, is far too little.

3.1.4 Main characteristics

One of the most important facts in regards to the Austrian health care system is that free access to almost all forms of medical care is guaranteed to everyone, as well as the opportunity to see the physician of everyone's choice. This means, that physicians have no gate-keeping function in the health system, as in other countries. It has to be considered that some selected health care services may include additional payments, as for instance the prescription fee for medicines, which has been EUR 5 in 2010, as well as a variety of other health services which are not covered by the insurances. This can affect specific dental services, or any service of a physician who has no contract with the social health insurance fund. (see Bundesministerium f. Gesundheit, Key Facts, 2010)

3.1.5 E-Health

E-health has become a fundamental component of the Austrian health care system; any activities related to e-health are known under the name ELGA, which stands for electronic health file, that can be translated as "*elektronischer Gesundheitsakt"*. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

In 2005 the electronic patient card was implemented in order to track patient's history as well as to avoid bureaucratic work.[4] (see Bundesministerium f. Gesundheit, Key Facts, 2010)

[4] For further information follow: ELGA

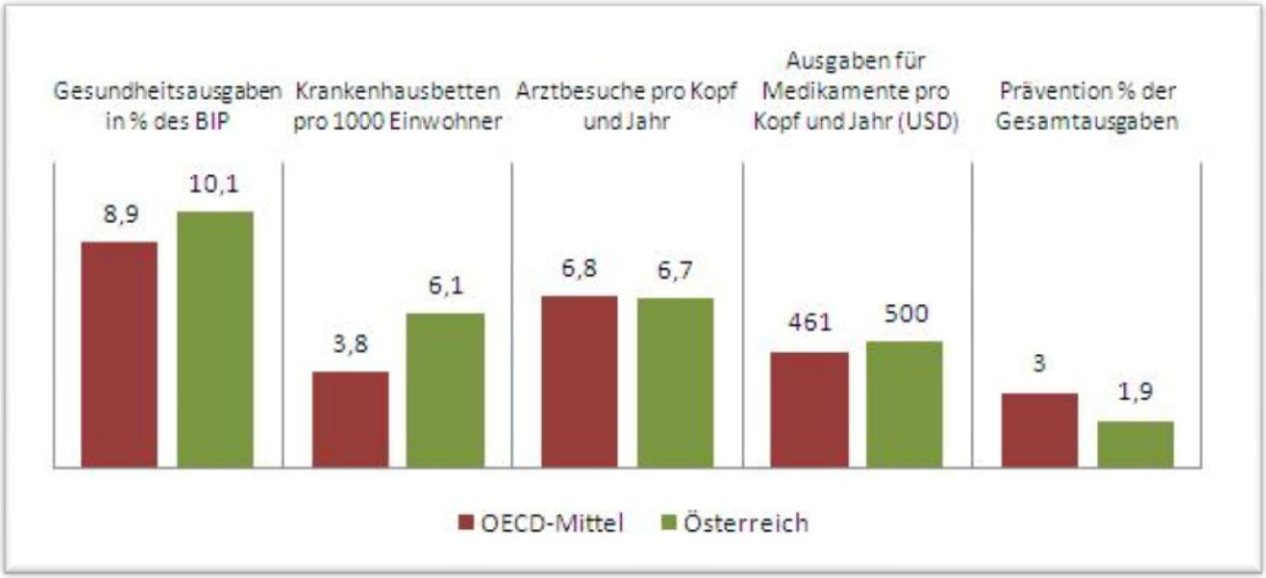
3.2 Health Promotion in Austria

Health promotion in Austria might be very important on paper, but as we all know, “paper is patient”.

In 1990 the expenditures for prevention and public service were 144 million Euros, and it increased steadily until 2008, when 439 million Euros were spent. This seems to be a lot, but when comparing with other countries, Austria only spends 1.9% of the total health expenditures in smoking prevention programs, although it is statistically proven, that Austria is leading the ranking in regards to smoking girls (30%) and boys (24%) in the age of fifteen years. (see Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009) Compared to countries like Finland, Canada, or the Netherlands that is for instance spending 5.1% of its total budget on such kind of programs, it seems rather poor (see Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009), that can be seen in figure 2 and figure 3.

Diagram of the Austrian Health Care System: (see Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009)

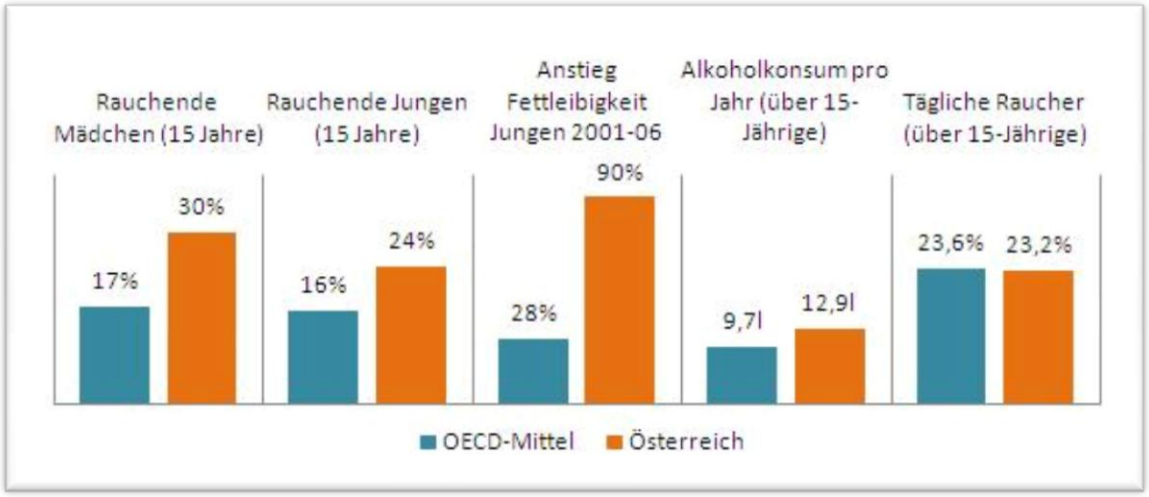
Figure 2: Gesundheitssystem Österreich – Überblick (overview of the Austrian health care system)



Source: Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009

Diagram of the risk-behaviour in Austria: (see Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009)

Figure 3: Risikoverhalten Österreich – Überblick (risk behavior in Austria)



Source: Organisation für wirtschaftliche Zusammenarbeit und Entwicklung, 2009

3.2.1 Examples of prevention programs

- **"Mutter-Kind-Pass" (mother-child-pass)**

One of the most well known prevention programs in Austria is the "*Mutter-Kind-Pass*" (mother-child-pass). (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

Women living in Austria are invited to join this program without any fee; it was implemented in 1974 and is meant to assist mothers already during her pregnancy until the end of the 62nd month of the child's life. In this so called "Mutter-Kind-Pass" all kind of vaccinations of the child are listed, as well as any other medical examination in order to follow up easily later on in life.[5](see Bundeskanzleramt, 2011)

[5] For further information follow: Mutter Kind Pass

- **Vaccination**

Since 1998 defined vaccinations are without any costs for children. Vaccination has been covered since then by the Federal Government, the provinces, or the social insurances. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

- **“Gesundenuntersuchung” (health check)**

Since 1974, the social health insurance fund offers the Austrian population (18 years and older) the so called “Gesundenuntersuchung” (preventive health-check), in order to perform basic medical checkups, like blood-sugar testing etc., but also to detect any illnesses at an early stage, as well as to promote an overall healthy lifestyle. Further preventive measures include also preventive health examination of students at schools; which are under the main focus in this work and on which I will go into more detail later on; the health examination for army recruiters, caries prophylaxis, as well as other initiatives which aim at improving care for chronically ill individuals. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The preventive medical examination was implemented in Austria in the year of 1974 and as the expectancy of life at that time was 75 years for women and 67 years for men, women nowadays live seven years longer and men even eight years. Researchers are of the general opinion that this increase in the expectancy of life is due to the very good reaction from the Austrian population towards the preventive medical examination. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

The effectiveness of the preventive medical examination is also proven in singular diseases. Since the implementation of the smear-examination for women, the so-called PAP-smear, the mortality rate of cervical carcinoma could be decreased for almost fifty percent within the last twenty years. (see Öffentliches Gesundheitsportal Österreich, 2011)

The key aspects of the "*Gesundenuntersuchung*" are mainly dedicated to the early detection and diagnosis as well as the prevention of specific diseases. (see Öffentliches Gesundheitsportal Österreich, 2011)

According to the Öffentliches Gesundheitsportal Österreich (2011) the program embraces the early diagnosis of:

- risk factors for cardiovascular diseases
- risk factors for metabolic diseases
- risk factors for the most frequent carcinoma
- prevention for addictive diseases
- prevention for dental diseases
- prevention for diseases due to great age

By offering the annual preventive medical examination, it was intended to enlighten and inform the public about hygienic risks and to promote further on the importance of preventive measurements. Based on the fact that access to this medical examination is granted to everyone, key players within the Austrian health care system hope to, on the one hand to reduce the risk factors for by taking the right measurements and on the other hand to combat disease through early detection. (see Bundesministerium f. Gesundheit, The Austrian Health Care System, Key Facts, 2010)

4 The British Health Care System

4.1 The British Health Care System before the NHS

Bagott (2004) says that before the NHS (National Health Service), the British health care system was rather disorganised and characterized by the fact that it was a mix of private and public services.

Voluntary hospitals, private general practitioners and other organisations formed together the private sector; whereas the public sector consisted of municipal hospitals and community health services. All other areas of health care, as for instance housing or sanitary health services were regulated by the local governments. Before the NHS was established, general practitioners (GPs) were private physicians who had the right to charge for their services. As these fees could not be paid by the majority of the public, so-called club practice evolved. The more wealthy part of the society subscribed to societies or organisations, which in turn, hired a general practitioner who was paid with the contributions of the society's members. In the end of the nineteenth century this club practice covered almost a third of the working society. (see Fendt, 2010)

At the same time it also marginalized the part of the public who was not in work, which affected mostly children, elderly and women. In 1911 the government implemented another plan for general practice. This plan was called National Insurance Act, which was supposed to assure sick benefits, free GP services and free drugs; but only for the working class. (see Fendt, 2010)

During the Second World War, data was collected that around forty-three percent of the population was covered by the National Health Insurance scheme and it additionally covered almost ninety-percent of all general practitioners. Still the fact that this scheme marginalized unemployed people, children, elderly and women was a great challenge to face. (see Fendt, 2010)

Already after the First World War the British health care system was highly criticised. Health care was completely split into various areas and co-ordination between them was missing. Still, the very vulnerable groups as children and elderly people were excluded from the system and the fees for medical service were constantly rising. (see Fendt, 2010)

4.1.1 The creation of the National Health Service

The crucial factor for the creation of the NHS was certainly the end of the Second World War, when the government saw itself confronted with the urgent need of a comprehensive hospital service. In 1942, William Henry Beveridge suggested to have a comprehensive health care service which would be available to everyone. (see Fendt, 2010)

On 5th of July 1948, it was the health minister Aneurin Bevan who established the NHS. From that moment on, the United Kingdom was the first western state which launched a national Health Care System that offered medical maintenance to the whole population independently from the income of each individual. (see Fendt, 2010)

Already in the fifties it was obvious that the centralization of hospitals brought along synergistic effects within the utilisation of resources. Furthermore an increase of health personal had a great impact on the quality of the medical maintenance in rural areas. (see Fendt, 2010)

In the focus of interest was always the demand-orientated allocation of resources in order to increase quality and efficacy. General practitioners were assessed by the amount of treated patients and also their salaries were dependent to this amount. (see Fendt, 2010)

The NHS underwent several changes and reforms, but the most important one in the history of the NHS is definitely the one induce by Margaret Thatcher who won the election with her Conservative Party in 1979. Even if the reform became effective almost ten years after her election, the major impulse was initiated in the late seventies. (see Fendt, 2010)

Caused by the worldwide oil crisis, Margaret Thatcher initiated reforms that aimed at the more efficient assignment of resources instead of increasing them. Manager from the private sector were employed within the upper management of the NHS and several fields of responsibilities were sourced out of the hospitals. (see Fendt, 2010)

Not only custodial services were passed into private hands, but also food supply and long-term care of elderly and physically impaired people. As the financial resources were short of funds, it was necessary to reduce several services of different areas. Patients, who were not necessarily needed to be taken in, were sent away and also departments of hospitals were temporarily closed and furthermore free positions within the health personnel were not covered again. (see Fendt, 2010)

The committee of experts which was brought into being by Margaret Thatcher advised to stick to the public financing and displace the discussion from the question of financing to the improved allocation of resources within the NHS. (see Fendt, 2010) This discussion resulted in the radical reform of the organisational structure in 1990. With the NHS and Community Care Act the starting shot was given for an internal market for health services. Community hospitals, health care centres and other medical constitutions were modified into so-called *trusts* which were motivated in regards to economic efficiency. (see Fendt, 2010)

The institutions were taken over the role of the sales persons, whereas the governmental authorities were representing the consumers. Thereby it was hoped to create a competitive environment, in order to push the efficiency of services and at the same time decrease the costs. (see Fendt, 2010)

In 1997 the government was taken over by the Labour Party, headed by Tony Blair. Despite the fact that the Labour Party highly criticised the implementation of the internal market for health services, which was initiated by the Conservative Party; it was decided to maintain the system. (see Fendt, 2010)

Major part of the reform under Tony Blair was the establishment of locally operating Primary Care Groups, which were supposed to be responsible for the health care of communities, as well as for all aspects of communal health care policies. In 2002 all Primary Care Groups were modified into Primary Care Trusts which implicated their independent competency for the assignment of the budgets. (see Fendt, 2010)

In 1999 the system still suffered from financial problems. The Labour Party deployed the so-called Modernisation Action Teams, which consisted of medicines, politicians, researchers, as well as patients. The task of these teams was to work out the NHS Plan, which aimed at describing how to use available resources efficiently as well as how to adapt health services adequately to the needs of the patients. (see Fendt, 2010)

In the focus of interest was to improve the general health conditions of the population and to improve the medical services dedicated to specific diseases which claim most of the deaths. The Labour Party was convinced to reach these aims by offering more frequent and easier access to preventive medical examinations. (see Fendt, 2010)

Furthermore a new controlling system was created which was supposed to observe the performance of the several members of the NHS. The ministry of health appointed new parameters and performance goals that were supervised by the Commission for Health Improvement. On the one hand, organisations that met the requirements received in return additional autonomy as well as additional financial resources; on the other hand, those that did not meet the requirements were supported by consultants. (see Fendt, 2010)

To sum it up, the reform under Tony Blair has definitely reached impressive results. Waiting times for surgeries could be decreased, and also the efficacy as well as the quality of medical services could be improved. (see Fendt, 2010)

Nevertheless the system has to fight with a lot of problems that need further changes and re-structuring.

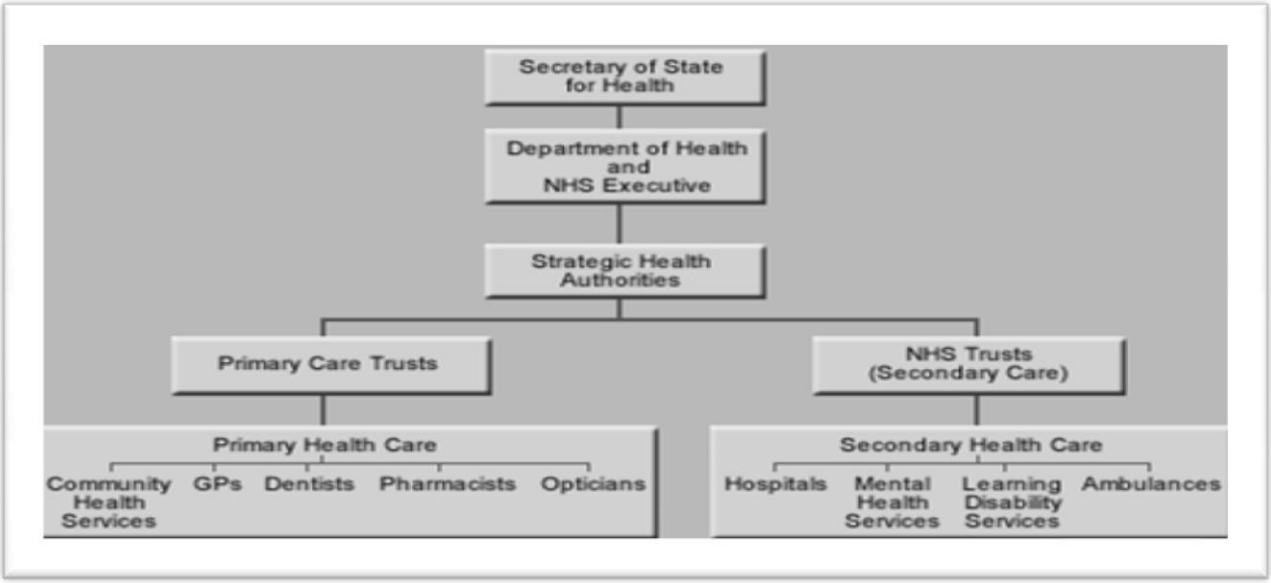
4.1.2 Organisation of the British Health Care System

Due to many extensive reformations of the Labour Party, the organisational structure of the four countries of the United Kingdom (England, Wales, Scotland and Northern Ireland) was separated in 1999. Since then they are administered independently from each other. (see Fendt, 2010)

As the English NHS is representing the most populous part of the United Kingdom, it is necessary to decrease the amount of subordinated public authorities and to dwell on only the most important. (see Fendt, 2010)

Figure 4 shows the actual organisation chart of the English NHS.

Figure 4: Organization of the British Health Care System



Source: OHE – Office of Health Economics, 2010

- **Secretary of State for Health**

The health minister is the supreme organ of the ministry of health and coexistent part of the parliament. The major task of the health minister is theoretically to guarantee the health care of the population through various organisations. Practically the health minister does not have any influence on concrete arrangements. (see Fendt, 2010)

- **Department of Health**

The department of Health is part of the government and is responsible for social and medical questions. Even if the department of Health is on top of the hierarchy of governmental health care, it simply indicates guidelines and is taking over a consultative role. (see Fendt, 2010)

- **Strategic Health Authorities**

Instead of having homogeneous Health Authorities, the government substituted them for twenty-eight new *Strategic Health Authorities (SHAs).* Since their foundation in 2002, they have been dedicated to the shifting of the responsibilities of the health ministry to a local level. The SHAs have to follow the instruction of the health ministry and are in close contact to local health authorities. It is their aim to focus on specific problems in the various regions within the country and to orientate locally, with an efficient dedication of resources, in order to solve these problems. (see Fendt, 2010)

- **Primary Care Trusts**

Health services are provided by hundreds of organisations of the NHS- the so called “Trusts”. Already mentioned in 1997 within the reformation papers, the Primary Care Trusts were only implemented in 2002. Differentiated from their predecessors, the Primary Care Groups, the Primary Care Trusts took over not only a consultative role within the consumption of health care services, but also the responsibility for budgeting. About three-hundred Primary Care Trusts are operating in England, and are responsible for the health condition of several thousand individuals. (see Fendt, 2010)

- **NHS Trusts**

Services, that are more specialised and also provided by fewer organisations or institutions, are assigned to secondary care. Secondary health care includes not only hospitals and ambulances, but also specialised health services for mentally ill patients or patients with a certain disability, as for instance learning disability. (see Fendt, 2010)

4.1.3 Primary Care

In the United Kingdom, primary care comprises besides general practitioners, dentists, opticians and pharmacists. (see Fendt, 2010) Around 40% of the budget is spent in primary care , which is not a lot compared to the fact that primary care is taking over 80% of all patient-contacts. Specialised doctors do not have their own ordination, but treat their patients within the hospitals. Whereas in Austria, the patient can choose which medical specialists he or she wants to see, the patients in the United Kingdom rely on a referral from the general practitioner first. That is why medical specialists belong to secondary providers in health care.[6] (see Department of Health, 2011)

- **General Practitioners/ GPs**

General Practitioners can be seen as the first contact point of a patient. As so-called gatekeepers for the health care system, they have the responsibility to decide on further treatments accomplished by a medical specialist, as well as on the necessity of hospitalization. (see Fendt, 2010)

Every citizen has to register with a general practitioner in the close surrounding of residence, in order to benefit from medical treatment. Since 2004, general practitioners can delegate some functions to the Primary Care Trusts. There is a differentiation between essential services, additional services and enhanced services, for which general practitioners are responsible. (see Fendt, 2010)

Essential services are including any standardized treatment of ill patients; additional services include for instance vaccination, whereas enhanced services include smaller surgeries. (see Department of Health, 2011)

- **Walk In Centres**

Founded by the government under Tony Blair, the Walk In Centres are meant to offer an additional form of Primary Care to the population. Within these institutions, experienced nurses treat smaller injuries and facile diseases. One of the reasons why these centres have been founded was primarily the work-relief of general practitioners, but also the possibility to offer medical service at a timely convenience of the citizen. (see Fendt, 2010)

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[6] For further information follow: Department of Health

- **NHS Direct**

Representing an interactive health consulting program, the NHS Direct is operating since 1998 and was meant to enhance the efficacy of activities within the health care system. With their implementation it was intended to unburden the General Practitioners, but more important to rupture their monopoly as gatekeepers. (see Fendt, 2010)

Also within the NHS Direct most of the employees are experienced nurses and advise citizen in any health related question. The aim is, to, if possible, diagnose in an uncomplicated way, and advise what further action has to be taken. Many times it can therefore be avoided to see a doctor without proven necessity, which is extremely cost-intensive for the health care system.[7](see NHS Direct, 2011)

In case a treatment is needed, the consultation of the NHS Direct leads to a more efficient activity from the patient's side. But also from the side of the NHS Direct an efficient data flow can be enhanced, by sending the patient to a certain doctor or hospital and furthermore inform the respective partners. Another ad-on of the NHS Direct is the mentoring and general support subsequently to any medical treatment or surgery. The experienced staff is offering advice for self-treatment, mainly in relation to the intake of medicine. Also after-treatment in hospitals is also coordinated by the NHS Direct. By reviewing all these tasks and functions of the NHS Direct, it can be allocated to Primary Care as well as to Secondary Care. (see Fendt, 2010)

It has additionally to be highlighted, that the service of the NHS Direct is not only accessible via the telephone, but also via interactive, digital TV and via the internet. The offering ranges from information about certain diseases, to diagnosis-programs, health care consulting and information about address of physicians and hospitals.[8] (see NHS Direct, 2011)

[7] For further information follow: NHS Direct

[8] For further information follow: NHS Direct

4.1.4 Secondary Care

In the United Kingdom the Secondary Care is strongly connected to the service provision within hospitals. As already mentioned, the patients need a referral from the general practitioner in order to be able to be treated in a hospital. (see Fendt, 2010)

Different than in other countries, the treatment in the hospitals is not mainly represented by surgeries, but also by several services which could not be fulfilled by a general practitioner. Even if these services could be provided theoretically, the system wants the patients to be transferred to the facilities of the hospitals. (see Fendt, 2010)

- **NHS Hospital Trusts**

One of the main ideas behind reforming the NHS and re-organising its organisational structure was to modify hospitals into independent corporations. (see Fendt, 2010) The intention of the government was, to enhance a more efficient business within the internal market for health care services. Nowadays the NHS Hospital Trusts are directly responsible to the Special Health Authorities, who are supervising the achievements and strategic aims of the NHS Trusts.[9] (see Fendt, 2010)

- **Foundation Trusts**

The difference between NHS (Hospital) Trusts and NHS Foundation Trusts is basically that the NHS Foundation Trusts are fulfilling particular performances and thereby receive special status within the Health Care System. Monitoring by the government is less tight and the Foundation Trusts benefit from more financial flexibility. (see Cambridgeshire and Peterborough NHS Foundation Trust, 2008)

To develop from a NHS Trust to a NHS Foundation Trust it is needed to apply for a monitor who is delegated by the minister of health. (see Department of Health, A shortguide to NHS Foundation Trust, 2005)

In case the monitor approves the request of becoming a NHS Foundation Trust, the hospital from then on has the possibility to work independently from the guidelines of the ministry of health as well as from the Strategic Health Authorities. (see Fendt, 2010)

[9] For further information follow: NHS Choices

It almost goes without saying that the only requirement the Foundation Trusts have to fulfil is to offer efficient health care services to the population. (see Department of Health, A shortguide to NHS Foundation Trust, 2005)

The most interesting characteristic of the NHS Foundation Trusts is that they are operating as Non-Profit Organisations, which are supposed to make profit, but to invest these profits at the same time into health care services or any equipment.[10] (see Department of Health, A shortguide to NHS Foundation Trust, 2005)

- **Treatment Centres**

Operating as autonomous corporations, the Treatment Centres should also be mentioned at this point. Treatment Centres were founded in 1999 and were meant to offer an additional opportunity to receive medical care. These centres can be operated by Primary Care Trusts as well as by NHS Trusts and provide special medical treatment and services as well as small surgeries.[11](see Care UK Ltd, 2011)

The main intention to reduce long waiting times for routine, short-stay selective surgery of patients as well as to unburden the more or less overloaded hospitals, is still one of the biggest problems the NHS has to fight with. (see Department of Health, A shortguide to NHS Foundation Trust, 2005)

[10] For further information follow: A short guide to NHS foundation trusts

[11] For further information follow: Care UK

4.2 Who is responsible for Public Health Promotion in the United Kingdom?

Politicians in the United Kingdom are of the opinion that only the implementation of the NHS was the main Public Health intervention in the UK's Public Health policies efforts. The idea behind the creation of the NHS was to improve the health condition through the provision of comprehensive health services; including also preventive services. (see Hunter, Marks, Smiths, 2007)

But as many other Health Care Systems in Europe also the NHS remained a “sickness service” system. (see Hunter, Marks, Smiths, 2007) The country was dominated by the hospital service and every health personnel were busy rather with treating ill patients than in taking preventive actions. (see Hunter, Marks, Smiths, 2007)

During a time of severe economic crisis, the topic suddenly rose up again and all of a sudden, it was more cost effective to prevent illness and the economic benefit resulting from a healthy and long-living population seemed to be obvious. (see Fendt, 2010)

The government identified key areas increased the spending in health education and every motivation to develop preventive health projects within the communities were encouraged. (see Hunter, Marks, Smiths, 2007)

The Department of Health puts a lot of effort in the general combat and control of infectious diseases. The Department furthermore struts with the fact that the informational system is very up to date, so newly arising diseases and other health threats would be detected at a very early stage. (see Department of Health, 2011)

Campaigns are performed related to smoking, heart disease, drugs; campaigns that should address all individuals directly. The key message suddenly is that each individual is responsible for her or his health condition. Strong communication and co-operation with the councils and in the following their communities is in the focus in order to guarantee an overall public health service to the population. Also on its webpage the Department of Health points out that most of the widespread diseases, such as diabetes, smoking related diseases, drug addiction, cancer and many more, can be prevented easily, if people are willing to change their lifestyle. (see Department of Health, 2011)

4.2.1 Achievements of Public Health

When tobacco advertising started to be under focus, expectations were high for what would come after. Indeed, advertisement was banned in 2003. Smoking was prohibited in 2007 in all indoor public places. (see BBC, 2006)

Alcohol and road safety has always been a thorn in the governments' side. Until today, the government is in steady combat with the drinks and leisure industry, as well as road lobbies and this issue is meant to be one of the greatest Public Health challenges. (see Department for Transport, 2011)

A more pro-active attitude towards sport and physical activity has always been tried to put in the centre of interest. Discussions are ongoing whether *health promotion* addresses the targeted persons efficiently as well as if there will be benefit from simply promoting. (see Hunter, Marks, Smiths, 2007)

To be highlighted shall be the achievement of the government under Tony Blair that free fruits and vegetables for children at school have been provided as a big Public Health Promotion campaign.[12](see Wordpress, Keep Tony Blair, 2008)

Additionally educational programs were funded, dedicated to sexually transmitted diseases and teenage pregnancies. Condoms and other ways of contraception are free for most people in the United Kingdom.[13] More focus is put on screening programmes, such as screening for Chlamydia and in close connection to it, the easy access for the population to these services via walk in centres. (see NHS, 2011)

Strategies to fight drug abuse were worked on and the Blair government finally succeeded in changing the classification of cannabis from a class B to a class C drug.[14] (see Fendt, 2010) In 2008, under Prime Minister Gordon Brown, the discussion came up again and it was considered to upgrade the classification of cannabis once again, due to the upcoming of other substitution drugs, which puts its consumers at a higher risk. (see BBC, 2008)

[12] For further information follow: Tony Blair

[13] For further information follow: NHS choices: getting contraception

[14] For further information follow: List of the controlled drug in the UK

4.2.2 Future prospect

With the paper “Equity and Excellence, Liberating the NHS”, in 2010, the Department of Health admits that the health system needs to undergo a reform. (see Department of Health, 2010)

Five major aims are presented in the paper: (amongst others)

- In the centre of interest is the decrease of the steadily growing bureaucratic paperwork that keeps most professionals in the health care system from performing their work efficiently. It is planned to review all regulations within the health and social system, in order to find a way to unburden the system from unnecessary costs. Also medical research will be under examination in order to see if bureaucracy which is so strongly represented in this area, is essential in the extent it can be found today. (see Department of Health, 2010)

- Patients as individuals are supposed to come to the fore. This means that each patient is supposed to make decisions about his/her treatment; about which GP to see, about which hospital to go to. It is planned to have patient evaluation for every kind of institution in the health care system and thereby assess and rate hospitals and physicians. This will most probably push the competitive environment that is already dominating the Britisch health care system, even more. (see Department of Health, 2010)

- Patients are promised in the paper of the Department of Health in 2010, that the best possible informational services will guarantee a good overview within the system, in order to choose the most reasonable way of treatment or simply advocacy. (see Department of Health, 2010)

- Very strong focus will be put on results of clinical trials and clinical development. Also in this context it is highlighted that bureaucracy should be decreased as much as possible and only the outcome is in the centre of interest. Clinical development in connection to widespread diseases are mentioned to be more important than ever, as this results will have a direct impact on improving Public Health strategies. (see Department of Health, 2010)

- Further education and mainly empowerment of all professionals working in the health care system, are one of the most important topics, the Department of Health intends to aim at. (see Department of Health, 2010) Responsibilities are supposed to be reviewed in detail and in case it is needed, shall be distributed again in a more reasonable way. This means, that professional who are in close contact with patients might probably receive more controlling functions. As already mentioned above, patients shall be included in the decision-making process. (see Department of Health, 2010)

5 Health Systems

Health systems were and still are characterised through a permanent alteration. They are dependent from changes within the population structure, economic issues and many more. The Austrian health care system and the health care system of the United Kingdom could not be more different from each other.

5.1 Austria - the Bismarck-Model

The Austrian health care system is representing a so-called „Bismarck-Model“.

This nomination can be deduced from the former chancellor of the German empire, Otto von Bismarck. In 1883 it was him who introduced the first health insurance by law. His major motive to do so was a political intention- to prevent any social disturbances. (see Fendt, 2010)

The basis of the Bismarck-Model is represented by the social insurance agencies, which are independent organizations of the public sector. On the one hand they levy national insurance contributions from the insured individuals, whereas on the other hand, they negotiate the prices for the services of any care provider. (see Fendt, 2010)

Within the Bismarck-Model some differences can be identified: In Austria, Germany and the Netherlands the patients do not receive any invoice after having received a service. The care providers are directly paid by the health insurance funds after providing their service. In France, Belgium and Luxembourg the patients are charged for each medical service and have to make a restitution of the originated costs. (see Fendt, 2010)

The basic principle of the Bismarck-Model is to make the claim of any medical service depended from gainful employment. (see Fendt, 2010)

This means that only individuals who had an employment and therefore paid their insurance contributions were allowed to benefit from any medical service. This fact resulted into the majority of people not being insured in the very beginning. (see Fendt, 2010)

One of the major problems, states with a social insurance system have to deal with, is the basis of employment. It may the financial basis that is the main reason to maintain a good and effective health care system of high quality, but at the same time, the system is very much depending on the economic and structural development of the labour market. These of course in turn depend on the contingent of full-time employees, part-time employees, short-time work, internships and any other way of employment. (see Fendt, 2010)

Another problem that states, founded on the Bismarck-Model, have to face is the possibility to opt out of the governmental health care insurance and to be insured on a private basis. Most people, who are earning very well, go for this option as it offers a much more expansive absorption of costs for medical services than any other health care insurance. This boost of escapes out of the governmental and at the same time solidarity health care insurance makes the health insurance funds struggle with their budgets that draw to a close. (see Fendt, 2010)

5.2 England - the Beveridge-Model

It was the British academic William Henry Beveridge, who was authorized in 1942 by the government to create a concept for the national social system. His main idea was the implementation of a homogeneous health care system, which would be based on the free of charge access for any citizen to health care services, independent from the citizen's financial income or social status. The main aim of Willem Henry Beveridge's consideration was to guarantee open access to health care services, to avoid social disturbances and most importantly to enhance the general health condition within the British population. One expected a stronger economical productivity from the implementation of this health care model. (see Fendt, 2010)

After the Second World War, in 1948, the NHS, the National Health Service, was founded. It was the first common health care service worldwide. With the implementation of the NHS, access to the Public Health sector had become awarded the right of every state resident. (see Fendt, 2010)

The main characteristic of the Beveridge Model is that it is financed by the general tax revenues, which means that no work and income related contributions are levied. Furthermore every citizen has the right, independently from his income or employment, to be provided with medical services if needed. (see Fendt, 2010) Within the European Union, besides to the United Kingdom, it is Ireland, Sweden, Denmark, Portugal, Spain, Italy, Greece, Malta and Latvia that are also based on a common health care system, which is mainly financed by tax money. (see Fendt, 2010)

5.3 Differences between Bismarck and Beveridge

Whereas the main problem, the Bismarck model has to face, is the employment as a basis in order to be obliged to make use of any medical service and therefore is very much dependent on economical developments within the employment market, the Beveridge Model has to struggle with the fact that there are no contributions within the government spending that are dedicated to healthcare. This means that there is no direct assignment to healthcare and therefore its financial needs are in a direct competition with other governmental spending. (see Fendt, 2010)

One of the major problems within the Beveridge-model, as well as the Bismarck-model is that the phenomenon of a “two class medicine” appears. This is most probably caused by the fact that the governmental provided medical services offer only the most necessary, basic services and therefore people with higher salaries tend to buy better and more extensive services by having private additional insurances. (see Fendt, 2010)

Is health seen as a valuable good in order to maintain the ability to work and therefore a part of the salary is being taken to finance the health care system; we are speaking from a health care system based on the Bismarck-model. (see Fendt, 2010)

Is it the well-being of every single citizen as a taxpayer, and is part of the general taxes being used for the health care, it is the Beveridge-model we are speaking about. What both systems have in common is the fact that if expenses increase quicker than the income, each and every individual of the state is forced to contribute personally. These personal contributions may either be in the form of earnings of personal capital, or can be collected in case of treatment; the so called patient's contribution. (see Fendt, 2010)

As both systems see themselves forced to undergo reform, the question arises, what is a desirable health care system for the future? Medical treatments may never been detained, neither be forced. Keyword in this context is definitely the individual responsibility. Wherever the individual is not able to be responsible for his or her own health condition, the community should show solidarity without restraint. (see Centre for economic studies, 2008)

B The importance of Public Health Promotion for a younger generation- are we in need of Public Health Promotion for the youngest?

Of all generations and age groups, the healthiest one is of course the one of children and adolescents. In medicine it is said that the first five years of all the individuals may be challenging due to a not fully developed immune system, but after this point it is expected to be in a very good health condition, until problems in adulthood will have to be faced.

What has to be clear is the fact that during the period of childhood and adolescents the foundation can be laid for a healthy life later on. Physically healthy children will grow to physically healthy adolescents who will become more likely physically healthy adults. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

I want to highlight here the fact that I am speaking about physical health, as it is known that physically very healthy individuals can be psychologically ill of course. As already mentioned, health has to be considered under different aspects. New Public Health approaches only speak about a healthy condition if all dimensions are addressed to: sexual health, mental health, emotional health, physical health, social health, spiritual health and environmental health.

In this work, it shall be only the physical health that is in the centre of interest.

Growing up means becoming self-assured and to show increasing autonomy. Adolescents is dedicated to an experimental lifestyle, every decision made, determines the individual health condition and further development. Key factors like peer-group pressure play a very important role of course. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

One step back in growing-up, before the transition to maturity, early childhood offers a lot of potential to form and lay the foundation for a long life under healthy conditions. In general the standard of living has increased a lot in comparison to the past fifty years. It goes without saying that most children are at a lower risk of infectious diseases and they have greater possibilities to be educated. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

Early childhood can be definitely seen as the period of great importance when Public Health intervention can be made and the opportunity to acquire health-related knowledge, to form an attitude towards health-related issues and to build up values is greatly given. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

Furthermore the environment is crucial to determine the health condition. Homes, schools, workplaces, can highly influence the health condition of the youngest. Such factors might be clean water, chemicals, food supply and stressors like harassment and abuse and others. These factors have a direct or indirect affect on the health of children and adolescents. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

It has to be considered that these factors are also dependant and may vary from country to country. While developing countries have to face the challenge of infectious diseases like tuberculosis or sexually transmitted diseases like HIV, developed countries have to struggle with the prevalence of road traffic accidents, injuries or suicide. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

No matter in which country the risk factors are more prevalent, they all share the fact that they are putting the young generation at risk to not develop into healthy adults later on. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

All these are reasons why the age group of childhood and early adolescents deserve massive attention from governments and organisations and of course, the public.

Very few children and adolescents are going to die from the above mentioned risk factors during their childhood, but the chances are very high that a lot of them increase the risk of a premature death due to continue health-risk behaviours from childhood into adulthood. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

6 Health risks for the young generation

To highlight the main health risks, all children and adolescents are exposed to during their lives, it shall be listed: (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Injuries**

In general mortality rates for men are higher than for women whereas women are at a higher risk of facing intentional injuries. There is hardly any difference between the number of the percentage of accidents and injuries in developing and developed countries. The high numbers result from unintentional injuries, such as sports, traffic accidents and less from intentional injuries. As already mentioned, women and girls are at a higher risk towards injuries, as they also have to face additionally domestic violence. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Depression and Suicide**

Growing-up is not an easy thing to undergo. The prevalence of mental disorders and depression is increasing. In European countries, it was revealed that depression, or the feeling of being depressed at least once a week, is more common in boys than in girls. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

About death from suicide only very little is known, as it is quite hard to differentiate between suicide and accidental death, so it is assumed that many suicides are assigned to accidental deaths or to deaths from unknown causes. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Tobacco and Substance Use**

During adolescents and young adulthood it is very much likely to be confronted with prohibited substances. Most affected are young people who are concerned with personal autonomy, who are not very interested in conventional things, who receive less support from family and friends and are exposed to a big peer-group pressure. Research states that peer use of substances is the primary influence and is responsible for using other drugs at a very early age. (see WHO, Mental Health: Evidence and Research - Department of Mental Health and Substance Dependence, 2005)

Alcohol drinking is one of the biggest challenges Public Health has to face. In Austria every 13 to 14-year old adolescent is consuming alcohol at least once a week. (see Borsoi, MedUni Wien, 2008) A large portion of pupils start at the age of 12 years to drink alcohol regularly. Not only is the consumption of alcohol strongly connected to an increase in traffic accidents or injury-related death and disability, but over time, it leads to serious degenerative diseases. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

More and more young people start to smoke at a very early age, the general age of frequent smoking habit in most European countries is under the age of fifteen and it is expected that this age will go even below in the future. Austria is leading the European ranking of early tobacco-use initiation among young students or pupils. (see Borsoi, MedUni Wien, 2008)

In addition the daily consumption is also increasing quickly, a fact that is strongly linked to the wealthy situation; young people are living under, in mainly western European countries. Not only is it going to be harder to stop smoking at a later age, the risk of becoming a chain smoker and additionally developing a smoking-related disease is incredibly high. Thinking about the health consequences later on in a smoker's life, it is obvious that there is a high need for smoking initiatives targeted towards young people. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Nutrition**

The range of health problems in connection with nutrition are multifarious, they vary from stunting, anaemia, eating disorders, such as anorexia nervosa, bulimia; or obesity, which represents one of the biggest challenges for Public Health in developing countries. Mainly among younger children the physical activity has decreased drastically. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

To consume more fats and sugar than the body actually needs is one of the major characteristics of our modern nutrition in Europe. In regards to the age group of fifteen years old boys and girls, quite a high number are exercising at least twice a week to the point of being out of breath and sweating. It needs to be highlighted that this sportive action is mostly taking place outside of school. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

But in the age group of less than fifteen years-old, the percentage is a lot lower. Just as this age is that groundbreaking, it would be much more important to do physical exercise regularly from a very young age on, to also implement physical activity in the children's life. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Fertility**

In developing countries, the trend is going towards longer education, which is linked to the fact that adolescents start their professional carrier later and therefore also start to have families in a later lifetime. Studies (The Young People's Health in Context study, 2004) say that the age at first marriage is one of the most important factors influencing adolescent fertility. It goes without saying that there are huge differences between developing and developed countries, but also within Europe there are major differences. In Great Britain for example, politics are trying to fight against unplanned teenage pregnancy. Adolescent mothers usually quit their education and therefore already influence their professional options later on. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

- **Unhealthy sexuality and its consequences**

While marriage and family founding takes place at a later stage in life, sexual activity is happening at a younger age. The results are very often sexually transmitted diseases and unplanned pregnancy. (see WHO, Improving Health through Schools; National and International Strategies, 1999) Sexual activity at an early age has increased significantly, which at the same time brings along the fact that on the one hand the use of birth control pills and other contraceptives has almost doubled over the past 20-25 years and on the other hand the use of condoms has decreased. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

The declination in using condoms is representing a threat, as it means that priorities are different from the past. It seems to be less important to protect oneself against sexually transmitted diseases, including HIV infection than to be prevented from unplanned pregnancy. (see WHO, Improving Health through Schools; National and International Strategies, 1999) This fact appears very much in the developed countries, in which the female adolescents tend to focus on founding a family much later and try to get work experience first. The most common sexually transmitted diseases among young people are: HIV/AIDS, gonorrhoea, syphilis, Chlamydia infection and herpes. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

In general it can be stated that there is far too less data available that clearly describes the health status of young people from the age of five to nineteen. More clarification of facts about mortality at a very early age, as well as the main reasons of death has to be done further on, in order to push international communities towards interventional activities and implementations. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

What experts are certain about is the fact that basically most behaviors are developed in early stage of life, which means focus has to be put on the age-group of five to nineteen years old. These behaviors might be smoking, alcohol abuse, drug abuse, poor nutrition or malnutrition, and others. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

Later on these behaviors can be strongly connected to leading causes of death among young people, like accidents, coronary diseases, violence and HIV. No matter to what it may contribute later on in the children's life; may it be a liver disease, may it be an accidental death; simply the fact that these behaviours are preventable, obliges Public Health, politics and international communities, to intervene. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

7 The school setting

In 1986, the Ottawa Charter says that “health is created and lived by people within the settings of their everyday life - which means, the location where they spend most of their spare time, where they learn, where they work, play or love”. (Improving Health through Schools; National and International Strategies, WHO, 1999, p. 16)

Health is created by every individual and the interaction between all individuals in the setting, and all affected individuals basically rely on the fact that society additionally creates conditions which further push the maintenance of a healthy lifestyle. (see Ottawa Charter, WHO, 1986)

Health risks have to be prohibited in their initiation exactly where students spend most of their time. The school setting represents a great possibility to improve the health status of the students, as well as their families in the broader sense, school personnel and any other member of the school community. The message is very simple: school reaches worldwide millions of students and through them indirectly their families and communities. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

In 1995 the WHO called in a team of experts in order to create a committee which’s aim was to identify what schools can do to use all their resources available in order to improve the health status of children and students, school staff, families and other members of the community. The committee sat together for 4 days in the WHO's headquarter in Geneva and the result was a long list of recommendations. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

Acceptance of school health programs have to be understood and supported by decision-makers in influential international, national and local agencies, politics, but also the public. The broad public may say it is worth to invest and develop such kind of programs, but still they are often seen as secondary priority. The most important factor which was among all other outcomes of the Committee was the fact that more alternative investment has to be done in general in schools. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

Secondly mentioned was the factor that girls have to be better enrolled in educational opportunities. The committee goes even that far that they state that every attempt in improving and expanding educational possibilities is one of the best health and social investments a country can make. The fact that provision of a safe learning environment for students has to be taken care of by the school as an institution was mentioned before the fact that every school must enable pupils and students by all means to learn how to keep up a healthy lifestyle and how to protect themselves from infectious diseases. (see WHO, Improving Health through Schools; National and International Strategies, 1999) Another very important point that came up between the experts of the Committee was the fact that schools must see themselves as THE setting for health promotion in which basic, but overall important knowledge is passed further. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

There must be general understanding that schools could have the opportunity to provide the most cost-effective way to improve health; first of its pupils and students, and subsequently of the society. Communities, families and the public should understand of what great importance health education within the school setting actually is and support it by all means. Any school program that has been developed in order to increase health in schools has to not only be professionally designed, but also monitored throughout its conduction and evaluated by experts. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

The call for international support and further development has to be heard and action has to take place. International coordination between all member states would be highly appreciated in order to found a general idea of comprehensive school health programs. More important than anything else of course is the fact that every individual that is responsible for educational health skills and promoting health in general has to be well trained in order to address perfectly to the health needs of children and students. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

7.1 *Schulgesundheitspflege*(maintenance of health in school) in Austria

Development of *Schulgesundheitspflege* in Austria

Before going into detail, it shall be stated at this point that the word *Schulgesundheitspflege* as maintenance of health in school, will be kept in the German language, as it does justice to the definition in a more accurate way.

In the second half of the nineteenth century natural sciences were arising; a fact that was strongly supported by scientists and politicians. Together with chemistry and physics also hygiene was in the focus of interest. Not only this interaction between medicine and natural sciences is seen as the initiation of *Schulgesundheitspflege*, but also the growing importance of paediatrics, the extended access to health care services and most importantly the implementation of compulsory education. (see Kogler, 2007)

With the obligation to attend school in 1744, health condition of pupils and adolescents became of greater interest, as it was already well known that healthy pupils would most probably turn into efficient workers and at the same time contributors to economy. Medicalisation, the construction of health care establishments and the inclusion of medicine into public health matters and interests represented the foundation of the implementation of School Physicians in the setting of school. (see Kogler, 2007)

To understand the necessity of the implementation of the *Schulgesundheitspflege*, it is important to have a clear picture of the social conditions of the beginning of the nineteenth century. It was characterized by a very fast increasing population which had to face huge challenges as unemployment, medical shortage and in general very hard living conditions. Due to the unsatisfying health conditions of most workers, it was easy to realize that health promotion and health care services had to be provided to the public. In 1889 one of the most effective, long-term, measurements was implemented in Austria; the health insurance by law for the working population. (see Kogler, 2007)

Only medical checks in regards to the employability, the physical ability to work, vaccination programs, the physical ability to attend the military, the conduction of campaigns in order to fight infectious disease as tuberculosis or the implementation of medical checks in schools, were an opportunity for the public to benefit from medical provision. Not only was this a necessity in order to screen for various infectious diseases; it was mostly the only medical supervision that many children could have access to. (see Kogler, 2007)

Furthermore the importance of the interaction of medicine became obvious and politics became aware of the fact that medical experts were indispensable and needed to be included in various areas of public life. (see Kogler, 2007)

The nineteenth century was characterized by the transformation of natural scientists to experts in health related issues. More and more communities of experts (as the *Ärztegesellschaft*) or scientific papers were founded, which pushed the development of specialised, medical disciplines. (see Kogler, 2007)

This transformation had a very strong impact on the changing understanding of health and illness. Increasing knowledge mainly in science of biology brought new skills in regards to treatment of bacterial infections and thereby founded the basic of various vaccinations. Strong and efficient research and mainly better technologies (as for instance microscopes) gave more insight into the origin of diseases and knowledge was gained about how to prevent or treat them efficiently. (see Kogler, 2007)

These scientific attainments had two very important outcomes. First of all the importance of medicine and practitioners became more obvious for politics. Secondly, the progress of science in bacteriology gave green light for a totally different and new approach towards hygiene. (see Kogler, 2007) Still, it was not possible to erase most of the popular infectious diseases due to the fact that scientific knowledge was not sufficient. Additionally the dominating lack of hygienic and social conditions in regards to living was still representing a huge challenge. (see Kogler, 2007)

Interestingly to mention shall be the fact that one of the reasons for the implementation of School Physicians in schools was the lack of work placement for medical doctors in general. The existing positions for physicians were not going to be broadened and also within the public there was no need for additional medical services. It goes without saying that the solution was to create new placement for work and the school seemed to be a good possibility to newly implement medical doctors. (see Kogler, 2007) Mainly the upcoming discussions about hygienic conditions among the public and a lack of knowledge in regards to hygiene, but also the interest of the state to be able to get back to a healthy and well working society, pushed the initiatives to implement physicians at school. Also scientific papers were dealing all of a sudden mostly with health promotion at schools and the importance of medical surveillance of the youth in the setting of schools. (see Kogler, 2007)

7.2 School Physicians in the context of *Schulgesundheitspflege*

As already mentioned *Schulgesundheitspflege* had its origin in the hygienic conditions under which pupils had to live, learn and work. It goes without saying that these hygienic conditions were poor. (see Haupt, 1963) Gym classes were implemented in the early nineteenth century as a result from many discussions about the safety of the health of children in the context of *Schulgesundheitspflege*. From the side of the medical experts it has been and still is no matter of discussion whether *Schulgesundheitspflege* should be an integral part of every day school life. In the beginning of *Schulgesundheitspflege* it was the teachers and pedagogues who were against any influence from physicians. (see Haupt, 1963)

School Physicians did exist though, but not in the context of *Schulgesundheitspflege*. Their responsibility given by the governments was mainly to take care about the condition of the school buildings itself. De facto the School Physician was consciously used to control the quality of constructional work and was kept busy as he or she should not take over any initiative in regards to medical services. The **School** Physician was responsible for the **school**, but not for pupils. (see Haupt, 1963) Interestingly to mention is the fact that when it came to sexual education, teachers were very happy to pass this responsibility over to the School Physician, although it was not intended to include the School Physician in classes. (see Haupt, 1963)

Industrialisation, the obligation to attend school and in relation the fact that infectious diseases showed an increasing occurrence due to the high number of pupils in narrow space; all these were still not initiating that School Physicians would have their eligibility in the setting of school. Slowly, with the nineteenth century coming to an end, the child started to be in the focus of interest of several physicians and the call for individual medical examinations of pupils at schools got louder. This was the most innovative approach to child public health in the school setting when considered that this happened to be at a time when *Schulgesundheitspflege* itself was still in its “children’s shoes”. Haupt (1963) defines this new approach at that time as the transition of **school hygiene** to **pupils’ hygiene**. This transition founded the basis for the position of a School Physician as we know him or her today. Services provided by the School Physician started to be organised and was seen as an integral part of medical provision. (see Haupt, 1963)

Finally it was the Second World War and its consequences that can be seen as **the** cause that made School Physicians suddenly becoming a real necessity. The emotional as well as the physical damages of children and adolescents required new working methods and medical services also in schools. A fact that created also new places of employment. Suddenly the School Physician could make decisions about meals at schools for malnourished pupils or furthermore send them on reconvalescence treatments. (see Haupt, 1963)

Experts did not get tired of writing publications and doing research about the hygienic and health needs of pupils and adolescents. But all the formulated goals were hardly ever implemented and realized; and if, then at different time points and in different federal states. Only the *Schulunterrichtsgesetz* of 1986 should bring along the realisation that was so urgently needed in order to structure the health care system at schools by law. (see Kogler, 2007)

7.3 Schulunterrichtsgesetz of 1986

The Schulorganisationsgesetz from 1986 regulates the admission as pupil to the institution of school. Not only does it state the legal requirements in order to be able to receive admission to a school, it also defines the possibility to skip classes in case of exceptional learning abilities, but also the repetition of specific levels of education. (see Wagner-Kreimer, 2005)

Browsing through the Schulorganisationsgesetz from 1986 in order to find any connex to the School Physicians tasks, one will find him or her mentioned in the following paragraphs:

- § 3 admission as pupil: the School Physician has to examine the physical eligibility and the health condition of the pupil in order to find the appropriate school (compulsory school, high school, etc) (see Wagner-Kreimer, 2005)
- § 11 obligatory subjects: in case a pupils has to be freed from specific subjects, a medical attest has to be presented which may be provided by the School Physician (see Wagner-Kreimer, 2005)
- § 26 skip classes: admission to the next but one level of education is only granted if there is no doubt of excessive demand. The School Physician may perform a medical examination which proves the physical and psychological maturity of the pupil (see Wagner-Kreimer, 2005)

- § 27 repetition of levels of education: in case of health related issues a pupil may be allowed to repeat a level of education. The School Physician may perform a medical examination in order to integrate the pupil accordingly (see Wagner-Kreimer, 2005)
- § 45 absence of class due to illness: absence is granted in case a pupil suffers from a severe disease that might infect other pupils. Also in case of bad weather conditions that might put the pupil's health at risk on the way to school, absence may be granted. The School Physician may perform a medical examination in order to approve leaving class. (see Wagner-Kreimer, 2005)
- § 63 class and school forums: events in regards to Schulgesundheitspflege are organised by these forums. The School Physician may be involved in the organisation or execution (see Wagner-Kreimer, 2005)
- § 64 school committee: When dealing with matters of Schulgesundheitspflege, it is mandatory to invite the School Physician to attend meeting of the boards (see Wagner-Kreimer, 2005)

7.4 § 66 Schulgesundheitspflege/ medical care

§ 66 is of great importance for health promotion within schools as well as for the activities of a School Physician and basically the only paragraph dedicated to pupil's health in connection with the School Physician.

Divided into four main pieces, it states as following: (see Wagner-Kreimer, 2005)

1) School Physicians are obliged to assist teachers in any questions thtat are related to health issues of pupils, as well as education and attendance of school. School Physicians are obliged to advise and additionally perform medical examination of the pupils.
2) Pupils are obliged to attend once in a year the medical examination performed by the School Physician. Furthermore it is possible to perform additional examinations, which requires the acceptance of the pupil. In case the School Physician detects any health deficiency, he or she has to inform the pupil or respectively the parents or legal record.
3) In case matters of Schulgesundheitspflege are discussed within conferences or committee meetings as well as questions in regards to pupil's health are coming up, School Physicians have to be invited to attend in order to advise.

7.5 Schulgesundheitspflege as of today

The health care system embraces amongst many others the matters of health education as well as the matters of health prevention in relation to children and adolescents attending school. With regards to content, health prevention defines systemic, organised preventive, medical measurements dedicated to a specific target group, in this case pupils. Irrelevant is the fact where these medical measurements take place; they can be performed in- or outside of school. It is crucial that they are affecting pupils. Due to this given factor, the school as institution has no responsibility in regards to health prevention. (see Frankhauser, 2008)

In comparison to the health care system the responsibilities within the school system are totally split. Not only does this refer to the legislation, but also to the execution. As an example it shall be highlighted that School Physicians who are operating in secondary schools are seen as organ of the federal government. Whereas School Physicians working in compulsory schools, are part of their municipality. (see Frankhauser, 2008)

Crucial part of the school system is the field of education. Schulgesundheitspflege is assigned to the field of education and is carried out by the School Physician who is under supervision of the respective school administrator. Equally as teachers, the School Physician can be seen as organs of the school, or rather the school administration. In dependence of being employed within a compulsory and secondary school, the School Physician is in service with the municipality or the federal government. (see Frankhauser, 2008)

The School Physician's activity is regulated within the Schulunterrichtsgesetz, which will be get back to in a later chapter. At this point it shall be indicated that within the § 66 of the Schulunterrichtsgesetz, it is stated that the School Physician is obliged to exclusively advise teachers in regards to the health condition of pupils in a dimension that is necessary for the design of education. The School Physician can be seen as assisting teachers within their education activities. Focus is put on the collective of pupils, not on individuals. The School Physicians advisory function is not individual-related. In order to comply with his or her obligation to advise, the School Physician has to examine the pupils once a year. (see Frankhauser, 2008)

It goes without saying that there are many more activities that are performed by the School Physician. These are then anchored outside of the field which is marked out by § 66 of the Schulunterrichtsgesetz and are based on contracts with the head of the respective school. These additional activities are discussed later on in detail in chapter 9. Important to mention at this point is the fact that many of the School Physician's activities (as for instance spontaneously planned medical checks, shortly before school trips) are based on the initiative of parental association that have a quite strong influence on events in school. (see Frankhauser, 2008) Even if these additional activities are not legally anchored, it is legally inoffensive as § 66 in the Schulunterrichtsgesetz states that besides the yearly medical examination additional examinations can be performed. Therefore it becomes obvious that every additional activity of School Physicians is only an offer to pupils and parents. (see Frankhauser, 2008)

8 School Nurse, School Physician- what makes them so important?

The British and the Austrian health care system share one characteristic. In English, as well as in Austrian schools, very important key players can be found who are representing the health care system. These key players might have a very different educational background from each other, but they have one thing in common:

They work in the setting of school and are responsible for the health of young pupils and students.

Medical examination and preventative measurements, conducted and implemented by a School Physician or a School Nurse only have one target: to reduce diseases and health risk factors within a population. As the setting of school offers the unique possibility of working with a corporate population of children and adolescents, best possible and successful strategies have to be defined and preventative interventions have to be implemented. (see Dür, 2008)

Important to bear in mind is the fact that most of the preventative measurements bring along a risk-potential, caused by wrong positive diagnosis, or treatments, which are not necessary to perform. (see Kaminski and Gartlehner, 2009)

- **Definition of screening**

Screening is an essential part of clinical prevention in school aged children. Screening is defined as a number of examinations of healthy individuals without any discomfort or health problem. On the one hand, screening is meant to detect any disease related risk factors, on the other hand it is supposed to realize either existent diseases, or any illness, which has not yet shown any symptoms. The aim is to detect any pathologic change, in order to start any necessary treatment as early as possible. (see Kaminski and Gartlehner, 2009)

Screening only represents the suspicion of a change or disease, but requires continuative diagnostic examination. In order to be declared as efficient screening, knowledge about the necessary steps of treatment, as well as access to this treatment is needed. The primary endpoint is the improvement of the patient's condition. (see Kaminski and Gartlehner, 2009)

The United Kingdom Screening Committee[15] summarizes the required preconditions of screening as following: (see Kaminski and Gartlehner, 2009)

- Screening-tests shall be easy, safe and validated
- The allocation of test-values needs to be known within the targeted population
- The test shall be accepted by the population
- Further diagnostic procedure in case of a positive result shall be scientifically accepted, as well as available for every patient

Effective treatment of diseases or symptoms, which shall be detected in an early stage, has to be possible and feasible. Scientific evidence is needed in order to prove that treatment of the disease in an early stage leads to a better outcome than treatment which is done after the disease has already progressed. (see Kaminski and Gartlehner, 2009)

But screening is more than one separate test. Screening ranges from diagnostic follow-up examinations, treatments, to possible negative side-effects. The biggest risk of screening is so-called false-positive results, which means that pathogen changes of healthy patients are detected. This fact implicates that healthy individuals are have to undergo more diagnostic tests and also therapies, which simply are not necessary and furthermore can cause negative side-effects. It goes without saying that in almost all cases, false-positive results are very likely to be emotional and psychological burden for the patients. (see Kaminski and Gartlehner, 2009)

It is obvious that screening measurements, performed by a School Physician or a School Nurse have to well chosen to be part of the medical examinations of the pupils.

In their report "*Screening im Schulalter*"("Screening at school-age"), Kaminski and Gartlehner worked on various screening recommendations, in order to highlight the most important ones for school-aged children from 6 years to 19 years old.

[15] NHS, UK Screening Portal

From five international organisations which gave recommendation about evidence-based screening interventions for healthy children and pupils; thirteen different screening recommendations could be identified, which shall be listed: (see Kaminski and Gartlehner, 2009)

- Obesity
- Arterial hypertension
- Urinary tract infection
- Iron deficiency anaemia
- Developmental disorder of motor activity and behaviour
- Disorder of lipometabolism
- Overweight and underweight
- Amblyacousia
- Idiopathic scoliosis
- Caries
- Visual impairment
- Developmental disorder of language and speaking ability
- Disturbances of growth

From the above listed health condition that should be screened for, the below shown Table 2 gives more details in regards to recommendations for **school-aged children**:

Table 2: Screening Recommendations

From these thirteen screening recommendations surprisingly only following are recommended for school-aged children:	• Disturbances of growth • Overweight and underweight
Recommended for school-aged children, who did not attend any kindergarten or pre-school, is screening for:	• Visual impairment • Amblyacousia
For these screening interventions there is a lack of evidence:	• Obesity • Developmental disorder of motor activity and behaviour • Disorder of lipometabolism • Caries • Developmental disorder of language and speaking ability

Source: own illustration based on Gartlehner and Kaminski, 2009

Regarding to Kaminski and Gartlehner (2009), there is international consensus that screening interventions should only be performed if there is scientifically proven sanitary benefit. The outcomes mainly in regards to screening for obesity and caries are surprising. More than ever it seems to be that sanitary benefit is not achieved by screening interventions, but by preventative measurements. (see Kaminski and Gartlehner, 2009)

Both, School Physician and School Nurse have the challenging responsibility to take over these preventative measurements. In what way they do so, shall be discussed in the following chapters.

One of the major characteristics of the Austrian School Physician system is the fact that it is neither hardly standardized, nor is it clearly regulated by law. (see Kaminski and Gartlehner, 2009) Which kind of screening methods, examinations or preventative measurements are done, is completely within the responsibility of each School Physician. Kaminski and Gartlehner discuss in their report "*Screening im Schulalter*" (Screening at school-age), that the reason of the obvious inhomogenity in regulation, is a lack of evidence-based recommendations for School Physicians in Austria. As a result, the Austrian health care system is facing the fact of over-treatment or under-treatment of school aged children. (see Kaminski and Gartlehner, 2009)

9 School Physicians in Austria

The first governmental clause, which was dealing with the issue of „hygiene“, was released on 9th of June in 1873 by the „Ministerium für Unterricht und Kultus. (see Gamper, 2002)

Within this clause, it was mainly aimed at the construction of school buildings, the illumination, the toilet and waste water system, and the supply of water. For the very first time, the School Physicians were assigned officially to health topics within schools. The tasks of the School Physicians were dedicated to the role of an advisor in medical questions and also to inspect the schools in regards of hygienic conditions. Also mentioned in this clause is a remuneration which was paid for great endeavour and efforts for promoting health and health care within the school setting. (see Gamper, 2002)

In the following years the ministry for education and cult enacted further orders in regards to the health care in schools. It was demanded that School Physicians would educate and inform about sanitary interests and needs and would put special focus on the good illumination and the proper posture of the students. In 1900 the ministry again insisted on consulting the *„Amtsarzt"* (Public Health Officers) before constructing new school buildings. Furthermore Public Health officers were deployed in order to conduct hygienic inspections school buildings. (see Gamper, 2002)

After having an insight into these ministerial absolutions, two aspects clearly come to the fore. First of all, only Public Health officers were concerned in the role of the School Physicians as we know them today; secondly that the role of consulting in regards to sanitary issues was mostly taken over by teachers. The physicians, who were dedicated to the health care within the settings of school, were interested much more in the hygienic conditions of the school building than in the individual health condition of the students. (see Gamper, 2002)

At that time the designation „School Physician“ was more related to the school as an institution, rather than to its students. That is why we can speak of a transformation from the School Physician to the student's physicians. Nevertheless, over all these years, the designation „School Physician“ kept its importance until today. (see Gamper, 2002)

Around 1890, more and more absolutions came up, but the idea of sending Public Health officers to the schools in order to examine students, who did not develop physically as their class colleges, disappeared as quickly as it came up. The reason was most probably a lack of financial resources. (see Gamper, 2002) It was in 1895 in Vienna, when an absolution was enacted which enabled the district physician to keep an eye on the sanitary regulations within the schools and furthermore to testimonialize, if a child had to be excluded from certain subjects. Additionally it was also constituted that the district physician had to make a report to the authorities in case an infectious disease occurred in one of the schools. (see Gamper, 2002)

It was 1907/08 in Berndorf in Austria when Dr. Robert Dehne for the very first time examined all students of Berndorf. The interesting fact in this case was that these examinations and efforts of developing the first medical service for all students within one city were financed by an owner of a local fabric. (see Gamper, 2002)

His motivation to finance Dr. Dehne, the first Austrian School Physicians, is not clear. He could have done this out of philanthropical reasons, but what seems to be more obvious is that he already wanted to have a positive influence on the health of his future employees. If this was in fact the reason for his financial support, he can definitely be seen as a thought leader of his time. (see Gamper, 2002)

In 1908 the regularly medical service at schools in Berndorf was implemented. Before the children could be examined in the beginning of the school year, the parents had to answer the questions that were asked within the parents-questionnaire. This had to be done by the parents each year, shortly before school started. Each and every year the results were written in the so called „Gesundheitsbogen“ and in addition the parents were also informed about the outcome of the medical examination. (see Gamper, 2002)

The medical examination was very extensive and the aim was to screen all students, in order to consult the teachers afterwards where to place which child in the classroom. Ill or conspicuous children were examined more often by the School Physician and the fact that children from poor families had the opportunity to receive free recipes is very remarkable if one considers that this happened more than hundred years ago. (see Gamper, 2002)

The children were measured and weighed. It has to be stated that this procedures were taken over by the teachers! Focus was put on postural deformity, tuberculosis, diseases affecting the skin and the nervous system. Another responsibility of the School Physician was to find out whether a child had received a specific vaccination and in case it did not, to send it to a so called „*Impfarzt*"(vaccination-physician). (see Gamper, 2002)

Furthermore, focus was also put on dental hygiene. Not only had a dentist come to visit the students at the schools in Berndorf, but also an ophthalmologist as well as an otologist. Again the owner of the local fabric reimbursed these examinations. (see Gamper, 2002)

In order to educate the children about how to take care for their personal hygiene, bath rooms were provided. The idea behind this extraordinary effort was the hope that the attitude towards personal hygiene would be spread within the families. (see Gamper, 2002)

Berndorf is representing an example of an extensive, innovative package of measurements. The fundamental idea of Public Health and health promotion has definitely been implemented. But it goes without saying that this was only possible due to the financial support of the owner of the local fabric. (see Gamper, 2002)

This exceptional system, as it could be found in Berndorf, did not fundamentally influence the medical service for schools in the rest of the country. It was the communities, cities and territories which were taking over responsibility of sending physicians to the schools. Still, the main task of the physicians was to supervise the sanitary conditions of the schools and the individual health care of the students. School Physicians were asked to teach the subject of hygiene in the schools and thereby their integration within the schools started. (see Gamper, 2002)

Around 1910 the ministry of public work decided to hire seven School Physicians, responsible for twenty-six schools. In 1913 it was the high schools which were now attended by School Physicians in Vienna and Lower Austria. As there were no consistent regulations, the School Physicians had no strict guidelines; they could conduct the medical examination as they wished. (see Gamper, 2002)

Financing was done through different ways. Either the physicians were paid by the parents or the communities. In 1923, medical service within secondary schools was regularized through an absolution of the ministry of education. From this point of time, School Physicians received their salaries from the collected contribution of the pupils, which they had to pay for physical education in any case. (see Gamper, 2002)

One of the main characteristics of the Austrian development of School Physicians is that the historical overall view is very hard to summarize, due to the very different sphere of competences of territories, districts and communities. (see Gamper, 2002)

9.1 The development of the School Physicians in Vienna, Austria's capital

From 1895 it was the District Physicians who were responsible for supervising the hygienic conditions in schools. After the First World War a reform of the whole school health care system took place, which was also accepted internationally. It can be assumed that the very bad health condition of the children of that time was the reason for this reform. (see Gamper, 2002)

Furthermore also the general understanding of health care and health policies influenced the implementation of School Physicians. The new social democratic government developed a new health care system, which aimed at serving all individuals from their birth until their death. Prevention started to be in the centre of interest. (see Gamper, 2002)

Based on this new perception, new positions for School Physicians were offered for the schools of the city. On July, 11th 1919 it was officially decided to hire District Physicians as School Physicians. It has to be mentioned here that at this time there were only men employed as School Physicians, due to the fact that women were only registered to the studies of medicine from 1900. (see Gamper, 2002)

Not too long after implementing the school medical service, its weaknesses became obvious. Due to the huge operational field of each and every School Physician, they were not able to handle the most important of their duties. Talking about medical service at school, it was not only about hygienic conditions in schools anymore; even if it was still of great importance for former health care policies; more and more also the medical examination of the pupils, consulting of their parents, the combat of infectious diseases as well as consulting teachers in case of any medical questions. All these were activities which needed much more time than one was considering in advance, and therefore almost none of the newly announced School Physicians could cope with all these tasks. (see Gamper, 2002)

One of the measurements which were taken to solve this issue was to hire not only general practitioners, but also specialists. In 1929 additionally an ophthalmologist as well as an otogist were employed in the order of the city of Vienna. (see Gamper, 2002)

As it was the directors of the schools who had the responsibility about how to arrange the school medical service which was provided by the School Physician, it was in 1923 when the ministry of education finally announced an absolution about the instructions for School Physicians. It has to be stated that this absolution only defined the medical service in gymnasiums. (see Gamper, 2002)

For the very first time, it was the medical observation that was in the centre of focus and not, as many times mentioned before, the hygienic conditions within the schools. Within the first four weeks after the school started, the School Physicians had to examine the students. The already filled-in parents-questionnaires gave guidance to the School Physicians what has already been detected and what treatment the child had already received. (see Gamper, 2002)

In case of any epidemic it was the School Physicians task to examine the affected students and to supervise them after taking measurements. Preventative measurements became also more important than before. (see Gamper, 2002)

It was intended to have also some spare time in order to be available as a consultant for hygienic questions for teachers and parents. It was furthermore demanded that each School Physician should have their examination room at the schools where they had the possibility to hold medical conferences. These conferences should cover topics as alcohol abuse, infectious diseases or genital diseases. (see Gamper, 2002)

Additionally it was the School Physicians responsibility to provide the school with a first-aid kit. As already mentioned above, these instructions were only valid for a very limited domain within the school system. In 1919 a consistent law for School Physicians was called for, but it took until 1974, when the "*Schulaerztegesetz*" was enacted which is still effective today. (see Gamper, 2002)

9.2 Legal basis of School Physician in Austria

Basically there is no differentiation between the various medical specifications, and all medical doctors are obliged to follow these regulations. (see Wagner-Kreimer, 2005)

The main regulations, which are called „Hauptstuecke" in the German language, shall be listed here: (see Wagner-Kreimer, 2005, p.15-24)

- document and inform about infectious diseases
- obligation of secrecy; notification and reporting
- detection of illness and its evaluation
- precautionary measurements
- dissociation of ill individuals
- disinfection
- exclusion of individual persons from educational establishments in case of reportable diseases
- closing of educational establishments in case of reportable diseases
- surveillance of reportable diseases
- prevention of reportable diseases through medical examination, and preventive measurements in educational establishment
- report of mistreatment, assault or batter

The legal basis for School Physicians is anchored in the: (see Wagner-Kreimer, 2005, p.30-47)

- Aerztegesetz 1998, BGBI. I Nr. 169/1998
- Epidemiegesetz 1950, BGBI. Nr. 186/1950
- Verordnung des Bundesministeriums für soziale Sicherheit und Generationen betreffend anzeigepflichtige uebertragebare Krankheiten, BGBI. II Nr. 456/2001
- Tuberkulosegesetz, BGBI. Nr. 127/1968: Bundesgesetz vom 14. Maerz 1968 zur Bekaempfung der Tuberkulose
- Gesetz vom 22. August 1945 ueber die Verhuetung und Bekaempfung uebertragbarer Geschlechtskrankheiten
- Aids-Gesetz 1993, BGBI. Nr. 728/1993
- Impfschadengesetz, BGBI. Nr. 371/1973
- Verordnung des Bundesministerium fuer soziale Sicherheit und Generationen ueber empfohlene Impfungen, BGBI. II. Nr. 280/2001
- Bundesgesetz vom 23. Jaenner 1974 ueber die mit gerichtlicher Strafe bedrohten Handlungen, BGBI. Nr. 60/1974
- Allgemeines buergerliches Gesetzbuch (ABGB)
- Schulorganisationsgesetz, SchOG, BGBI. Nr. 242/1962
- Schulpflichtgesetz 1985, BGBI. Nr. 76/1985
- Bundes-Schulaufsichtsgesetz, BGBI. Nr. 240/1962
- Schulunterrichtsgesetz 1986 SchUG, BGBI. Nr. 472/1986

- **Schulorganisationsgesetz from 1962**

The Schulorganisationgesetz from 1962 gives attention to the duty and regulations the school, as an institution, has to follow. (see Wagner-Kreimer, 2005)

Under paragraph 2 it is stated that Austrian schools have the duty to contribute to the development of ethical, moral, religious and social values of the students by offering the best possible education. The schools are responsible to provide the knowledge and competences which are necessary for any future profession, but as well for life. The young individuals shall be educated in order to become healthy, hard-working, dutiful and responsible members of society. Furthermore they shall be lead to self-defined judgement and social comprehension, as well as openness towards economy and culture of Austria, Europe and the World. (see Wagner-Kreimer, 2005)

Within the article of the Schulorganisationsgesetz from 1962, the only time a term in connection with health is coming up, is highlighted above. Neither a term that is strongly connected to health condition, nor a term as *prevention*, *disease*, or *health promotion* could be found in the article.

In the Schulpflichtgesetz from 1985 these terms appear at times. In only very rare occasions the term „medical examination“ shows up in order to describe the necessity of conducting an examination to identify whether a child is ready for pre- or primary school, whether a special educational need is required, or whether a student has to be excused from school for longer periods. (see Wagner-Kreimer, 2005)

As far as health care and hygiene is concerned, only the Schulunterrichtsgesetz from 1986 addresses this issue very briefly. It is stated that a so-called „Klassenforum“(class committee) is responsible to carry out and establish courses and lectures that deal with health care. (see Wagner-Kreimer, 2005)

Finally in the Schulunterrichtsgesetz from 1986 under paragraph 66 the „schulaerztliche Betreuung“, the medical supervision and care can be found. In the first paragraph it is stated that School Physicians are obliged to support teachers in any health related questions that are raised by the students, as long as these questions are concerning the educational curriculum as well as the school attendance; and to advise and to conduct all necessary examinations of the students. (see Wagner-Kreimer, 2005)

The second paragraph states that it is the student's liability to attend the annual medical examination aside from the very first examination, the school readiness examination that is obligatory in order to be able to attend any kind of school. In addition to this annual medical examination, further examinations are possible, if it goes along with the acceptance and agreement of the students. The School Physician is obliged to report any sanitary deficiency to the pupils. (see Wagner-Kreimer, 2005)

Under paragraph three it is stated that in case of any health related topics and an affair being discussed in a teacher’s committee or conference, the School Physician has to be invited in order to attend in a consultative function. (see Wagner-Kreimer, 2005)

Deduced from the legal perspective given above, the main duty of the School Physician in Austria is the medical examination of the students, which is meant to assess the physical condition the student is in. (see Wagner-Kreimer, 2005)

9.3 How to become a School Physician in Austria?

The main requirement to become a School Physician in Austria is the so-called “ius practicandi”. After successfully earning a medical degree, students receive the title “*doctor medicinae universae*” (doctor of overall medical science). To be able to work as a physician, it is needed that the students absolve a 3-years program which is dedicated to various, pre-defined disciplines. Each head of department has to evaluate the students positively before a final exam has to be done. Thus, the ius practicandi is acquired. (see Ärztekammer für Wien, 2011)

To become a specialist, a so-called “*Facharzt*”, the students have the possibility to start straight into the specialised education program, which lasts for 6 years. Typically School Physicians are general practitioners, although paediatricians and women are favoured for the position of a school physician. The function of a School Physician is classified as additional occupation, which means that most of the School Physicians run their own ordination. Still, there are some full-time School Physicians to be found. (see Ärztekammer für Wien, 2011)

Even though the Austrian medical association (the so-called “*Ärztekammer*”) offers a specific educational program for School Physicians, the so-called “*Schulärztediplom*”, it is not required to obtain it in order to be able to operate as School Physician.

Generally schools do not have any impact on the choice of the School Physician, if the position is to be occupied. Job offers can be found on the webpage of the ministry of health. (An example will be displayed in the annex; Figure 6) In rural areas very little School Physicians are found, as the general practitioner, the so-called “*Gemeindearzt*” takes over the function of the School Physician and is in charge of medical services in schools in the close surrounding. (see Ärztekammer für Wien, 2011)

9.3.1 The School Physician Diploma

Courses for the School Physician diploma are offered in Vienna, as well as in Tyrol. Regarding to the information from the side of the medical association, increased demand for these courses can be observed. (see Österreichische Akademie der Ärzte, 2011)

The overall aim of the course is the deepening of knowledge in specific medical disciplines concerning children and adolescents. Moreover in the centre of focus are theoretical, as well as practical methods of examination and treatment; a general introduction into science of education and communication, as well as legal aspects and basics.

In addition the participants are expected to be trained in Public Health promotion and health prevention, and shall also refresh their skills in first aid. Knowledge about how to prevent disease caused by false nutrition, as well as their prevention is communicated within the course additionally. Furthermore the awareness of drug abuse and familial violence is supposed to be raised. (see Österreichische Akademie der Ärzte, 2011)

- **Target group**

Particularly the content of the course is designed for paediatricians, but participation is possible for general practitioners as well. (see Österreichische Akademie der Ärzte, 2011)

- **Duration of the course**

The course consists of 6 workshops; of which each workshop lasts for 2 days. In total the course comprises a 135 hours and has to be absolved within one year. The course is accompanied by E-Learning. (see Österreichische Akademie der Ärzte, 2011)

The tuitions in scope of the *Arztakademie* are as following:

Table 3: Courses of the Arztakademie

• School as place of employment	• Sexual education
• School buffet	• Heart diseases
• School psychology	• School enrolment examination
• Orthopaedic diseases	• Smoking free school
• Doping	• School and addictions
• Sporting injuries	• Physiotherapy
• Logopaedia	• Disturbance of growth
• Wound management	

Source: own illustration based on Österreichische Akademie der Ärzte

- **Fees**

The total fee for the completed course is € 1.500,-. Members of the medical association have to pay uniquely the amount of € 42, - in order to receive a certificate. Participants who are not members of the association, have to pay uniquely € 84,-. (see Österreichische Akademie der Ärzte, 2011)

- **Continuing education**

The medical association provides optional further training for School Physicians. Every one to two months, School Physicians have the opportunity to attend scientific sessions and lectures dedicated to specific needs of pupils and students. These sessions are chaired by medical doctors who are specialists in the field of interest. (see Österreichische Akademie der Ärzte, 2011)

In order to give an example of these courses, those from the actual year 2011 shall be listed here (see Ärztekammer für Wien, 2011)

- June 2011: vertigo and its clarification
- Sept 2011: homoeopathic pain therapy
- Oct. 2011: counselling for 6 to 18 year old pupils and food intolerance
- Nov. 2011: asthma and COPD in children and adolescents
- Dec. 2011: children and adolescent's gynaecology

9.4 Job description of a School Physician

Searching for a position of a School Physician in Vienna or elsewhere in Austria, one can easily find vacancies on several platforms in the internet. Major sources are the Ärztekammer Wien or the Ministry of Health. One will be confronted with one-A 4 sheet which is quite straightforward and basically doesn't contain too much text. (Figure 6) After essential information in regards to the place of employment, the extent of the position and the starting date, only a few points are dedicated to the requirements to fulfil the job. (see Bundesministerium für Gesundheit, 2011)

The listed essential requirements are following:

- Obtaining the Austrian citizenship or a citizenship within the European Union
- Qualified Medical Practitioner as General Practitioner or Specialised
- Capability to work in a team
- Capability to work with and for adolescents

These requirements are followed by others which can be considered as being an asset:

- Perennial experience as General Practitioner or Specialist in Paediatrics
- In depth knowledge in terms of psychosomatic diseases of adolescents and conduct disorders
- Knowledge and experience in terms of prevention of narcotic drugs

The Job description is then after filled with some general information in relation to the contract and insurance, but doesn't respond at all to the job profile or tasks anymore.

In comparison to the job profile of a School Nurse in the United Kingdom this profile seems to be rather without expression. The job profile of School Nurses shall be described later on in chapter 9.8.

9.5 Medical examination

School enrolment/ Einschulungsuntersuchung

Königswieser (2005) writes about the so called "*Einschulungsuntersuchung*", the school enrolment or readiness examination which aims at detecting the physical and sanitary appropriateness to enrol school at a certain age.

School readiness is the keyword in this context. In earlier times it have been somatic criteria that determine the physician's decisions whether the child was ready for school or not. Nowadays medicine advances the view that the School Physician, as basically every physician, should consider the whole human being, physics and psyche. If this is realistically feasible and operable- also in a timely manner, leaves certainly space for discussion. (see Königswieser, 2005)

How can school readiness be then defined?

Children develop physically very quickly until the age of six, whereas in the following years their development slows down very much compared to the time before, as it was found out. (see Königswieser, 2005)

This fact complicates the decision about school readiness which is defined by physical development. Medicine and school policies have to realize and accept that school readiness is a hypothesis, that is based less on knowledge and experience but based on assumption. Would one want to really capture and comprehend a child's readiness for school, it would be necessary to know and evaluate a variety of different variables of the child's life. Unfortunately this is not realizable, but this does not mean of course that medicine and politics have to resign. More important than ever it is, to effectively take moderate advantage of the time available, without falling back on time-consuming, extensive and circumstantial test procedures. (see Königswieser, 2005)

For the accomplishment of the medical examination, a minimum of facilities is necessary: a light, calm, heated and friendly room is the optimal environment for any kind of medical examination or conversation. It is recommended to have a writing desk, seating accommodation, storage possibility and of course an examination-couch. The most important equipment which is needed for a School Physician is a scale, a reliable device to measure the body length, as well as basal equipment needed. (see Königswieser, 2005)

The appropriately completed parental questionnaire, the so called "*Elternfragebogen*" (parents' questionnaire) should be brought by the child, who is most probably accompanied by the mother or the father; and is supposed to replace the standard medical history. (see Königswieser, 2005) Figure 5 of the "*Elternfragebogen*" can be found in the addendum of this work.

Focus should be put on greeting of the student and any companion. Only by the presence of a child, the School Physician can already receive a lot of information about the child's interaction and the socio-economic status. Some School Physicians ask the students to bring a questionnaire with them, from which they can get all information about children's diseases, any injuries, surgeries, or any other health problems. In the focus of the anamnesis is definitely the history of vaccination and to detect any lack of vaccination, which has to come after with a co-operative consideration to the general practitioner of the child. (see Königswieser, 2005)

From a Public Health point of view, vaccination of children is in the centre of interest for every physician and therefore it is his duty to motivate each child and respectively their parents or their majors to undergo vaccination.

Severe physical or sensorial impairment or any other disabilities are most likely to be known already and under treatment. One of the main aims of the medical examination in order to define school readiness is the detection of any deficiency in the development of the child, as for instance various cognitive functions (sense of form and space, structuring and differentiation, calculative thinking, entry of quantities and language), willingness to work, duration of concentration, attentiveness and motivation. (see Königswieser, 2005)

Furthermore it is in the centre of interest to see whether the children are able to be without their parents, respectively their psychological parent and whether it is capable of showing independence within a group of similar age. (see Königswieser, 2005)

In order to receive a complex overview, the School Physician is also supposed to absolve a short, but detailed social anamnesis. Here he or she should choose open questions that, preferably, are answered by one of the parents and give some detailed information about the social network and social competences of the child. (see Königswieser, 2005)

Questions like "What happens, if Christoph spends some time with his friends?", or, "Please describe Marta's afternoon!" can be quite helpful to receive an impression of child from another perspective. (see Königswieser, 2005)

After the social anamnesis, a short test should be accomplished. Specific guidelines, about which kind of skills a child at a certain age has to be capable of, can be used by the School Physician during the test. (see Königswieser, 2005)

Table 4 shows that an age-appropriate motor function is represented by following facts:

Table 4: Capabilities for motor function

Capability Test Königswieser (2005)	• Explain the difference and similarity between a pen and a pencil • Explain the difference between familiar objectives, as dog and bird • Explain how many parts one will have in hands when dividing an object • Explain what a wood is composed of.
Capability Evaluation Meinert (1997)	• Stand on one leg • Bounce on each leg • Fun ambulation on a five-meters long line • Take a seat on a chair and to step down • Catch and throw back a ball • Unwind a ball of wool

Source: own illustration based on Königswieser, 2005

During this motor assessment the School Physician has to pay attention to noticeable problems and asymmetries, as well as to the child's handedness. When it finally comes to the physical examination it is most important to be very considerate of the child's shamefacedness, as it has to be undressed for some time.

Body length while standing and body weight should be measured and compared with the recommended values according to the sex. Body length should be related to the age, whereas body weight should be related to the body length. Also the circumference of the child's head should be measured and be compared to the norm. (see Königswieser, 2005)

Additionally blood pressure would give important information about the child's health condition, as well as the examination of the genitals. The most common noticeable problems, which can be identified quite easily by the School Physician, are: (see Königswieser, 2005)

- Phimosis: a condition where the male foreskin cannot be fully retracted from the head of the penis
- Hydroceoele: accumulation of fluids around a testicle
- Labial adhesion: partial or complete adherence of the labia minora
- Retention of the testicles: abnormal displacement of one testicle

Last but not least also the feet of the child should be examined. In the focus of interest is the very common flat foot, which can easily be identified by asking the child to stand on its toes, as the arch of the foot should be visible. (see Königswieser, 2005)

Summing up, the school enrolment examination is a big challenge for the School Physician.

Apart that with this medical examination the individual readiness of a child is defined and assessed, this examination gives a lot of important information about the development and the health condition of a whole peer group. Valuable data can therefore be collected for further epidemiological research. (see Königswieser, 2005)

At the same time it has to be seen as a great chance, to be able to screen a lot of children in-depth who would not attend any general physician at this age. So far children attended the paediatrician due to the so called "*Mutter-Kind-Pass*"[16] at the age of three, four and also five years.

[16] The „Mutter-Kind-Pass" was implemented within the Austrian Health Care System in 1974 and is representing a monetary stimulus that is supposed to motivate parents to undergo pediatric examination with their children. It is strongly linked to the childcare benefits and is free of charge for any person, regardless the person's citizenship.

For more information follow: Mutter-Kind-Pass

After the period which is covered by the "*Mutter-Kind-Pass*" is over however, many children run the risk to not be medically tested anymore. Of course this won't inflict damage on most of the children, nevertheless also a healthy child should be screened once to twice a year, in order to identify any physical disorder and more important to prevent any physical damage by giving some basic information in a suitable way for children about leading a healthy lifestyle. (see Königswieser, 2005)

The school enrolment examination is of great importance if done precisely as it is the very first preventive medical check-up when entering into the school system. It allegorizes a very important contribution to the evaluation of school readiness and is supposed to be the fruitful basis for all future interventions between the School Physician and the child. (see Königswieser, 2005)

Furthermore, as already mentioned, it is highly important for statistical-epidemiological data. (see Königswieser, 2005)

To be questioned is, whether the School Physician can influence, over a long period, children and students by the annual medical examination which each student has to undergo during his academic career. In the focus of interest is the question if an annual examination is sufficient to have an effective influence on the students. This shall be subject of further research and discussion.

Fact is that during the annual medical examination it is impossible to cover all medical areas as urology, orthopaedics or ophthalmology. Therefore it is more important to focus on prevention and promotion of an overall healthy life style.

9.6 The role of the School Physician

In 1998 a lot of effort has been put into the attempt to obtain as much information as possible about the role of School Physicians. The *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie* (since 2008 named *Ludwig Boltzmann Institut Health Promotion and Research*) designed the project "SchularztNEU" which consisted of a survey among School Physicians, teachers and head of schools and additionally 2 workshops (of which one lasted one day, whereas the other one lasted 3 days), in order to learn more about their opinions and mindset.(see Dür, 1998)

The reason why workshops were held in addition was that it seemed to be reasonable to discuss the outcome of the survey additionally with a significant number of School Physicians with the aim that people, coming directly from the job, would be able to deliver valuable input. The overall goal was to frame overall recommendations that would be helpful to create a new job profile for School Physicians, the "SchularztNEU". (see Dür, 1998)

The above mentioned discussion took place as a 3 days workshop under the name "SchularztNEU" (New School Physician) and started with various abstracts to focus on specific topics as

- The role and function of School Physicians from the perspective of teachers, head of schools and School Physicians
- Role and function from the perspective of parents (as this perspective is not relevant to this thesis, it won't be considered)
- Medical examinations and screening
- Health care services at schools
- Results of the workshop

At this point it has to be stated that the survey as well as the workshop "SchularztNEU" intended to get feedback also from the perspective of teachers and school staff. In relation to the interest of this thesis, only the perspective of the School Physicians will be considered.

9.6.1 Role and function of School Physicians from the perspective of School Physicians (results of the survey in 1998)

Three questions were in the centre of interest when the project “SchularztNEU” was designed:

1) How do School Physicians assess their role and tasks?
2) What is their expectation and in what way reformation has to take place?
3) How can School Physicians be involved in organisational issues from the perspective of teachers?

Through randomization 181 School Physicians, 362 teachers and 181 head of schools were chosen to be asked to fill in the survey. Interestingly to mention at this point is that 75 School Physicians replied, compared to 376 teachers and head of schools. (see Dür, 1998)

- **Range of responsibilites**

In order to evaluate the scope of tasks of School Physicians, several tasks were listed and it was asked whether some of these tasks should rather be included or not included into the responsibilities of the School Physicians. A significant number of the questioned School Physicians were of the opinion that the role of a School Physician is not sufficiently defined. They differentiated between their scopes of tasks in two ways: either it was far too diffuse and unclear or it was too tightened. To be highlighted at this point shall be the fact that the questioned School Physicians were all supporting an extension of their scope of tasks. (see Dür, 1998) Most of the School Physicians were of the opinion that administrative tasks should not be included into their responsibilities, whereas most would prefer to be more busy with preventive measurements, health promotion or psychological care. (see Dür, 1998)

- **Contacts and cooperations**

A School Physician basically depends on cooperation throughout his or her tasks. In regards to contacts and cooperation between School Physicians and other school staff, School Physicians indicated that their contact in the setting of school is limited to pupils only. When it comes to meetings with teachers, the questioned School Physicians referred to very short meetings compared to preferable continuing cooperation. (see Dür, 1998)

Almost never teachers or parents ask for an appointment with the School Physician, whereas pupils most likely address to the School Physician and therefore give the impression of trusting into them. School Physicians consider themselves to be the person of trust for many pupils and are of the opinion that this is a major aspect within their scope of tasks. (see Dür, 1998)

The central relation in terms of cooperation within the setting of school is definitely the relation between School Physician and pupils. This fact arises clearly from the feedback given by the questioned School Physicians. One outcome of the survey was the fact that consultations were hardly ever initiated by the target group- the pupils. Initiation is mostly coming from head of schools or teachers. To be highlighted shall be the fact that there is almost no contact at all with parents. (see Dür, 1998) Part of the questionnaire was the basis of trust as an indicator for successful cooperation. Trust as a basis of cooperation is of great importance to the School Physicians within the survey. (see Dür, 1998)

As far as contacts to teachers are concerned, following situation can be pictured: most of the meetings with teachers are having consultative character and take place within school projects or at class. Interesting to mention at this point is the fact that contact to teachers is actually limited to teachers that are teaching specific subjects; which were biology and gym classes. (see Dür, 1998)

In terms of contacts with parents the situation seemed to be quite frustrating for the questioned School Physicians. Most of them were unhappy with the fact that hardly any contact takes place with parents. Referring to the answers within the survey, the reasons are diverse and shall be listed: (see Dür, 1998)

- Lack of interest from the side of the parents
- Shame to be confronted with uncomfortable situations
- Communication problem due to languages
- Problem of timing (School Physicians are not present any more when parents come to pick up their children)
- Parents only show up upon request of the School Physicians which has a forced character
- Parents only address to School Physicians in case of emergency

- **Claims and desires of School Physicians within the survey**

Health promotion to a greater extent is demanded by the School Physicians in regards to more advisory activities, more informative conferences as well as more education in class. When being questioned about their wishes in connection to extend their scope of activities, School Physicians were of the general opinion that they would wish to be included in health related decisions within the setting of school as well as developing their role into the function of a works physician. It has to be stated at this point that no differences have become obvious in connection to the type of school the School Physicians were employed in. (see Dür, 1998)

In terms of organisation within the setting of school, as for instance to arrange a health-conference, School Physicians would be very open-minded towards a closer integration. Involvement in class education as well as various projects that take place at school would be desirable as well. (see Dür, 1998)

Screening has also been one of the key words within the workshop that was hold in order to discuss the results of the questionnaire. Screening was defined and recommendations of several popular scientific committees have been discussed. The outcome of this discussion was (as again confirmed in 2009 by Gartlehner and Kaminski, see chapter 8) rather unsatisfying. Whatever screening was done by a School Physician in Austria is not fully recommended by the scientific committees for school-aged children.

The overall outcome of the survey as well as of the interactive discussions within the workshop “SchularztNEU”, made clear that not also were School Physicians longing for more involvement and basically an extension of their scope of activities; the legal possibilities would be given, as the legal embedment of School Physicians allows more space for integration. (see Dür, 1998) To be highlighted has the fact that a more defined identification of the so called customers has to take place. Whom are School Physicians focusing on? Pupils, parents, teachers? The questioned School Physicians believed that the more orientated and focused on specific customers, the more the role of the position would have a chance to change. (see Dür, 1998)

As a result from the story-telling experience within the workshop, one keyword seemed to be from great importance to the participants. Teambuilding and teamwork was in the focus of interest of the questioned School Physicians, as teamwork is believed to advance cooperation between the various parties involved as well as would guarantee a stronger significance of the health related issues in schools. (see Dür, 1998)

Under the perspective of School Physicians their major responsibility should be to be a neutral promoter of health promotion. He or she has to be a contact person of trust who is responsible to decide whether to pass on specific information to parents or teachers. Not only should he or she be a promoter, but also an expert who should be additionally a manager of crisis. (see Dür, 1998)

Table 5 summarizes tasks, which were mentioned by the questioned School Physicians within the survey in 1998 in connection to the fact that more focus should be put on them.(see Dür, 1998)

Table 5: Claims of School Physicians

• Availability for pupils	• Treating injuries
• Meetings with pupil	• Teaching in classes
• Providing vaccination	• Dispensing medication
• Visiting conferences related to children's' health issues	• Supervising health status of pupils
• Health promotion	• Teaching sexual health care
• Screening visits	• Running sickbay
• Contact person for families	• Providing consultation hours

Source: own table based on Dür, 1998

Table 6 gives a summary about the barriers that School Physicians face and that represent a limitation of their scope of activities.(see Dür, 1998)

Table 6: Barriers in the scope of activities of School Physicians

• No specific education in terms of social challenges and development in societies	• Insufficient didactic and methodical abilities within group processes
• Insufficient knowledge in regards to project management	• Insufficient knowledge in terms of organisational aspects within schools
• Insufficient knowledge when it comes to supervise teachers and school staff in health related issues as for instance burn-out prevention or treatment	• Insufficient knowledge in regards to core areas of schools (sports, music)
• No involvement in projects and parents-evenings	• Fear of teachers that School Physicians might be taken over organisational responsibilites
• No interests of the side of the parents	• Too many serial medical examinations which keep from promoting health

Source: own illustration based on Dür, 1998

10 School Nurses in the United Kingdom

In 2000 the WHO declaration of Munich states the following:

“We believe nurses and midwives have key and increasingly important roles to play in society’s efforts to tackle Public Health challenges of our time, as well as ensuring the provision of high quality, accessible, equitable, efficient and sensitive services, which ensure continuity of care and address people’s rights and changing needs.” (WHO, Declaration of Munich, Nurses and midwives: a Force for Health, 2000, page 1) For many centuries, nurses deliver Public Health to the public and contribute largely to improve health of individuals and specified target groups or so called communities.

The *Royal College of Nursing* (2005) in London describes the aims of delivering Public Health through nursing services with these selected main tasks, which can be done by the identification of the individual and population health need, by using professional experience and knowledge and assess. (see Royal College of Nursing, 2005)

- Reduce health inequalities - for example, reducing obesity, alcohol or drug abuse, improving sexual health behaviour. One possibility to do so is to target the services at vulnerable individuals and communities. Most possible also access to nursing services has to be improved for specific communities. (see Royal College of Nursing, 2005)

- Increase the awareness in communities about positive healthy behaviors. Health information has to be shared with the public in order to encourage individuals, families and communities to become more active in developing a healthier lifestyle. By promoting health enhancing activities, working within the families and communities can be a huge chance to prevent ill health. (see Royal College of Nursing, 2005)

- Improve population health. Identify and access hard-to-reach groups, engage them around their specific needs. Catalysing health and create new resources and collaborations to sustain good health In local groups and communities, as for instance schools. (see Royal College of Nursing, 2005)

- Promote and develop social capital. Advocate for health gain in relation to all public activities- housing, shopping, transport and many more. Lead partnership work for health with other key organisations. (see Royal College of Nursing, 2005)

- Engage with individuals, families and communities to influence the design and development of services. The contribution and the development of services that protect the Public's Health is a major issue in this specific case. This can be done through immunisation, emergency planning and the prevention of communicable diseases. (see Royal College of Nursing, 2005)

Nurses are known to work with and for the public, they are recognised for their ability to influence behavioural changes within a health promoting environment. (see Royal College of Nursing, 2005)

In the focus of interest is the long history of the important role of nurses in the United Kingdom.

10.1 Legal basis of nursing and midwifery

In 1858 the United Kingdom started to register all medical professions, first with no intention to register also nurses. Soon after, criticism came up and called for the need of a similar system for nurses. A system was then established in 1860 and the associated organisation implemented training and further education for nurses. In 1880 it was the *Hospitals Association* that was responsible for the registration for nurses and further training. Upon the discussion about the length and duration of training and education for nurses discrepancies came up between the *Hospital Association* and the *Matrons Committee*, which was composed of all the matrons of the leading hospitals. (see McGann, Crowther, Dougall, 2009)

One even tried to call Florence Nightingale in, the famous nurse, writer and statistician; because of whom professional nursing was established at St. Thomas Hospital in London in 1860. Florence Nightingale (1820 – 1910) didn't want to get involved, as she was of the opinion that no form of regulation for nursing was needed as the essential qualities could neither be taught, nor examined or regulated! (see McGann, Crowther, Dougall, 2009)

In 1887 there were two voluntary registers, from which the one by the *Hospital Association* tended to be more administrative and the other one which was established by a bunch of nurses who were led by Mr. Ethel Bedford Fenwick (1856 – 1947), named the B*ritish Nurses' Association*. The *British Nurses' Association* was known to have a more explicit public protection remit. (see McGann, Crowther, Dougall, 2009)

Throughout the 1890s the pressure for state registration was growing continuously, but didn't show any progress as there were still too many disagreements. With the establishment of the *Midwives Registration Act* in 1902 it was hoped to have the strongly desired state regulation of midwives and only two years later, the *House of Commons Select Committee* was set up to consider the registration of nurses. Considered that it took the *Commons Select Committee* another two years to set out a detailed and persuasive case for registration, it seems to be almost ignorant that the government then took no action and it took almost another decade during which a number of concepts were introduced but all failed to achieve any significant support or attention by the Parliament. (see McGann, Crowther, Dougall, 2009)

As in many other cases, it was the unforeseen that made a quick establishment of the nursing regulation essential. During and mainly after the First World War, it was urgently needed due to the very important contribution by nurses to the war effort. (see Hallett, 2009) As another consequence the *College of Nursing* was founded in 1916 and another three years later, a regulatory system was established that was distinguished in separate Nursing Registration Acts for England/Wales, Scotland and Ireland; which were still one country at that time. (see McGann, Crowther, Dougall, 2009)

With the, by the *College of Nursing* strongly supported, foundation of another Committee in 1970, the *Briggs Committee*, topics like quality and nature of nurse training were slowly coming up. Regulation itself took slowly but certainly a back seat and in the focus of interest was the question about where to place of nursing within the NHS. The *Briggs Committee* furthermore called for a united central council and separate panel with specialised responsibilities for education. (see McGann, Crowther, Dougall, 2009)

Many years of discussion and reflexion followed and in 1979 the unbelievable happened; the basis of the Nurses, the *Midwives and Health Visitors Act 1979* was formed. Between 1983 and 2002 many more activities around the nursing debate were supposed to follow. One of the main important was the foundation of the *United Kingdom Central Council for Nursing, Midwifery and Health Visiting*. Maintenance of registration of United Kingdom nurses, midwives and so called health visitors, advising those who were about to register were its main duties. (see Nursing and Midwifery Council, 2010)

In order to supervise the educational courses of nursing and midwifery, National Boards were established for each of the countries in the United Kingdom. In 2002 the function of the *United Kingdom Central Council for Nursing, Midwifery and Health Visiting* was carried over by the new *Nursing and Midwifery Council*. The English National Board passed its responsibilities further to newly created bodies in each country and was cut back after this happening. (see Nursing and Midwifery Council, 2010)

Today the *Nursing and Midwifery Council* is still efficiently operating as regulator for England, Wales, Scotland, Northern Ireland and the Islands. It sees itself as a safeguard of health and wellbeing of the public. (see Nursing and Midwifery Council, 2010)

All nurses and midwives are supposed to be registered and the assurance is granted that all registered nurses are properly qualified and competent to work in the United Kingdom. Standards of education, training and conduct are set up that nurses and midwives need to deliver high quality health care consistently throughout their careers. (see Nursing and Midwifery Council, 2010)

The Council guarantees that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code. Furthermore the Council sets up rules for the nurses and midwives practice and supervision and investigates any allegations made against nurses and midwives who may not have followed the code. (see Nursing and Midwifery Council, 2010)

The environment in which nurses are working is changing. The Nursing and Midwifery Council is aware of this fact and set itself a strategic plan to implement until 2014. Their major challenges are represented by the evolving public with its growing needs, growing inequality, ageing population, changing health conditions. All this calls out for new demands to services of nurses and midwives. Technological advances are supposed to be opportunity and challenge at the same time; they bring along new means of monitoring due to more source of data and information. (see Nursing and Midwifery Council, 2010)

10.1 Nursing areas

In the focus of interest for this work is of course only the position of a School Nurses; but as the variety of nursing is that big in England, the most important areas of nursing shall be listed here.

Generally nursing is split up in following areas:

- **Health Care Assistants**

Mostly called social supporters or nursing auxiliaries, Health Care Assistants are persons who are not registered as qualified nurses in the NHS, but work with and for nurses and other health care professionals. Most nurses start their career in the field of social support to then further identify the field of interest and become a qualified and specialised nurse. (see Ball, Pike, 2009)

- **Midwifery**

Some midwives are working within the community, others are working in hospitals. Specialisation can be done in Public Health, woman's health, or teenage pregnancy. (see Ball, Pike, 2009)

- **Adult Nursing**

In the field of adult nursing, the variety of settings is most probably the biggest. The overall aim is to improve patients' lives, may it be by counselling, managing or teaching. Either nurses work in hospital, in older people's homes, within the community, in health centres, in nursing homes or in schools. Specialization is possible in: cancer care, woman's health, accident and emergency, critical care, practicing nursing, health visiting, or school nursing. (see Ball, Pike, 2009)

- **Children's Nursing**

Children Nurses focus on children aged 0 to 18 years old and have the opportunity to work in many different settings. These settings vary from baby care units to teenage services. Being advisors and supporters to parents or other relatives, children's nurses focus on the hospital or community sector. Specialization is possible in burns and plastic, intensive care, child protection and cancer care. This field of nursing is highly valued as the health care system in the United Kingdom is very much aware of the fact that health problems can affect the development of children and that is why it is so important to work with their families as well. (see Ball, Pike, 2009)

- **Learning Disability Nursing**

As learning disabilities can be identified much better in modern times, than it was before, there is also a much bigger need of specialists in learning disabilities. Nurses, specialised in this therapeutic area are expected to support patients to become independent and able to handle daily life activities by themselves. The settings vary also in this case, as it is possible to care for patients 24-hours in assisted living, in hospitals or in specialised secure units. Furthermore it is appreciated if a nurse is a specialist in a specific learning disability and is therefore able to focus on a specific need of a specific target group. The nurse is responsible for the social inclusion of the patients by reducing any barriers that keeps them from living a full-filling life. Main characteristic for Learning Disability Nurses is that they hardly ever work on their own, but are part of an interdisciplinary team, which consist of a general practitioner, therapists, teachers and in some cases also social workers. Nurses who decide to work in the field of learning disabilities have the possibility to specialise in many different kind of areas. (see Ball, Pike, 2009)

- **Mental Health Nursing**

Patients who suffer from mental disease can be found in the various settings in the health care system. This can either be an ordination of a general practitioner, of a social worker or a psychiatrist. Mental Health Nurses can be found in all the above mentioned settings, but they can also operate in a hospital, in health centres, or in the patient's home, as 24-hours assistance. It is possible to specialise in several areas, may it be rehabilitation, child and adolescent mental health or substance misuse. (see Ball, Pike, 2009)

Focus has been put on community care, in which Mental Health Nurses visit their patients as well as their families in their homes or place of residence. This area of nursing is said to be one of the most rewarding. (see Ball, Pike, 2009)

- **Nursing and Midwifery Education**

Nurses are educated generally in universities with the combination of having supervised working experiences in hospitals. Whereas the initial phase is homogeneous, the students are then requested to specialise in the fields of adult, children's, mental health, or learning disabilities. Within the midwifery studies, the students are educated in how to support pregnant women, they are thought about theory and praxis about how to deliver babies and furthermore educate and support future parents. Interesting to mention at this point is that the programs are already addressing to social, political and cultural issues that might come up in reference to maternity care. (see Ball, Pike, 2009)

- **District Nursing**

District Nurses are meant to be the most active group of nurses in terms of being on the road to visit all their patients. Patients will be of all age, but most of them will be elderly and need specific treatment. District Nurses will be most probably confronted with patients who suffer from terminal diseases, or recover after a surgery. In order to be able to work as a district nurse, experienced nurses who are registered with the NHS have to absolve an additional academic year to gain a degree in this specialization. The aim is to benefit from long-life relationships between patients and nurse and thereby achieve improvement of patients' lives. (see NHS careers, 2011)

- **Neonatal Nursing**

In this field of nursing, the patients are represented by a very sensible group: newborn babies who most probably were born premature. This brings along a wide range of physical difficulties, as for instance respiratory problems. To work within the area of neonatal nursing requires ongoing training of nurses who before worked as Children's Nurses or midwives. Many nurses aim at a career in research or consultancy. (see NHS careers, 2011)

- **Health Visitors**

Employed as registered nurses or midwives in the NHS, Health Visitors undergo specific training to be able to work in this field. Each Health Visitor is responsible for a specific geographic area and communicates to a network of institutions which are dedicated to peoples' health. Even though part of a health care team, Health Visitors work very independently and in so-called one-to-one nursing. Very challenging field of activity in this position is the possibility to work also with shelters for homeless and medical centres for deprived people and other disadvantaged groups. Many ways to progress the professional career are available for Health Visitors and can reach from managing positions in the NHS to team leader of a group of Health Visitors. (see NHS careers, 2011)

- **Practice Nursing**

Belonging to the primary care team, most Practice Nurses can be found in general practitioners' ordinations together with a multi-disciplinary team. This position requires a lot of flexibility as clinics are very well visited by the public. This position requires excellent communication skills as it includes running and organizing of clinics. Practice Nurses who undergo specific further education, if so required by the employer, have the chance to manage their own caseload. (see NHS careers, 2011)

- **Prison Nursing**

Representing a very sensible and challenging field of operations, prison nursing requires excellent training, mainly in the field of substance abuse and mental health problems. Prison Nurses are highly respected in public as one is aware that they contribute positively to the re-socialization of the prisoners by improving mental and physical health. Prison Nurses are generally based in prison and may provide 24-hour care. (see NHS careers, 2011)

- **School Nursing**

Being employed by a primary care trust, local health authority or individual schools, School Nurses provide a large variety of medical services to the pupils, their families and school staff. Most probably nurses with special education are preferred for these highly valued positions, but it is also possible to apply for a School Nurse's position after qualifying as a registered nurse. At this point this information shall be sufficient, as the role of the School Nurse shall be described in detail later on. (see NHS careers, 2011)

10.2 The role of School Nurses

With the Public Health paper “Choosing Health” in 2004, the government in England attempted to focus in much more detail on the improvement of services for school aged children by increasing the number of School Nurses. In 2005 the first Children’s Commissioner (at that time Professor Al Aynsley-Green, while currently it is Dr Maggie Atkinson) was announced and Children’s Trusts were established. Many initiatives have been funded prior to this development in order to support schools to be able to provide pupils with a healthier environment, but all these policies and initiatives need an operative arm which implements the theoretical part. (see Ball, Pike, 2005)

School Nurses are believed to represent this operative part and were therefore targeted in the Public Health Paper of 2004. They are operating in the setting of school, directly working with the target group and are therefore representing a highly valuable reliance between the policies and their implementation by promoting health in schools.

- **Employment figures**

There are various job titles for professional nurses who work within the setting of school, influencing the health of school aged children. Doing research in the worldwide web, a great variety of job titles for school nursing will show up. The most typical ones are School Nurse, School Health Nurse, School Nursing Co-ordinator, Clinical Lead, Specific Needs School Nurse, Sister, Matron. (see Ball, Pike, 2005)

The main differentiation between School Nurses can be found within their place of employment. School Nurses can either cover several state schools; typically in an area; or they work for, and in independent schools. (see Ball, Pike, 2005)

In 2005 the *Royal College of Nursing* in London, instructed an independent research consultancy, Employment Research Ltd, to conduct a huge postal survey among School Nurses in the United Kingdom, in order to identify the main tasks and to learn more about the activities of School Nurses in the country. In total 1291 out of 2200 nurses responded to the survey. 75% of the School Nurses, who took part in this survey, were employed by the NHS, 22% worked for independent schools, and 1% were employed directly by state schools. (see Ball, Pike, 2005)

The British government is aware of the risks that young children are exposed to within their environment of modern society. It therefore decided that each primary care trust should be supported to have financial resources for one full-time School Nurse per secondary school and its feeder primary schools (primary schools within a designated area, which works in conjunction with a secondary school in order to facilitate the placing of pupils). (see Ball, Pike, 2005)

- **The role of School Nurses**

Within the survey of the *Royal College of Nursing* 26 activities were presented to the respondents with the request to highlight five activities that they feel to be most time-consuming. There was a proof of evidence that these five activities showed a difference between School Nurses within the state sector and those who worked independently.

Within the state sector, these five activities were listed as most time-consuming: (see Ball, Pike, 2005)

- Being present at child protection conferences
- Providing vaccination
- Meetings with pupils
- Health promotion activities
- Screening activities

These activities are followed by many others, as for instance availability for students without any appointment made in advance, providing sex education and class education or social and health education. Within the independent School Nurses, following five activities were described as very time-consuming: (see Ball, Pike, 2005)

- Treating injuries
- Availability to pupils without appointment
- Running sickbay
- Dispensing medication
- Meetings with pupils

It goes without saying that the variety of activities performed by a School Nurse is enormous; a fact that makes it very challenging to describe and classify all tasks. One of the most important roles of School Nurses is definitely the interference between schools and pupils and pupils and other professionals, as for instance social services, child protection coordinators or child health services. (see Ball, Pike, 2005)

Regarding to the survey of the *Royal College of Nursing*, a third of all respondents expressed their worries about their unclearly defined role. It was reported, that only 21% had a proper job description. Further research is needed, in order to find out whether these job descriptions are representing an accurate reflection. (see Ball, Pike, 2005)

- **Employment facts**

Three main categories of employers can be identified: state school, independent schools (boarding schools or day schools), or any other. (see Ball, Pike, 2005)

State sector School Nurses are responsible for an average of 8 schools, most commonly 1 secondary school and 6 or 7 primary schools[17]. This results in an average of 2,728 pupils. Compared to these numbers, the amount of 663 pupils which has to be covered by an independent School Nurse seems to be much easier to manage. (see Ball, Pike, 2005)

A differentiation has to be made between nurses who manage School Nursing teams, who of course then cover up to 90 schools. Besides these managing positions, it is furthermore possible that a very large number of schools are covered in case a nurse is a specialist, offering a particular service to pupils across many schools. On average, a team of School Nurses consists of 8 to 9 School Nurses. These teams are occupied with various disciplines, which can range from health care assistants to non-School Nurses, or any other staff groups. (see Ball, Pike, 2005)

The average of part-time work is 26 hours per week- to this group of part-time workers belong almost two thirds of all school nurses, 80% of them, working in state schools. Interesting at this point is the fact, that the majority of School Nurses are employed with a term-time contract; almost 83% of School Nurses in state schools belong to this group.

[17] Primary school in England corresponds to so-called “Volkschule” in Austria, whereas secondary schools correspond to “Gymnasium” or “Hauptschule” or “Gesamtschule”.

Alarmingly high are the numbers of covered schools of part-time working School Nurses, when compared to the covered number of schools by full-time working school nurses: 8.9 schools for full time and 8.2 schools for part-time staff. (see Ball, Pike, 2005)

Not only do School Nurses work far behind their agreed working hours, the large amount of schools which they are responsible for, has a negative impact of their quality of life. Big workload is significantly related to a negative attitude towards the job. Compared to the working hours of NHS hospital nurses, a huge gap in between the two groups is obvious and proves that the current staffing level is not even close to the level that would be needed in order to meet the government's requirements. (see Ball, Pike, 2005)

- **Salary**

It is well known that almost all School Nurses work additional hours. Compared to other groups of nurses, there is significant statistic that shows that School Nurses are much more likely to work more hours several times a week. (see Ball, Pike, 2005)

Regarding to the survey of the *Royal College of Nursing* the workload of School Nurses is not paid off at all financially. In average, School Nurses bring along quite a lot of years of experience, but still are only paid low with very slow progression. The average salary of a School Nurse in the United Kingdom in 2010 is 22,692 British Pounds. (This corresponds to approximately 25,258 European Euros) (see Ball, Pike, 2005)

- **Schools/ Pupils**

The majority of School Nurses are employed within primary and secondary schools. 65% of the respondents of the survey of the Royal College of Nursing in 2005 were providing their service in primary and secondary schools. State School Nurses typically have to cover a bigger number of pupils than nurses who work in independent schools. As far as gender, mix and age range is concerned, a huge variety is not uncommon. The majority of pupils are aged from 4 years to 19, and most of the School Nurses provide their service to mixed sex schools. (see Ball, Pike, 2005)

Respondents who were employed in the state sector are typically employed in schools, where almost 35% of the pupils are eligible to be served with free school meals. This is a very interesting fact, as eligibility for free school meals in the United Kingdom is an indicator for the level of social deprivation. (see Department for Children, Schools and Families, 2009) It goes without saying that the services provided by a School Nurse are of great importance as socially deprived children are at higher risks when it comes to health risks, sexual health risks or any other health promotion issues as drug, nicotine or alcohol consumption. (see Ball, Pike, 2005)

- **Volume of work**

No matter if employed within the state or the private sector, 64% of all respondents stated that their volume of work would be too big to handle it professionally. The general assumption behind this fact is that there are basically not enough School Nurses to cover all schools within an area. Alarmingly high is the number of School Nurses who do not feel that they would have enough resources to perform well. (see Ball, Pike, 2005)

Questioned by Employment Research Ltd; we are able to have a clear picture of what reasons keep School Nurses from performing well in their job: (see Ball, Pike, 2005)

- The caseload is too big
- There are not enough School Nurses in the working environment
- Not enough capacities to perform well
- The feeling of being overstrained takes over
- To not be given the assistance needed

There is of course a strong connection between the volume of work and the numbers of schools covered. 82% of state school respondents were expressing their feeling that there wouldn't be enough School Nurses in the area, and also complained about too much work; hence there is a very strong correlation between the individual assessment of volume of work and the number of School Nurses in the area. (see Ball, Pike, 2005)

- **Activities**

As already discussed above, the activities performed by a School Nurse are enormous. The survey of the Royal College of Nursing in 2005, listed 26 activities, which are all considered to be part of the major tasks of the role of School Nurses. In order to demonstrate once again the variety of tasks undertaken by a School Nurse; regardless of her job title; all of the identified tasks shall be listed again. The ranking refers to the most time-consuming activities: (see Ball, Pike, 2005)

Table 7: The most time-consuming activities

• Availability for pupils	• Treating injuries
• Meetings with pupils	• Teaching in classes
• Providing vaccination	• Dispensing medication
• Visiting conferences related to children's' health issues	• Supervising health status of pupils
• Health promotion	• Teaching sexual health care
• Screening visits	• Running sickbay
• Contact person for families	• Providing consultation hours

Source: own illustration based on Ball, Pike, 2005

Table 7: The most time-consuming activities

• Cooperating with other school staff	• Providing education regarding specific needs
• Providing educational service to other school staff	• Look after pupils at their homes
• Making obesity a topic discussed	• Generating health guidelines and policies for schools
• Developing further one's personal abilities	• Managing financial resources
• Offering supportive and educational groups	• Combat bullying
• Counselling in regards to drug or alcohol abuse	• Consultation for pupils

Source: own illustration based on Ball, Pike, 2005

Every School Nurse is confronted with these activities in her career; there is no correlation to the sector the nurse is working in, or the job title. It goes without saying, that the activities undertaken, vary in connection to the needs of the pupils, but the survey of the Royal College of Nursing showed, that at least 11 of the listed activities are actively done by School Nurses, working in the independent sector and at least 17 of the listed activities are actively done by School Nurses, working in the state sector. (see Ball, Pike, 2005)

Generally it is very important to highlight the differentiation of activities performed, between nurses who are employed in state schools and those who are working in independent schools. (see Ball, Pike, 2005)

The main differences shall be shortly listed: (see Ball, Pike, 2005)

- **Home visits**

While almost 90% of state School Nurses perform home visits, only 9% are doing so in the independent sector. (see Ball, Pike, 2005)

- **Child protection conferences**

Almost 95% of state School Nurses attend regularly child protection conferences, whereas only 38% of the School Nurses in the independent sector. (see Ball, Pike, 2005)

- **Sex education and family support**

School Nurses working in the state sector generally have much more contact to families and are furthermore more likely to be responsible for special educational needs service. (see Ball, Pike, 2005)

26 suggested activities in the survey didn't seem to be enough for the respondents. As usual in a survey, the option was given, to tick "others" in case another performed activity is not listed. One in five respondents took advantage of this option to either list an additional activity, or to describe an activity, which was already covered by one of the suggested by the *Royal College of Nursing*, with more detail. Activities, listed under the category "other", have to be added as well to the range of activities, as the respondents felt the necessity to list them separately and to not add them to one of the broad themes: (see Ball, Pike, 2005)

Social and hygiene issues, vision tests or gastronomy feeds, parenting classes, administrative tasks, enuresis consultations, behavioural support and the contact to external agencies as *Youth Advisory Services* were mentioned at this point. (see Ball, Pike, 2005)

- **Access to the service of School Nurses from the pupil's perspective**

As expected, a difference can be found again concerning the pupil's access to a School Nurses' services in the independent and the state sector. In independent schools, pupils are more likely to benefit from the school nursing services through drop-in arrangements, whereas pupils in state schools generally have this possibility only through fixed appointments. The reason for this is that School Nurses, employed in independent schools are generally based in the school, whilst state School Nurses cover various schools and have to commute between them. (see Ball, Pike, 2005)

- **Contact to other partners in the system**

School Nurses interact with many other disciplinarians or agencies. Close cooperation takes place also due to referrals which are undertaken to send pupils to School Nurses. Most probably it is the teacher, sending the pupil to the School Nurse, but it can also be undertaken by health visitors, social workers, parents, or the general practitioner. The frequency of contacts with other health professionals varies from daily to monthly. The survey of the Royal College of Nursing was meant to identify, what kind of agencies or professionals School Nurses have frequent contact with. Health visitors were indicated to be seen daily, followed by social services and child protection coordinators. (see Ball, Pike, 2005)

Ball and Pike (2005, p.32) defined in their study "Results from a survey of school nurses" the whole variety of contacts that School Nurses cooperate with; that can be seen in Table 8.

Table 8: Contacts

• Health visitors	• Community children's nursing teams
• General Practitioners	• Clinical nurse specialists
• Social services	• Educational social workers
• Child development teams	• Psychologists
• Child and adolescent mental health	• Youth Justice
• Dieticians/nutritionists	• Child protection coordinators
• Connexions in relation to careers services	• Police
• SENCOs (Specialised Educational Coordinators)	• Pregnancy advisors
• Paediatric liaison from A&E	

Source: own illustration based on Ball, Pike, 2005, p.32

Again the difference between the two big sectors has to be highlighted: in the state sector, School Nurses have stronger liaison with other professionals and disciplinarians than School Nurses in the independent sector. Whereas state School Nurse have a daily to weekly contact with General Practitioners, independent School Nurses have most contacts in the field of social service and health visitors. (see Ball, Pike, 2005)

- **Improvements in the field of activity**

After identifying the list of activities as well as other professionals School Nurses are collaborating with, the survey of the Royal College of Nursing aimed at working out several activities that respondents wish to spend more or less time on. Obviously many more respondents had more suggestions to make about how to reduce some activities in order to focus on others; they consider being more important. Interestingly to mention at this point is the fact, that quite a big number of respondents stated, that they didn't want to cut off any of their activities performed. (see Ball, Pike, 2005)

More time is desired to spend on following activities according to a significant number of respondents: (see Ball, Pike, 2005)

- Health promotion
- Teaching in classes
- Being available for spontaneous visits
- Advisory support for families
- Offering supportive and educational groups
- Teaching about sexual health related topics
- Making obesity a topic discussed
- Arranged meetings with selected pupils

Those activities, which respondents would like to spend less time on, aren't that numerous: (see Ball, Pike, 2005)

- Performing screening procedures
- Performing vaccination
- Financial monitoring
- Dispensing medication
- Supervising other school staff

The question of course has to be raised, what keeps School Nurses from performing their prior activities and developing them further? The idea suggests itself, that a lack of time and a big caseload are the primary reasons for School Nurses to not be able to follow up with activities viewed as priority. The major factors mentioned in the survey, which are responsible for preventing the respondents from performing well in their tasks or developing further, are obvious: (see Ball, Pike, 2005)

- Not enough time available
- Focus is on other activities
- Too little restrictions of the working area
- Not enough trained staff
- Financial resources

As in many other professions, it is not surprising to have “a lack of time” listed as the main factor that keeps School Nurses from performing and developing their role. Again, there was a significant difference between state sector nurses and independent sector nurses. Basically independent sector School Nurses have less desire to reduce some of their activities in order to focus on others, than state sector School Nurses do. (see Ball, Pike, 2005)

10.3 Training and qualification

Considered the group of respondents of the survey of the *Royal College of Nursing*, it could be identified that School Nurses first register a qualified nurses, approximately 25 years ago. The average amount of years School Nurses have been actively working as School Nurses was about eight years. As this is a fact which differs strongly from other nursing professions, it can be said that within the School Nursing sector, more experienced nurses are employed. Interestingly, it could be found out, that most of the respondents have been employed as community nurses in their previous post, including midwives and bank/agency nurses. Others were working as district nurses, health visiting nurses or practice nurses in their previous post. (see Ball, Pike, 2005)

Important to mention is as well the fact that most nurses come from the *NHS*, others from acute trusts, and again others come from community primary care trusts, and additionally some come from general practitioners. (see Ball, Pike, 2005)

Of interest was furthermore which qualifications the respondents of the survey of the *Royal College of Nursing* were holding. Almost all of the interviewed nurses were registered and are holding RGN/SRN/RN adult qualifications[18]. A smaller number of the respondents is holding a general nursing degree and more than one in five has proven qualification in RSCN/ RN child qualification.[19] There is an additional differentiation between the School Nurse Diploma and the School Nurse Certificate, which is held by many more School Nurses. Once qualified the nurses have the possibility to further specialise in a specific area. Courses can be taken to become a specialist in one of the endless areas of nursing. (see Ball, Pike, 2005)

[18] RGN stands for Registered General Nurse, SRN stands for State Registered Nurse, RN stands for Registered Nurse, who has recently graduated from college and has passed a national licensing exam

[19] RSCN stands for Registered Sick Children's Nurse, RN Child qualifications stands for Registered Nurses with specific qualifications in child protection

Within the survey of the *Royal College of Nursing* in 2005, it could be identified that on average the respondent nurses hold a minimum of three qualifications. Additional qualifications, which have not been addressed above were:

Family planning, health promotion/ Public Health modules, qualifications in first aid, asthma, continence, child protection, counselling, HIV, challenging behaviour and many others. (see Ball, Pike, 2005)

A difference in holding additional certificates and diplomas can be observed repeatedly between the state and the independent sector. Almost half of all respondents in the state sector hold a Specialist Certificate, School Nurse Diploma or any other qualification, compared to the independent School Nurses, of whom only few are doing so. It goes without saying that the more experienced School Nurses are, the more likely they show better qualifications. (see Ball, Pike, 2005)

A significant number of respondents of the survey of the *Royal College of Nursing* shared their opinion about a lack of training or education. This was mainly mentioned by younger School Nurses; Special Needs School Nurses and nurses who haven't been working as School Nurses for very long. (see Ball, Pike, 2005)

- **What keeps School Nurses from receiving more training**

As a significant amount of respondents answered in the affirmative regarding to a lack of education, it was important to identify whether there would and if so, which blockades were responsible of keeping the respondents from further education. More than half of all respondents affirmed the dominance of blockades. The most common reason mentioned is the obvious: funding, followed by having no time available to study, and a lack of back-up persons. (see Ball, Pike, 2005)

It has to be highlighted that nearly two thirds of respondents stated to have a personal training and development plan, which actively involves a direct line manager who designs the plan and is the first contact in regards to personal developing. Information about the intensity of the contact to the line manager was also asked for and it could be found out, that among those nurses who do have a line manager, meet him or her once a year. (see Ball, Pike, 2005)

To summarize this topic, the survey of the *Royal College of Nursing* got a positive feedback of the respondents concerning education and further developing. Almost all respondents said, that although they feel that more education would be needed, they feel at the same time well educated to perform professionally in their job. (see Ball, Pike, 2005)

A very interesting outcome of the study is the fact, that almost all respondents who hold specialised qualifications are much more likely to feel that more education would be needed to meet all professional requirements. The same respondents state furthermore that they feel very well trained to perform well in their job; as well as they feel to have good and easy access to further training and professional development. (see Ball, Pike, 2005)

These answers may result from a higher self-esteem, which is obviously growing in relation to higher qualifications. Additionally it could be identified that the respondents feel that there is a strong connection between good and high qualification and the status of School Nursing itself. Higher qualification comes most probably along with a raise in salary or any other financial reward, but it can only be a personal interpretation, as this was not asked for in the survey. (see Ball, Pike, 2005)

On the one hand, respondents are praising the need of further training and education, but on the other hand, some respondents claimed that there would be too much exaggeration in reference to professional training, as it would put too much pressure on the individual. (see Ball, Pike, 2005)

- **Satisfaction and Frustration**

Under this topic the *Royal College of Nursing* tried to identify the role of the job of a School Nurse itself as well as in what way School Nurses are managed and if/ how they are supported. The sources of possible satisfaction within the job of the respondents were given as following. As usual the ranking represents as well the high agreement of the respondents. (see Ball, Pike, 2005)

Table 9: Satisfaction within the Job

• Emotional connection with pupils and their families	• Positive feedback from the pupils
• Having a positive influence on children's health conditions	• Implementation of knowledge/skills
• Teaching and giving guidance	• Further development of the profession
• Changing work area	• Challenge of working on several issues
• Working with others in a team	• Emotional and physical health condition of children is visible and progressing
• Being counsellor	• Developing under the focus of supporting the pupils
• Responsible for own projects/independent decision making	• Train children to be self-responsible
• Students asking for an appointment	• Having an influence on health policies
• Having an authoritarian position	• Cooperating with an interdisciplinary team
• Being respected by the school	• Further education of the school staff
• Working on PSHE projects	• How much time is spent in the work place

Source: own illustration base on Ball, Pike, 2005

The collection of the data showed that nurses who have been in the role longer than others, tend to highlight the positivity of developing relationships, which was in general the mostly mentioned factor for satisfaction within the survey of the *Royal College of Nursing*.

As far as frustrating factors are concerned the following picture shows: The ranking of issues again is coherent with the answers given by the majority of respondents (see Ball, Pike, 2005).

Table 10: Frustration factors

• Caseload is too high	• Communication between all parties involved is not working well
• Position is not enough respected	• Line management is not providing any help
• Not enough financial resources	• No support for administrative work
• Condition of the facilities is inadequate	• No time/money for further education
• Administrative work is too much	• Skills available are not really implemented
• Needs cannot be met	• Never enough time to focus on
• Working area is not clearly defined	• Clinical, as well as on preventional tasks
• Cooperation with other school staff suffers	• Salary is not satisfying
• No proper respect from family members of the pupils	• Neither time nor support to develop further
• Feeling alone	• Feeling psychologically overstraint
• Poor technological equipment	•

Source: own illustration based on Ball, Pike, 2005

A very significant number of the respondents stated that the reason which is mostly responsible for frustration among School Nurses, is the general condition of being very busy and having a too heavy workload. In addition there is not enough staff, neither funding, nor enough time. (see Ball, Pike, 2005)

Having a closer look at the two groups of School Nurses, working in different sectors, there is almost no difference in the indication of factors which push satisfaction. But in regards to the factors which are responsible for frustration among School Nurses, very different indications could be identified between independent School Nurses and School Nurses, employed within the state sector. (see Ball, Pike, 2005)

Respondents working in the independent sector were indicating that isolation, working alone and not having other nursing colleagues, is what caused most frustration. (see Ball, Pike, 2005). Respondents from the state school sector mostly responded that lack of funding or resources, staff shortages and lack of time or workload as most responsible factors for frustration. (see Ball, Pike, 2005)

While within the state school sector the biggest issue in terms of frustration from the School Nurses' perspective is financial shortage concerning various areas of the role, School Nurses from the independent sector are more likely to feel frustrated by disrespect of their job and their role. (see Ball, Pike, 2005)

As several surveys have already been commissioned by the *Royal College of Nursing*, some data could be compared with the most actual one of the survey of School Nurses in 2009 (see "Past Imperfect, Future Tense, Nurses" employment and morale in 2009) and it could therefore been noticed that in the total comparison of all NHS nurses, state sector School Nurses report the less job satisfaction than all NHS nurses. Summarizing, it can be recorded that a significant number of respondents complain about a too heavy caseload. This issue is mainly affecting the state sector and the major reason for this might be that the number of School Nurses in the areas is not sufficient. Noticeable was the fact that a significant number of School Nurses stated, that they have the feeling that other school staff meet them with due respect and value their commitment. There is a significant difference appearing between both sectors again: independent School Nurses feel less likely to be valued and respected by the other school staff and the school management than state sector School Nurses. In total, all respondents are of the opinion that the expectations from the side of the school management are hard to meet. (see Ball, Pike, 2005)

As already mentioned below, independent sector School Nurses are more likely to feel satisfied in their job than School Nurses from the state sector. The reasons for this might be as various as the many aspects of work life and might be investigated in more detail. However it might be reasonable to attribute this result to the most affirmed issues by state sector School Nurses: having a lack of resources, additional support by colleagues and others, having a clearly defined role and having enough staff to work on the many caseloads. Obviously these aspects of work life, that cause high frustration among state sector School Nurses, do not affect independent School Nurses in a comparable manner. (see Ball, Pike, 2005)

Overall job satisfaction is of course strongly linked to the feeling to be overloaded and overstrained with work, emotionally as well as physically. Grouping nurses again, it was identified that state sector School Nurses are more likely to suffer from too heavy workloads than School Nurses from the independent sector. Thus the reason is also given, why on average, state sector School Nurses tend to be rather unsatisfied. (see Ball, Pike, 2005)

Another conclusion that can be drawn from the respondents' answers is that the job of a School Nurse requires a very high level of autonomy. Some School Nurses see an advantage in this autonomy, others experience it as negative. Mainly within the group of independent sector School Nurses this autonomy is obviously causing the feeling of isolation, of which the independent School Nurses are affected much more than state sector nurses. (see Ball, Pike, 2005)

Another issue that came up within the survey of School Nurses in 2005 by the *Royal College of Nursing* was that the role of School Nurses doesn't seem to be well integrated within a multi-disciplinary team. (see Ball, Pike, 2005)

- **Line Management**

As each School Nurse has a direct line manager, the postal questionnaire of the *Royal College of Nursing* aimed at identifying the professional background of the School Nurses' line managers. Almost half of all respondents had to report to a line manager who had a school nursing background as well and many others reported that their line manager would have other nursing backgrounds. (see Ball, Pike, 2005)

To be highlighted shall be the fact that mainly School Nurses from the state sector are additionally supported by another manager who is responsible for professional support, of whom most have a health professional background. (see Ball, Pike, 2005)

There is a small discrepancy, considered the fact that most respondents from both sectors responded negatively to the question, whether they would receive enough general support. Almost all of them reported a very high level of autonomy which is required in their operational field and the emotional pressure of working alone. Still a significant number mentioned to be satisfied with the support that is provided by the management. Interestingly School Nurses, whose line manager have a background in school nursing as well, are much more likely to be satisfied with the provided professional support, than School Nurses whose line manager have a different educational background. (see Ball, Pike, 2005)

10.4 Which role plays the School Nurse in Public Health Promotion?

- **Are School Nurses valuable to the health care system?**

After the insight into the role of a School Nurse, which was offered by the survey of the *Royal College of Nursing* 2005, the question about the impact of School Nurses still needs to be discussed. Does the service of School Nurses bring valuable benefit to pupils and students, and if, in what way? It goes without saying that there is data available, generated from other surveys, audits, social research and other evaluations. As the publication of the *Royal College of Nursing* aims at the view from the side of the School Nurses, the question was what kind of evidence would be available to show the value of the role of a School Nurse for the pupils. Also this highly interesting topic was covered by the questionnaire. (see Ball, Pike, 2005)

All respondents agreed on the fact that the efficiency of school nursing might be rather difficult, as the service of promoting health is mainly representing propagation as well as communicate information about how to lead a healthy lifestyle. The results won't be measureable in the short term; it needs time to be able to receive measurable data, whether the information taken in many years ago, shows results. As an example, this could be a pupil who was taught in detail about risks of smoking and its impact on cardiovascular diseases by the School Nurse in the beginning of his school career. Only if the same pupil is still not smoking many years later- already being an adult- we can speak about a positive result. (see Ball, Pike, 2005)

Many School Nurses showed themselves convinced about a measureable reduction of teenage pregnancies, as well as a measureable reduction of sexually transmitted infections. Also a decrease in health-harming behaviour, as for instance drug or alcohol abuse is reported by the respondents.

As working comprehensively with other social services, as for instance *Child and Adolescent Mental Health Services*[20]*,* significant changes can also be visible from their side. In case a School Nurse reports a conspicuous child to the *CAMHs*, so called child protection registers are maintained and filled with every detail about the affected child. (see Ball, Pike, 2005)

[20] see CAMHS

These registers therefore serve as informational data as if a child's name is no longer on these lists, it means that the initial intervention made by the School Nurse was successful and the *CAMHs* could intervene positively. (see Ball, Pike, 2005)

Most School Nurses agree on the fact, that their services and educational measurements provide significant benefit to the behavioural lifestyle changes of their students in terms of improved health condition. Through the educational impact of School Nurses, pupils report that it would be easier for them to make decisions regarding their lifestyle and furthermore being interested in boosting a lifestyle that leads to good health. Regarding to the *Royal College of Nursing*, influence of School Nurses through their education and support is a clear benefit to not only pupils, but also to their families. Questioning School Nurses about how they would receive any feedback about their work and from whom, most of them say that primarily it is the response of pupils, families, schools and staff; but also the positive response of other service centres with whom they work together closely. Given evidence is also the fact that pupils actively access the services of other centres, which were proposed by the School Nurses. (see Ball, Pike, 2005)

Positive feedback to the School Nurses valued the most by them, was the one which came from schools and other school staff. This fact boosts the team spirit and gives School Nurses the feeling to be part of the team. (see Ball, Pike, 2005)

Very interesting to mention at this point is, that School Nurses are proud and are very keen to highlight the fact to be able to create a healthier environment and to develop schools as a whole institution in terms of influencing the curriculum, guidelines and policies. (see Ball, Pike, 2005)

The most significant outcomes of services provided by School Nurses, are strongly related to Public Health targets: (see Ball, Pike, 2005)

- Significant reduction of pregnant teenagers
- Number of immunised pupils is increasing
- Less pupils suffer from sexually transmitted infections
- The need of pupils to see a GP or specialist is reduced
- Pupils' presence at classes is higher
- Less pupils addicted to substances
- Monitoring of pupils who suffer from chronic disease
- Reduction of self-injurious behaviour
- Reduction of infectious diseases
- Child Protection registers show less registrations

As already mentioned, the feedback of pupils and families is from great importance to the School Nurses. Regarding to the results from the survey of School Nurses in 2005, conducted by Employment Research Ltd., feedback from pupils and families is of greater value to the School Nurses, than feedback from school staff; even though it is also essential for the team spirit.

Even though some results are measureable, as for instance the decrease in teen pregnancies, most of the outcomes will be visible only later on in life of the pupils. An overall healthy lifestyle and an improved awareness of health issues and risks, as well as better knowledge regarding to health at a very young age will bring great benefit later on in life. (see Ball, Pike, 2005)

Indirectly School Nurses have a positive impact additionally on developing policies and guidelines within schools; they create furthermore a good liaison between schools and other health agencies and moreover are sometimes responsible for the further education of school staff.

Good atmosphere and working environment between school staff and School Nurses is essential, not only to value each other's contribution, but mainly as both parties should be involved in the development or enhancement of the curriculum. (see Ball, Pike, 2005)

- **Performing well, but still place for improvement**

Even though most of all questioned School Nurses have the feeling to have a positive influence on pupils and deliver measureable benefit to their pupils and to the school as an institution, they agree on still needing additional support in order to perform better and more efficient. (see Ball, Pike, 2005)

Most of respondents stated that more staff is needed, in order to be able to delegate workloads and to not work completely independently from other professionals. A significant number also wishes more general support from their management, whereas also administrative support is highly demanded. (see Ball, Pike, 2005)

Interesting to mention is, that many School Nurses are desirous to create materials in terms of health education, as leaflets or posters, but have no financial resources for these kinds of add-ons. Many of the questioned School Nurses express their disappointment about the fact that they feel not fully respected in their role as a nurse and that better understanding of their job and position is needed from all sides- pupils, families, school staff, management, as well as the public. (see Ball, Pike, 2005)

10.5 How to become a School Nurse?

Nursing jobs are very much respected in England, as it is known that the educational path to become a nurse is quite hard to go. Nursing environments are seen to be very challenging, but also rewarding. (see NHS careers, 2011)

The National Health System states on its homepage, that the main requirement to become a nurse is to be interested in caring for people. (see NHS careers, 2011)

As nurses work in every kind of health settings in England, it is easy to find a role which is suitable to the to-be nurse. The first steps for a person who decides to follow a career in nursing are possible in two ways: either one starts his or her way up from support roles or health care assistants, which require no specific qualification and then later on start training to become a registered nurse in the NHS. The other possibility is to apply to university to have a degree in nursing and in addition being a specialized nurse, as most university programs represent specification. (see NHS Jobs, 2011)

In order to be able to work later on within the British health care system, it is needed to hold a degree or diploma. All students, independently from what way of education has been chosen, will be supported financially by the *NHS* throughout their studies. Once being registered, the *NHS* tries to attract nurses by offering various benefits, flexible working hours and opportunities to progress within the job. To be able to work as a nurse within the *NHS*, it is essential to be registered with the *Nursing Midwifery Council* (NMC) as already discussed in chapter 10.1. (see NHS Jobs, 2011)

As the most challenging educational path is a Master's degree in advanced nursing practice, I will focus on the curriculum within this program. Basically a Master's program at universities aims at experienced nurses who would like to gain in-depth knowledge. Most of the university programs in nursing include also Public Health leadership, evidence-based practice and health care research. (see NHS Jobs, 2011)

Universities in England network with clinics and hospitals, which might be one of the reasons that the English academic education in nursing is seen to be one of the best programs. Mainly universities in the big cities brag about the fact that they offer their students access to world leading clinical resources. Another advantage students can benefit from within the university programs is the fact that additional seminars and lectures are offered; given by leaders in healthcare.[21] (see King's College London, 2011)

One of the universities in London, offering academic education for advanced nursing practice is the *King's College London*. With its multi-faculty environment and popularity for clinical and academic expertise, the *King's College London* provides inter-professional learning experience to its students. Students are supported by a so-called pathway leader who is supporting the students in choosing the most suitable formation of the curriculum and acts as a contact person further on during their studies at the college. (see King's College London, 2011)

In order to be trained to become a School Nurse or Health Visitor, the *King's College London* offers the full-time Master's program "Advanced Practice; Specialist Community Public Health Nursing/Health Visiting/School Nursing". (see King's College London, 2011)

Graduates are expected to work as a Professional Supervisor, Public Health Specialist, and Health Consultant or School Nurse later on. In order to receive a Master's degree, students are supposed to study for three years (maximum of six years); in order to receive a diploma it is necessary to study for two years, whereas for a certificate the duration of one year is sufficient. The NHS is funding the program for students from the United Kingdom, while students from overseas have to pay the fees. Important to mention is the fact that for each starting program only 10 to 30 students are accepted. (see King's College London, 2011)

Graduates who successfully go through these programs are respected as qualified nurses, who have a registered specialist practitioner status within the Nursing & Midwifery Council. Their future roles can verify from supporting registered practitioners to contributing to educational development in specific clinics or performing clinical leadership. (see King's College London, 2011)

[21] For further information follow: King's College London

- **Enter the program**

To follow a specialist pathway, to-be students should work in a practice role, preferably having contact with clients. The major requirement is to have a good degree (which represents the Bachelor program in Austria and is typically achieved after three years), but there are also options to enter the program for those without a degree, but other qualifications. To apply for a program like the “Advanced Practice” means to be in a very competitive environment, it is simply as applying for a job. To-be students have to try hard to convince through a specific curriculum vitae, as well as through a meaningful letter of motivation in which they have to point out the evidence of their potential success. (see King’s College London, 2011)

- **Program**

Public Health, leadership in Public Health Nursing, evidence-based practice and decision making, health care research, child protection, specialist practice and community Public Health Nursing, nurse prescribing represent the core modules of the program. School nursing students have the opportunity to subscribe to a clinically focused option. The pathway leader plays an important and supportive role within these decisions. Students who take part in the Master’s program have to perform in an extensive project, which is dedicated to their area of interest. (see King’s College London, 2011)

Students might possibly undergo optional modules, which can be chosen from the undergraduate courses. Again, the pathway leader is the contact person in this respect and consults the students in their decisions of which course to take in addition to the core modules. (see King’s College London, 2011)

These optional modules include a huge variety of courses, from which the most relevant for school nursing shall be mentioned: social and political dimensions of children’s health, advanced assessment skills for non medical practitioners, professional development and organization changes or clinical specialties. (see King’s College London, 2011)

Students undergo a mix of assessments, either this is done by oral or written examination of some modules, or students are assessed by coursework, which represents the predominant way of assessing throughout the program. (see King’s College London, 2011)

To successfully absolve the studies, it is necessary to write a dissertation which includes project involvement. Typically a project will last for twelve months with an extensiveness of thirty hours per week. Each student is supported by a supervisor throughout the project and additional tutorials and seminars are offered to the students. In order to finish the project successfully, it is needed to provide a report with approximately 20.000 words. (see King's College London, 2011)

By going through the website of the *King's College London*, the aim of the course is obvious. It is not meant to form School Nurses after only 3 years of studying. It is neither not meant to fill the students with loads of knowledge and information. It is thoughtfully dedicated to provide students with the knowledge which is required to identify best evidence for practice. (see King's College London, 2011)

Gaining this knowledge by lectures, workshops and the great opportunity to work together with experienced individuals, the students get out of the program with the ability to face challenges as identifying and assessing health needs of their clients and searching for evidence from health care research. (see King's College London, 2011)

10.6 Job description of a School Nurse

If one is searching for a job as a School Nurse within the *National Health System*, one is confronted with comprehensive job descriptions; some of them even containing 10 A4 sheets, filled with every single detail connected to the position of a School Nurse.

A job description of a School Nurse, which was displayed on the webpage of the NHS in July 2011 shall be described in detail. After that, the so-called Person Specification shall be included as well. (see NHS Jobs, 2011) Both documents (Figure 7 and 8) will be available in the annex.

The first paragraph is dedicated to the main aim of the job. The following list gives only a short overview about the numerous points that can be found on the job description: (see NHS Jobs, 2011)

- Lead of a unit of School Nurse Team and other Community Staff Nurses
- Coordinate and delegate work
- Use evidence based practice
- Identify health needs of children and families
- Work in partnership with partner organizations
- Undertake assessment
- Contribute to safeguarding
- Offering enhanced services to those in need
- Represent contact person for caseloads

Secondly, an organization chart is shown to reflect the reporting structures within the department. Thanks to this chart, the applicant is able to clearly see his or her position in the organization. (see NHS Jobs, 2011)

The third paragraph is focusing on the description of the spectrum of duties and responsibilities. Again the applicant will find a large list of points which are meant to describe his or her future work tasks. Again only the most important will be listed here: (see NHS Jobs, 2011)

- Leadership and line management
- Awareness of the key performance indicators of the department
- Mentorship and training
- Undertake further education or developing programs
- Representation of the department
- Work and act client orientated
- Engagement with other organizations

Paragraph four is dedicated to the key result areas; again it goes without saying that this list is impressively long: (see NHS Jobs, 2011)

- Understanding of the key priorities for children's health services
- Participation in the recruitment procedures
- Manage immunization programs
- Perform home visits
- Act as a leader
- Grow and develop further on a self-responsible basis
- Represent clinical leadership

Paragraph five gives more information about the governance within the organization. Trainings participation in audits, advocacy and adherence to the policies of the organization are in the centre of interest. (see NHS Jobs, 2011)

While paragraph six and seven are surprisingly short, only mentioning that there would be scope for own actions and the awareness of professional boundaries, and health and safety within the working environment, paragraph eight is highlighting equality and diversity within the organization. (see NHS Jobs, 2011)

Paragraph nine to fourteen gives short, but detailed information about information governance, personal development planning, trainings, safeguarding, infection prevention and smoke-free policies. (see NHS Jobs, 2011)

This detailed and highly informative job description is followed by an equally detailed document; the person specification. (see NHS Jobs, 2011)

10.6.1 Person specification

In order to be considered as an applicant it is needed to be a registered nurse as well as to have a Bachelors or Masters degree in School Nursing or equivalent. Additionally it is desired to be able to demonstrate experience as a mentor and clear evidence of professional development. (see NHS Jobs, 2011)

Knowledge about child development, current political drivers, Public Health indicators, clinical governance and supervision, understanding of research in the field and many more is required to be chosen for the position of a School Nurse. (see NHS Jobs, 2011)

Required experience ranges from staff conflict solving, operational planning, managing skill mixed teams, collaboration with other agencies and organizations, time management, mentoring and many more. (see NHS Jobs, 2011)

Reading through skills that are expected from the to-be School Nurse, one has the feeling the job position is designed for a managing position in corporate governance. The applicant should show strong communicative skills and proven evidence in leading, managing and developing teams. Besides the ability to delegate within the team; the ability to meet deadlines and to work under pressure, to manage effectively and autonomously as well as the ability to identify safeguarding concerns and communicate appropriately with other organizations are desired. IT skills are required, a fact that goes without saying. (see NHS Jobs, 2011)

Last but not least, I would like to highlight the client focused approach that is dominating the person specification and the whole job description. It is very much visible that for the employer it is in the centre of interest to pursuit a client orientated service. Service to clients, this might be students, pupils, families and others; must be delivered responsively and actively, following an innovative approach. (see NHS Jobs, 2011)

Browsing through the NHS webpage and searching for jobs in school nursing; one is able to find plenty of job offers. These job offers may vary from employer to employer; they might focus on different specializations and requirements. But all of these job offers get an important message across to the applicants. To follow a career as a School Nurse is a highly responsible and rewarding mission. To identify clients' needs and to react in a sensitive way and to deal with diverse issues is essential for a good performance in School Nursing. (see NHS Jobs, 2011)

11 Discussion

When it comes to the question whether the work of a School Physician can be done by a School Nurse it seems to be necessary to clarify primarily if their field of activity can be compared and equalized?

Not a lot of information about the role of a School Physician in Austria reaches the public. More important than ever are surveys, as the one conducted in 1998 by the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie* (since 2008 named *Ludwig Boltzmann Institute Health Promotion and Research*) in Vienna. Together with the survey of the Royal College of Nursing in London in 2005, valuable information could be gathered to get a close insight into the daily life of both professions. Both surveys were addressing their target groups via postal questionnaires, whereas the survey of the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie* furthermore organised 2 additional meetings with a smaller group of participants in order to discuss the outcomes of the survey.

The main categories that allow both professions to be compared to each other have been identified during literature review and have been deduced from the literature available:

	School Physician	School Nurse
Role	- not clearly identified - tasks are known, not specified - feeling of insecurity - field of activity too narrow in regards to limitations - wish not to reduce tasks - wish to extend field of activity - role and performance is unknown by school staff and parents - not enough time for individual care - advisor for pupils only - serial examinations	- not clearly identified - too many tasks to perform - wish not to reduce tasks - have to cover many schools - spend a lot of time in commuting - same amount of schools to be covered no matter if part-time or full-time - not enough assistance - not enough capacities to perform successfully - home visits - weekly consultations with pupils - interface between pupils/school staff/partners/agencies - stronger focus on individual pupils
Contacts/ Co-operation	- serial screening of pupils - running sickbay - hardly any contact to school staff - see a lack of interest from the teachers' side - cooperation with biology and gym teachers - hardly any contact to parents - see a lack of interest from the parent's side - short contacts/consultations - hardly any long-term cooperation	- planned screening of pupils - running sickbay - spontaneous visits of pupils - daily to weekly contact with general practitioner - social services - dieticians - police - pregnancy advisors - parents - school staff - other school nurses, in case a team of school nurses is operating - line managers - mainly long-term cooperation
Job profile	- announced at (homepages of) ministries/Ärztekammer/ schools - short, 1 A4 sheet - not detailed - school physician diploma seen as advantage, not obligatory	- announced at (homepage of) NHS - long, 10 A4 sheets - detailed - contains description of core job - contains organisation chart - contains person specification - requires specific training and a university degree
Education	- ius practicandi (studies of human medicine plus minimum of 3 years training at least) - school physician diploma (not obligatory) - further training offered by the Ärztekammer and Ärzteakademie	- nursing degree or diploma - registered within the Nursing Midwifery Council in order to work in the NHS - in-depth knowledge through Master's program at university - university programs offer a lot of specification
Involvement	- not involved in organisational decisions - no involvement in projects, conferences, parent-teacher-conference - strong need of involvement in teaching, projects, informational conferences	- attending child protection conferences - family support - teaching sex education - train and brief other school staff -leading own projects/contribute to projects - interdisciplinary teams as child development teams

Source: own table based on literature review

Role

As far as the operational field of School Physicians and School Nurses is concerned; both professions consider their job not to be fully specified. Both professions report about a lack of knowledge when it comes to scope of tasks; either it is very diffuse, or it is not clear whether there are some limitations in regards to decision-making. What both professions have in common is what they consider to be their major responsibility- they see themselves as advisors in health related issues and topics. When questioned about whether they would like to cut some activities from their attributed responsibilities; a significant majority of both professions surprisingly do not wish to reduce their scope of tasks. In fact, both professions express their desire to actually spend more time with the pupils, may it be as medical examinations or spontaneous visits by pupils. Whereas School Physicians would mostly like to decrease the amount of administrational tasks, School Nurses showed a great interest in increasing screening interventions.

Both professions expressed a strong desire to spend more time with public health promotion and teaching in class. Additionally School Physicians mentioned to additionally spend more time with curative measurements and individual care of pupils in need (not only emergency cases). (see Dür, 1998)

To sum it up, it can be said that both professions know well about their responsibilities; but still experience a lack of clear definition of their responsibilities, as well as essential tasks.

Co-operation

As far as co-operations within the setting of school are concerned, an immense difference can be identified between a School Physician and School Nurses. Whereas School Nurses have to deal with a variety of partners involved in school, School Physicians report about the need of co-operate much more with other partners in school. (see Dür, 1998) The variety of partners a School Nurse is in steady contact with is quite impressive. May it be social services, psychologist, youth services or even the police; close cooperation is an integral part of the daily tasks of a School Nurse.(see Ball, Pike, 2005) Thanks to the very detailed questionnaire of the *Royal College of Nursing*, which has been sent out in 2005 to a large number of School Nurses, I learnt that through this cooperation with other partners, School Nurses are convinced to have a strong impact on the life styles of their pupils and in the following also their families. The majority of the interviewed nurses expressed their pride related to this fact. (see Ball, Pike, 2005)

School Physicians in Austria do not have numerous contacts with their pupils. (see Dür, 1998) It is also very rare that parents call on the School Physician. Contacts to teachers do not appear frequently and take place only within projects in school or yearly meetings or conferences. It is not surprising that the teachers, School Physicians are co-operating with, are mostly holding classes in biology or gym. It shall be highlighted that School Physicians clearly see the need to be connected to all other teachers of other subjects as well, in order to be better informed, to get to know each other's field of activity, as well as being seen as an integral part of schools. (see Dür, 1998)

Special focus has to be put on the relationship between parents and School Physicians. As it was already mentioned, parents do not show a great interest in meeting up with School Physicians.(see Dür, 1998) If so, School Physicians report that it only happens in case of emergency, or due to the invitation from school. Interestingly, School Physicians are certainly aware of the barriers between themselves and parents: mostly they consider a lack of interest to be reason for an unsatisfying relationship, but also language problems, shame from the side of the parents, or simply a problem of timing (parents most probably come after work, whereas a School Physician leaves school much earlier).(see Dür, 1998) By addressing parents on an ongoing basis, positive influence could be taken on the pupil. School Physicians emphasize the need to implement a parent-teacher-conference. (see Dür, 1998)

It goes without saying that the central relationship is the one of pupils and School Physicians. (see Dür, 1998) It has to be clear that a School Physician as well as a School Nurse depend on ongoing co-operation and qualitative communication in order to represent the person of trust in health related topics.

Education

The biggest difference between a School Physician and a School Nurse appears when having a closer look at the education pathway of both professions.

The School Physician diploma which is available to all School Physicians in Austria is not yet obligatory to be authorized to work in schools with pupils and students. This is due to the unavailability of the diploma courses in a lot of regions in rural areas and the training school changes from year to year. (see Springermedizin, 2011)

Comparing to the (obligatory) educational way of a School Nurse in the United Kingdom, the School Physician diploma seems to be almost unimpressive. In this context I would like to highlight also one of the results of the questionnaire of the *Royal School of Nursing* in 2005, which stated that most of the School Nurses would bring along many years of experience and very good training documentation. (see Ball, Pike, 2005) Still, there is obviously a feeling of lacking training and not benefiting from sufficient further education from the side of the School Nurse. (see Ball, Pike, 2005) The same situation can be found within the outcome of the survey that has been conducted among School Physicians in 1998. School Physicians do in fact see a need of further training when it comes to sexuality, drug addiction, first aid, diabetes, prevention of accidents or reduction of stress. (see Dür, 1998) Again, it shall be highlighted that these needs (and there were many more) reflect the biggest health risks for the young generation, identified and discussed by the WHO in 1999. (see discussed in detail in chapter 6) Worth to notice is the fact that these health risks for the young generation have been identified by School Physicians already one year before they were published by the WHO. More than ten years later, these risks most probably did not change.

The *Ärztekammer* offers some courses each year though to School Physicians who feel the need to receive further training in specific health related topics. (see chapter 8.3) Still, there are many School Physicians around Austrian schools who do not at all have any specific training, neither do they have the School Physician-diploma, nor are some of them paediatrician by training.

Job profile

Primarily the job description or job advertisement of both professions was not in the centre of interest for this work. As an immense difference was noticed within the literature research, it shall still be mentioned shortly. At first sight this difference was visible in the length, but also the content of the profile. The job description of a School Nurse contained much more information about the tasks itself, and gave the impression for the applicant to apply to a highly demanding and challenging position. In comparison did the short job description of a School Physician give a lot of space for speculation in terms of expected tasks and field of responsibility. (job descriptions are discussed in chapter 8.2.2 and 9.7)

Involvement in class

Whereas School Nurses do teach in classes on an ongoing basis and additionally wish to spend even more time with it; School Physicians are not integrated into the curriculum of Austrian's pupils. Interestingly they do wish to be integrated much more actively into classes and they also wish to be dedicated a fix teaching unit. (see Dür, 1998) Subjects that were mentioned within the survey of 1998 were hygiene, social medicine and sex education. In connection with teaching is also the request for health conferences that would allow School Physicians to connect more often with parents and teach them as well. Additionally a call for more frequent consultation hours for parents became obvious within the survey of the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie*. (see Dür, 1998)

The School Nurse as a role is an integral part of the pupils' school-life, as well as of the school staff. He or she is holding classes and represents a contact person for the pupils not only in case of emergency. (see Ball, Pike, 2005) Different from the School Physician whom the pupils meet quite rarely during their school year, the School Nurse appears more frequent and plays an important role in the school as an institution. The fact that it is not uncommon that a School Nurse looks after pupils even at their homes, shows how deeply involved School Nurses in the United Kingdom are. (see Ball, Pike, 2005)

11.1 Health advisor

The compendium of School Nurses in the United Kingdom is adapted to modern public health needs and moreover monitored on a continuing basis. Questionnaires as presented in detail in chapter 9 (see Ball, Pike, 2005) of this thesis give a very concrete overview of the daily job life of School Nurses and need to be conducted regularly in order to detect any nuisance that can lead to bigger issues. Of great importance are at this point the discussion of also frustration and possible caseloads that are too big to be solved by School Nurses.

There is no need to discuss the importance of health promotion for the youngest in our society. There is also no need to discuss any further that the school, as a setting, is the most ideal place to implement public health strategies to address to pupils and students directly. More and more time is spent in schools due to both parents being employed; which means children eat at schools, have their afternoon breaks at schools, learn at schools, are actively involved in sports, create friendships; basically spend a crucial part of their lives in the setting of schools.

As it is very well known, pupils are confronted with many different teachers during their school career. So far I can speak for the Austrian school system, in which on average, each subject is held by another teacher. This is applicable for secondary schools only, as in primary schools normally one teacher is responsible for a class and covers all subjects. A various number of teachers, mainly in secondary schools, clearly show the necessity of transferring the responsibility of health promotion and prevention to **one** person that is very well known by all pupils of each school. This person shall be called *health advisor* from now on, in order to not create a connection to either the profession of the School Physician or the School Nurse.

This *health advisor* shall ideally be an expert in health related topics and ideally also teach the pupils. Besides teaching pupils; school staff should also be kept up to date by regular trainings and presentations that are provided by the *health advisor*. A *health* advisor does not necessarily have to be in the school every day; but there must be the possibility to see and contact him or her on a steady and official basis.

As already practiced in the United Kingdom by School Nurses and also claimed by Austrian School Physicians in the survey conducted in 1998 by the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie*; the *health advisor* teaches in classes and is presented to pupils on a continuing basis. At the best, this would be part in the curriculum of the pupils at least once to twice a month, whereas the subject shall be chosen by the *health advisor*. Any recommendation in terms of the intensity, duration and amount of hours shall not be part in this context and may be discussed in further research.

11.2 Focus on...

What School Physicians and School Nurses are in agreement with, are the health related topics that represent the highest risk to the young generation at the same time. In 1999, also the WHO identified these health risks for young individuals. The fact that they have been identified from the School Physicians within the survey of the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie* (see Dür, 1998); as well as in the latest survey conducted by the *Royal College of London* in 2005 (see Ball, Pike, 2005) from the perspective of School Nurses, shows the great importance they have in terms of public health promotion among the youngest. School Nurses and School Physicians are consonant with the fact that these topics are best addressed to when teaching in class; which is already being done in the United Kingdom, but not yet in Austria.

These discussed health risks and the *health advisors'* involvement shall again be shortly highlighted:

Sexuality

Pupils need to be informed about any possible risks they are facing when starting sexual activity. At the same time, this very sensible topic needs to be addressed in a way that no anxiety is spread among pupils; but that sexual activity can be seen as a powerful thing that can create love, as well as life. Sexuality is nothing to be ashamed of. It is even more important to talk about it openly and integrate it in a very self-evident way. The *health advisor* holds a very challenging position in this context and needs to be trained very well in order to address this topic beneficially.

Addictive substances

Nicotine

Damages that are caused by smoking and consuming tobacco are life threatening and incredibly hard to cure. We know today, that most smoking related health problems will occur during the middle years of one's life. (see Kunze and Schoberberger, 2005) More important than anything else it is therefore, to influence pupils in a way that they don't even start to smoke. This represents one of the biggest challenges, Public Health strategies have to face, as on the one hand smoking might very possibly start due to peer group pressure and many of the young smokers won't smoke longer than a couple of months. On the other hand many of them will indeed increase their consumption of cigarettes and will be facing a nicotine dependency at one point.

The *health advisor* is expected to be responsible for informing the pupils about the facts of smoking. First of all in the focus of interest should be the differentiation of the target group in smokers and non-smokers. (see Kunze and Schoberberger, 2005) In relation to this identification, the *health advisor* on the one hand needs to make pupils aware of the fact that development of drug-dependency is very easily reached. On the other hand, strategies to quit smoking need to be identified and implemented for those who are already used to consume cigarettes.

Alcohol

The interdisciplinary collaboration between *health advisor* and school staff is in the centre of interest, as teachers generally spend more time with pupils and due to this fact could become aware easily of an existing problem. Special attention has to be paid to a coherence of sudden alcohol consumption and critical and emotional life events. (see Kunze and Schoberberger, 2005)

Interestingly to mention at this point is the fact that the institution of school might be one of the triggers to consume alcohol. (see Dür, 2008) School related problems, like bad grades or social problems can lead to alcohol abuse. (see Dür, 2008) The question is what role does the *health advisor* takes over? Of course early diagnosis in case of alcohol abuse is very important to be able to take action against.

Drugs

The role of the *health advisor* in terms of drug abuse is a very sensitive issue and needs to be considered very well. Openness and directness in relation to this challenge as well as clear facts and an honest attitude towards this topic might be a very good basis between the *health advisor* and the pupils. A modern approach would be highly appreciated as it might communicate an authentic conflict from the *health advisor's* side.

An example for a modern approach would be the fact that the *health advisor* would be aware of the problem that addictive substances are very easy to find in Austria's drug market. It would be from great benefit for pupils to discuss how to deal with the situation of being directly addressed by a dealer on the street, as this can represent a very inconvenient situation for young children or teenagers.

Hygiene

Characteristic for European countries is that personal hygiene is taken for granted, also amongst the youngest of us. This picture is created by the widely spread fact that every teenager is putting so much effort in his or her appearance and look. But this doesn't automatically mean that basic hygiene is done at the same time.

Mainly for young people it can be hard to find the right balance between too little or excessive hygienic measurements, implemented in our daily activities. On the one hand cleaning and washing one's body is of course a daily necessity of the modern lifestyle, but on the other hand it can also cause damage. The field of hygiene shall include dental hygiene.

Movement and physical activity

Almost worldwide, sport has become an integral part of pupil's curricula. There is international, cross-cultural agreement which is independent from any political system, that physical activity should be part of public and private education. Besides educational goals as solidarity, equity, companionship and co-operation, the health benefit for each individual is mentioned as justification for the implementation of sports.

It is very well known, that physical activity supports the reduction of stress; it serves furthermore as prevention-factor for many diseases and social factors as companionship and community might have a positive impact on the mental well being of the pupils. It is for a reason people tend to say, that sportive activity is their drug and is a very good substitution for drugs in case of emotional needs.

Schools and school sports cannot deal alone with this Public Health challenge as it is not able to compensate alone with the chronic lack of physical activity of modern societies. Still schools and mainly *health advisors* have the chance to have an impact on pupils and children by implementing at least as many sportive activities into the curricula as possible. The little time which is spent in school sports nowadays has to be seen as a multiplier of motivation to go in for sports individually and get exercise outside of school. (see WHO, Improving Health through Schools; National and International Strategies, 1999)

12 CONCLUSION

To be a School Nurse in the United Kingdom is equalized with a precious position in the health care system, in which the scope of activities contains many responsible and valuable tasks. This is appreciated by the society as one is aware of the fact, that a School Nurse underwent a very challenging educational pathway as it was described in chapter 9.6. Not only is the training absolved at universities that have a very good reputation, but also is it necessary to have some work experience in the field in order to be eligible to join the studies, dedicated to the education of a School Nurse.

In Austria the picture is different. Nursing is equalized with the uncomfortable idea of accompanying old people to toilet, cleaning and feeding them. It is rare to find someone among young people who chooses to become a nurse. Additionally hospitals, clinics and other facilities have to fight a very high employee turnover. The overall picture of nursing is that it is exhausting due to shift-work, badly paid, and moreover not rewarding.

I personally think that the time for reform for the nursing field has come in Austria. In my opinion Austria needs to learn from the system in the United Kingdom and has to think over where nursing can be newly implemented as a public health strategy. Nursing has to become the additional part of modern public health promotion and needs to represent a crucial role in the health care system.

At the time of speaking, nurses are seen as people in the health care system who support patients to improve their health condition. It has to be understood that they can carry out what is needed to prevent to suffer from many diseases. As starting from the scratch, I would suggest to not substitute the School Physician totally, but let to-be School Nurses co-operate. It is definitely not a question about who would be able to do a better job; in the focus of interest has to be the overall benefit for society. What we know very well is that society at a very early stage benefits from health prevention and health promotion.

Two birds can be killed with one stone. A new working area in a highly challenging and rewarding setting would be created for the Austrian nursing sector and at the same time with the implementation of the School Nurse, Austria would move one step closer to modern public health promotion.

Once being involved with science of nursing in detail, it is obvious that the variety of nursing areas can be put on a par with specialised physicians. Nurses have become an integral part of modern medicine and together, with the work of physicians, complement the best possible approach to work for patients, clients, target groups, etc...

Regular questionnaires as conducted by the *Royal College of London* in 2005 shall be guidance for other nations to implement them as well, to get a detailed overview of the profession of interest. Since the accomplishment of the survey in 1998, performed by the *Ludwig Boltzmann Institut für Medizin und Gesundheitssoziologie,* no comparable survey has been conducted in Austria that gives a detailed insight into the profession itself. More than ten years afterwards, it would be reasonable to perform additional surveys. It can be considered whether a similar survey could be conducted with another target group; that is to say nurses. Their education and trainings should be reviewed to see whether there is some space for an additional job field. Would nurses feel addressed by this new field? Do THEY think it is feasible?

To gain more information from their perspective would be of great interest and should definitely be subject of further research.

When it comes to the question whether a School Nurse could take over the work of a School Physician in Austria; the United Kingdom shows very well, that it is possible. New trainings have to be developed for to-be School Nurses, awareness has to be created among the public about how much the role of a School Nurse (also the role of a School Physician) can contribute to an overall healthy lifestyle of children and in the following to families and communities. Politic will fall on deaf ears coming up with a suggestion like this, as physicians and their spokespersons will very probably feel offended and fight against it. Austria is quite conservative when it comes to take further steps; try new things. Mills grind slowly.

13 Annexes

Summary in German/ Deutsche Zusammenfassung

Gesundheitssysteme sind reformbedürftig. Die Zunahme von Volkskrankheiten, wie Diabetes, Arteriosklerose, Adipositas und viele mehr; verursacht durch übermäßige und ungesunde Ernährung, durch Rauchen, durch eine ungesunde Umgebung, durch ungesunde Lebensbedingungen, oder durch einen Mangel an körperlicher Bewegung; stellen eine immer größer werdende Herausforderung für die Gesundheitssysteme Europas dar.

Die hier erwähnten Faktoren sind nur einige der Probleme, mit denen sich Gesellschaften und Politik in Zukunft auseinandersetzen werden müssen. Indiskutabel ist die Bedeutung, die die Prävention hier einnimmt. Nun liegt es bei Politikern und Gesundheitsspezialisten, die Initiative zu ergreifen und auf präventive Maßnahmen zu setzen.

Prävention als Maßnahme kann am besten dann eingesetzt werden, wenn man in einem sehr frühen Stadium ansetzt; also bei den Jüngsten einer Gesellschaft. Somit ist auch die Zielgruppe identifiziert, bei der präventive Maßnahmen durchgeführt werden müssen- nämlich Kinder/SchülerInnen. Eine der wichtigsten Strategien der Sozialmedizin ist es, mit und inmitten einer Gemeinschaft, einer *community*, zu arbeiten und Maßnahmen umzusetzen. Daher liegt es auf der Hand, dass die Schule als das geeignetste Setting angesehen werden kann, wenn es darum geht, sich an so viele junge Menschen wie möglich zur selben Zeit wenden zu können.

SchülerInnen, allen Alters, verbringen in etwa fünf Tage pro Woche für zumindest vier bis fünf Stunden pro Tag, Zeit an der Schule. Von dieser Tatsache muss Gebrauch gemacht werden, da es für sozialmedizinische Maßnahmen genügend Zeit und Spielraum lässt, um mit der identifizierten Zielgruppe zu arbeiten.

Im Mittelpunkt des Interesses steht einerseits der *Schularzt/ärztin* (School Physician), der im österreichischen Gesundheitssystem die gesundheitlichen Interessen der SchülerInnen vertritt und Schulgesundheitspflege betreibt, und andererseits die *Schulkrankenschwester/pfleger* (School Nurse), die im britischen Gesundheitssystem große Verantwortung an Schulen übernimmt, was Gesundheitsförderung und das „Bewerben“, im Sinne des englischen Wortes *promoting*, eines umfassenden, gesunden Lebensstils betrifft.

Die Rolle des österreichischen Schularztes unterliegt momentan in Österreich einer breiten Diskussion; hervorgerufen durch eine aktuelle Studie, die an der Kremser

Donauuniversität in Niederösterreich 2009 unter dem Titel „Reicht Messen und Wiegen“ durchgeführt wurde.

Durch diese Studie geht hervor, dass viele der durchgeführten medizinischen Untersuchungen, einfach gesagt, nicht notwendig sind, die Methoden zum Teil inkonsistent sind und es generell keine einheitlichen Richtlinien für die schulärztlichen Untersuchungen gibt.

Wie auch die Sozialmedizin, sind viele Gesundheitsberufe großen Veränderungen und Innovationen ausgesetzt. Im Zentrum des Interesses ist mehr und mehr das Verstehen einer Gemeinschaft und das Eingehen auf deren spezifische, gesundheitlichen Bedürfnisse sowie die stetige Verbesserung bzw. Erhaltung deren Gesundheitszustandes.

Nach intensiver Beschäftigung mit den beiden Professionen *Schularzt/ärztin* und *Schulkrankenschwester/pfleger* ergeben sich auf den ersten Blick viele Gemeinsamkeiten, den Tätigkeitsbereich betreffend. Bei näherer Betrachtung allerdings, wird offensichtlich, dass sowohl die Kompetenzen des *Schularztes/ärztin* als auch der *Schulkrankenschwester/pfleger* nicht sehr genau definiert sind. Die der *Schulkrankenschwester/pfleger* sind grundsätzlich breiter gefächert; eine ihrer Hauptaufgaben ist es, Schulbesuche und medizinische Untersuchungen durchzuführen, Entscheidungen über das Menüangebot der Schulkantine zu treffen, den Sportunterricht mitzugestalten, Sexualkunde zu unterrichten, den SchülernInnnen als auch den LehrerInnen in beratender Position zur Verfügung zu stehen, Hausbesuche bei Schülern zu machen, aber auch die Interdisziplinarität und Kommunikation zwischen Lehrern, Schülersprechern und dem übrigen Schulpersonal herzustellen und aufrechtzuhalten. Die Aufgaben des *Schularztes/ärztin* beschränken sich hauptsächlich auf Reihenuntersuchungen der Schüler sowie Notfallsversorgung.

Schulkrankenschwester/pfleger und *Schularzt/ärztin* repräsentieren somit die Schnittstelle zwischen SchülernInnen und der Schulleitung, immer mit dem Fokus auf die Gesundheitserhaltung und Gesundheitsförderung der SchülerInnen in allen Bereichen.

Die Annahme, dass Gemeinsamkeiten im Tätigkeitsbereich des *Schularztes/ärztin* und der *Schulkrankenschwester/pflegers* und gleichzeitig große Unterschiede in der Ausbildung herausgearbeitet werden können, hat sich im Rahmen dieser Literaturarbeit bestätigt.

Nun gilt es herauszufinden, welcher Ausbildungsweg sich in den vergangen Jahren besser bewährt hat und von wem die Kinder und SchülerInnen mehr profitiert haben. Ich persönlich spreche mich für eine Erweiterung des Pflegeberufes in Richtung *Schulkrankenschwester/pfleger* aus, da das britische Gesundheitssystem vorzeigt, wie Pflege erfolgreich und effizient modernisiert werden und im Schulsetting eingesetzt werden kann.

Figure 5: Elternfragebogen

SCHULKLASSE: _____

Elternfragebogen

Liebe Eltern!
Ihre Angaben sind nur für die Schulärztin/den Schularzt bestimmt. Sie werden **streng vertraulich** behandelt und sollten in Ihrem eigenen Interesse in einem **Kuvert verschlossen der Schulärztin/dem Schularzt** übermittelt werden. Ein vollständiges Ausfüllen erleichtert die Arbeit der Schulärztin/des Schularztes.

Familienname der Schülerin/des Schülers _____ Vorname:_____
Geschlecht: männlich ◻ weiblich ◻ Geb.-Datum (TT.MM.JJJJ): _____

Name und Anschrift der Eltern (Erziehungserechtigten): _____

_____Telefon:_____

Berufstätigkeit der Eltern: Vater: ja ◻ nein ◻ Mutter: ja ◻ nein ◻
Geburtsjahr der Geschwister: _____,_____, _____, _____, _____, _____
_____

Sind die Eltern zuckerkrank? Vater: ja ◻ nein ◻ Mutter: ja ◻ nein ◻
Sind die Eltern übergewichtig? Vater: ja ◻ nein ◻ Mutter: ja ◻ nein ◻
_____

Welche Infektionskrankheiten hat die Schülerin/der Schüler durchgemacht?

Masern:	ja ◻ nein ◻	Keuchhusten:	ja ◻ nein ◻	Scharlach:	ja ◻ nein ◻
Röteln:	ja ◻ nein ◻	Windpocken (Schafblattern):	ja ◻ nein ◻	sonstige:	_____
Mumps:	ja ◻ nein ◻	Gelbsucht:	ja ◻ nein ◻	sonstige:	_____

_____

Bestanden oder bestehen andere Krankheiten, wie häufige Halsentzündungen, Gelenksentzündungen, angeborene Fehlbildungen, Erkrankungen an Herz-Kreislauf, Magen, Darm, Lunge, Niere, Harnwegen, Haut, Nervensystem.
Bitte Zutreffendes unterstreichen.
Nähere Angaben: _____
_____

Operationen oder bleibende Unfallfolgen: _____

Regelmäßige Medikamenteneinnahme, wenn ja, welche? _____
_____

Wurde die Schülerin/der Schüler gegen FSME (Zecken) geimpft? ja ◻ nein ◻ letzte Impfung am:_____
_____

Besteht im Besonderen:

Asthma bronchiale	ja ◻ nein ◻	Häufiger Kopfschmerz	ja ◻ nein ◻
Allergie (Ekzem, Heuschnupfen, Arzneimittel-, Insektenallergie)	ja ◻ nein ◻	Chronische Mittelohrentzündung (Trommelfellverletzung)	ja ◻ nein ◻
Zuckerkrankheit:	ja ◻ nein ◻	Sehfehler	ja ◻ nein ◻
Ohnmachtsneigung:	ja ◻ nein ◻	Hörfehler:	ja ◻ nein ◻
Anfallsleiden	ja ◻ nein ◻	Sprachfehler:	ja ◻ nein ◻
Auffälligkeiten (Schlaflosigkeit, verstärktes Schnarchen, Bettnässen, häufiges Erbrechen usw.)	ja ◻ nein ◻		

_____

Datum: _____

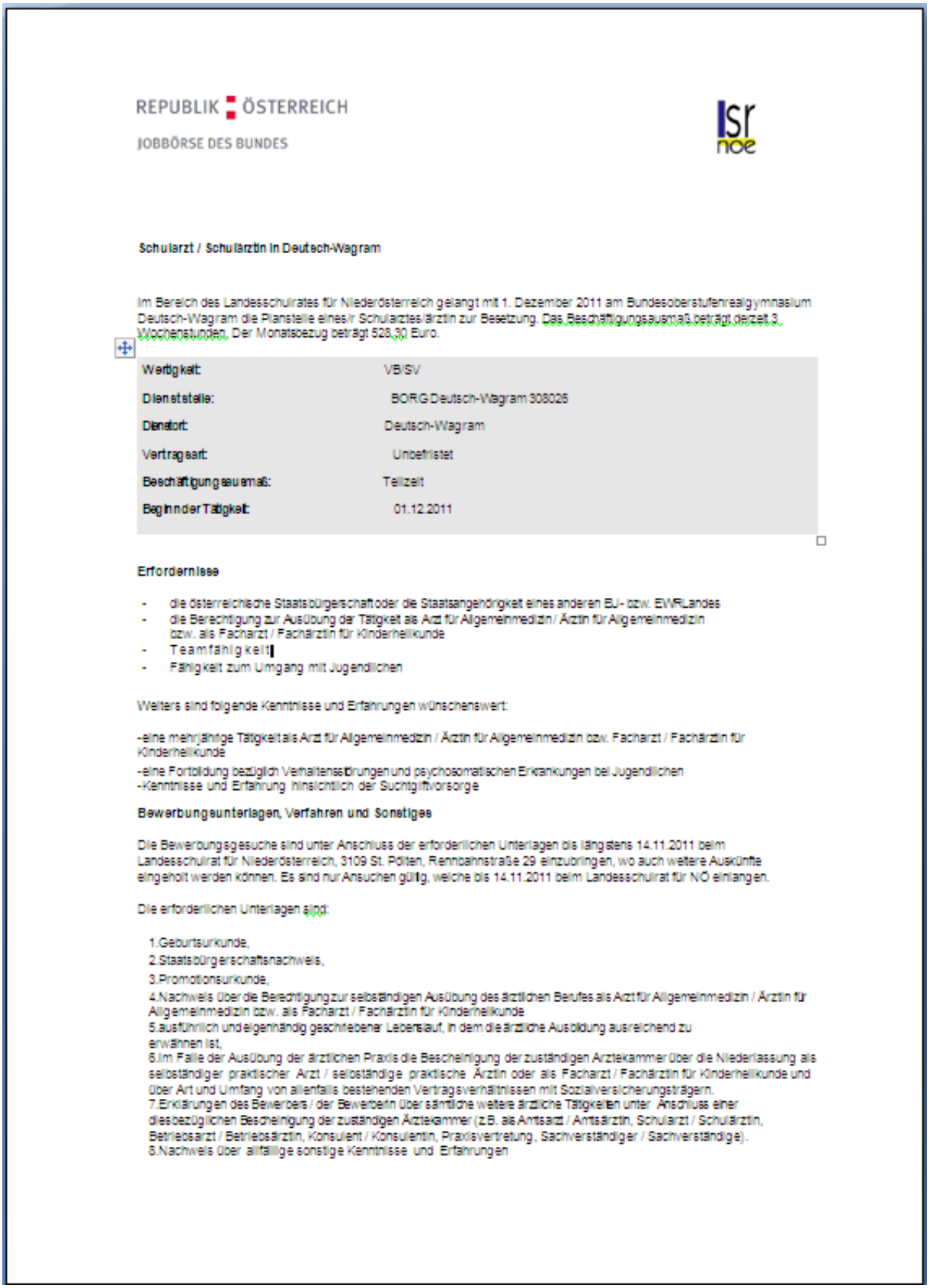
Unterschrift der Eltern (Erziehungsberechtigten): _____

Bundesministerium für Gesundheit
2009 DVR: 2109254

Bundesministerium für Unterricht, Kunst und Kultur
2009 DVR: 0064301

Source: Bundesministerium für Unterricht, Kunst und Kultur, 2009

Figure 6: Job description of a School Physician



REPUBLIK ÖSTERREICH

JOBBÖRSE DES BUNDES

Schularzt / Schulärztin in Deutsch-Wagram

Im Bereich des Landesschulrates für Niederösterreich gelangt mit 1. Dezember 2011 am Bundesoberstufenrealgymnasium Deutsch-Wagram die Planstelle eines/r Schularztes/ärztin zur Besetzung. Das Beschäftigungsausmaß beträgt derzeit 3 Wochenstunden. Der Monatsbezug beträgt 528,30 Euro.

Wertigkeit:	VB/SV
Dienststelle:	BORG Deutsch-Wagram 308026
Dienstort:	Deutsch-Wagram
Vertragsart:	Unbefristet
Beschäftigungsausmaß:	Teilzeit
Beginn der Tätigkeit:	01.12.2011

Erfordernisse

- die österreichische Staatsbürgerschaft oder die Staatsangehörigkeit eines anderen EU- bzw. EWR-Landes
- die Berechtigung zur Ausübung der Tätigkeit als Arzt für Allgemeinmedizin / Ärztin für Allgemeinmedizin bzw. als Facharzt / Fachärztin für Kinderheilkunde
- Teamfähigkeit
- Fähigkeit zum Umgang mit Jugendlichen

Weiters sind folgende Kenntnisse und Erfahrungen wünschenswert:

-eine mehrjährige Tätigkeit als Arzt für Allgemeinmedizin / Ärztin für Allgemeinmedizin bzw. Facharzt / Fachärztin für Kinderheilkunde
-eine Fortbildung bezüglich Verhaltensstörungen und psychosomatischen Erkrankungen bei Jugendlichen
-Kenntnisse und Erfahrung hinsichtlich der Suchtgiftvorsorge

Bewerbungsunterlagen, Verfahren und Sonstiges

Die Bewerbungsgesuche sind unter Anschluss der erforderlichen Unterlagen bis längstens 14.11.2011 beim Landesschulrat für Niederösterreich, 3109 St. Pölten, Rennbahnstraße 29 einzubringen, wo auch weitere Auskünfte eingeholt werden können. Es sind nur Ansuchen gültig, welche bis 14.11.2011 beim Landesschulrat für NÖ einlangen.

Die erforderlichen Unterlagen sind:

1.Geburtsurkunde,
2.Staatsbürgerschaftsnachweis,
3.Promotionsurkunde,
4.Nachweis über die Berechtigung zur selbständigen Ausübung des ärztlichen Berufes als Arzt für Allgemeinmedizin / Ärztin für Allgemeinmedizin bzw. als Facharzt / Fachärztin für Kinderheilkunde
5.ausführlich und eigenhändig geschriebener Lebenslauf, in dem die ärztliche Ausbildung ausreichend zu erwähnen ist,
6.Im Falle der Ausübung der ärztlichen Praxis die Bescheinigung der zuständigen Ärztekammer über die Niederlassung als selbständiger praktischer Arzt / selbständige praktische Ärztin oder als Facharzt / Fachärztin für Kinderheilkunde und über Art und Umfang von allenfalls bestehenden Vertragsverhältnissen mit Sozialversicherungsträgern.
7.Erklärungen des Bewerbers / der Bewerberin über sämtliche weitere ärztliche Tätigkeiten unter Anschluss einer diesbezüglichen Bescheinigung der zuständigen Ärztekammer (z.B. als Amtsarzt / Amtsärztin, Schularzt / Schulärztin, Betriebsarzt / Betriebsärztin, Konsulent / Konsulentin, Praxisvertretung, Sachverständiger / Sachverständige).
8.Nachweis über allfällige sonstige Kenntnisse und Erfahrungen

Source: Bundesministerium für Gesundheit, 2011

Figure 7: Job description School Nurse

Hertfordshire Community Health Services

JOB DESCRIPTION

Title: Specialist Community Practitioner School Nurse (Child and Family Health)

Band: Band 6

Location/Base: Designated Locality within PCT

Directorate/Dept.: Children's Provider Services

Reporting to Team Leader

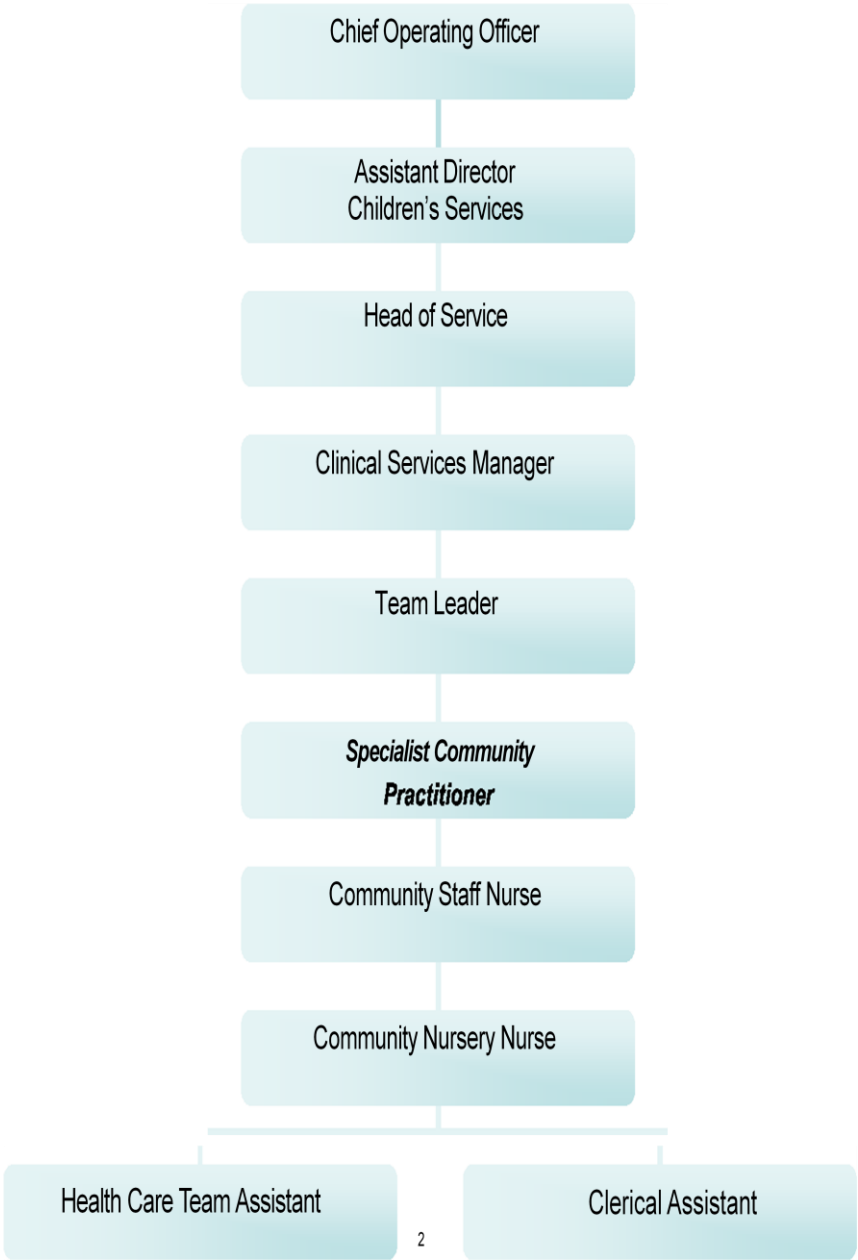
Accountable to: Clinical Services Manager

JOB PURPOSE:

The post holder will work as part of an integrated 0-19 team and will be responsible for assessing, planning and implementing health care in accordance with Trust guidelines. This care may be delivered in a variety of settings

1

ORGANISATIONAL POSITION



DUTIES AND RESPONSIBILITIES

Actively work towards enabling the following five Every Child Matters (DH 2004) outcomes to be realised for every child:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

The post holder will work within the PCT clinical governance framework, which is embedded in the day-to-day practice. Every clinical member of staff must work within the framework.

COMMUNICATION AND RELATIONSHIPS

The post holder will be required to

- Establish clear and effective communication links with children/young people, parents/carers, education staff, and a range of other professionals from both voluntary and statutory organisations.

- listen appropriately and take into account any sensitive issues and communicate these to appropriate persons/agencies ensuring that children are protected and that disclosures are acted upon appropriately

- utilise a range of communication skills e.g. negotiation to gain commitment from others and formal presentations, etc

- to act appropriately upon feedback obtained in order to enable appropriate interventions to be implemented.

- utilise a range of communication methods with colleagues and managers to include electronic communication

ANALYTICAL / JUDGEMENTAL

The post holder will be required to:

- assess, plan and implement interventions and programmes of care for school age children and young people.

- participate in clinical supervision sessions within the designated locality.

- use their own professional judgement to identify solutions to a range of day-to-day problems, seeking advice where appropriate from the team leader in the first instance

- identify the relevant health and social issues within the team's designated schools

- recognise indicators of child abuse and initiate Safeguarding measures in accordance with recognised policies, and procedures of the Trust, and relevant Local Safeguarding Children Board and attend any meetings as appropriate.
- be required to deal with situations where he / she will need to assess events, using a problem solving approach, making appropriate referrals as necessary

- lead in team objective setting and achievement of common goals

- participate and lead in steering groups and research programmes which influence service and policy development
- assist in the provision of support and training necessary to ensure learning occurs following accidents and incidents
- monitor and highlight areas of risk for discussion at meetings and bring to the attention of management

PLANNING AND ORGANISATION:

The post holder will be required to:

- manage their time effectively to ensure prioritisation of workload in order to achieve agreed deadlines.

- plan, organise and oversee the workload for both themselves and those for whom they are responsible within the team.

- be responsive to fluctuations in workload and resources and take action as appropriate.

- manage unpredictable and/or volatile situations effectively.

- manage programmes of care to meet identified need
- assist in the delivery of local implementation plans for the Hertfordshire Children and Young People's Plan, etc. In undertaking this role, work in collaboration with other Senior Managers, Service Leaders and stakeholders.

- identify and report appropriately all incidents and near misses that may compromise the safety of staff and clients and address and manage such issues in conjunction with the Team Leader.
- undertake the role of Lead Professional where appropriate (as defined in the Every Child Matters documentation 2004)

- undertake mandatory training as required by Hertfordshire PCT's and be responsible for own professional development updating of current evidence-based practice using a variety of resources.

- undertake these activities autonomously adhering to trust policies in a variety of settings

- lead on the planning and organisation of public health sessions including immunisation sessions
- act as a mentor to pre-registration students as appropriate and be involved in organising workload of student nurses and junior/new members of the team.

PHYSICAL:

The post holder will be required to:

- carry materials and equipment, e.g. weighing scales, Leicester height measure, boxes of leaflets, audiometers, etc in accordance with relevant health and safety PCT policies
- sit at a computer in order to input data on to systems which would require accurate keyboard skills.

- drive and hold a current driving licence and have access to a vehicle for work and to be able to travel efficiently around the local geographical area. Provide evidence that the vehicle is insured for business use

- move around effectively to undertake the roles and responsibilities of the post
- have the accuracy and dexterity to participate in public health sessions such as immunisations, growth monitoring and screening.

PATIENT AND CLIENT CARE

The post holder will be required to

- organise and undertake health surveillance and screening as determined by the core programme of care, referring to appropriate services as necessary

- undertake health promotion/education activities that are congruent with identified needs and local and government targets

- demonstrate an evidence-based approach to practice to enable the development of a high standard of service provision

- demonstrate cultural awareness in relation to client needs

- undertake home visits in accordance with the Trust's Health & Safety Policy, in relation to lone working

- participate in the Health assessment of 'Children Looked After' [CLA], seeking advice and support from Designated Nurse for CLA as appropriate.

- to identify the safeguarding needs of children and vulnerable adults and to ensure timely implementation of care as stipulated by legislation and local policy

- provide individuals, families or communities with specialist advice in order for them to make informed choices about their health

- to assess, develop and implement with clients, personalised care plans using evidence based care

- Plan and participate in the Department of Health National Childhood Measurement Programme.

- utilise health needs analyses to identify and plan programmes of interventions which will meet the health needs of individuals, families and communities

- Maintain professional records in accordance with both the Trust and NMC record keeping policies.

POLICY AND SERVICE

The post holder will be required to:

- work in accordance with Nursing and Midwifery Council (NMC) Code of Professional Conduct.

- ensure Trust policies, guidelines and protocols are adhered to and reflected in day to day practise. Implement and evaluate guidelines

- recognise ethical and legal issues which have implications for health care of children, young people and their families and take appropriate action
- work within the framework of the local Safeguarding Children guidelines to promote the health and safety of all children in partnership with parents and other agencies.
- be involved in the development of evidence based practice and to ensure that practice is current and dynamic responding to clinical evidence as it develops. To initiate and support innovative change within Children's Services in line with current clinical and academic evidence, national standards and relevant reports.
- attend relevant Trust and team meetings. Have an understanding of the importance of national and local health initiatives and contribute towards achieving specified targets.

FINANCIAL AND PHYSICAL RESOURCES

The post holder will be required to:

- be financially aware in order to manage the Trust's resources appropriately and effectively.
- ensure the establishment and maintenance of resources and equipment.
- be aware of, and have an understanding of the Strategic Direction and Business Plan of Hertfordshire PCTs.
- monitor project delivery for the service, ensuring activities are undertaken according to the plan.
- assist the budget holder in the identification of financial efficiency schemes, and assist in the implementation of schemes where applicable

HUMAN RESOURCES

The post holder will be required to:

- support the training and placement of students and new staff to facilitate their understanding of the role of the team.
- provide mentoring and supervision for team members.
- be involved in day to day supervision and co-ordination of local 0-19 team.
- actively participate in individual appraisal programme using the Knowledge and Skills Framework and appraise others.

- actively participate in regular clinical supervision and safeguarding children supervision

- assist in the recruitment and selection of individuals for posts based on objective assessment and agreed selection criteria, in line with relevant policies and procedures.

- assist in reviewing the skill mix and establishment of the teams in response to changing needs of the service and client needs.

INFORMATION RESOURCES The

post holder will be required to:

- demonstrate accurate keyboard skills with working knowledge of Word and Outlook.

- accurately record all data and client contacts in accordance with Trust policies and procedures, in light of Caldicott principles and Clinical Governance, including information that may be required for Safeguarding Children, audit and research purposes.

- ensure all records are accurate, contemporaneous and updated regularly, according to local and national guidelines

RESEARCH AND DEVELOPMENT

The post holder will be required to:

- undertake appropriate surveys and audit to influence local and national policies ensuring researched-based practice

- ensure personal practice is evidence based and take responsibility for own professional development and identify training needs

- gather research evidence required to ensure advances in nursing and high quality team performance

- assist in the delivery of an agreed audit and development programme that links into the healthcare governance framework

FREEDOM TO ACT

- work autonomously within trust and professional guidelines

- exercise accountability as set out in the NMC Code of Professional Conduct (2004)

- maintain personal competencies and professional development
- work independently with management support as requested within the scope of good management practice

ADDITIONAL INFORMATION:

PHYSICAL EFFORT

- Sitting to undertake data input at computer, maintain written documentation, and compiling reports at desk on a daily basis
- To carry clinical and other equipment short distances using light to moderate effort when necessary, e.g. weighing scales, bulky items etc
- Driving on a daily basis to and from base, client's homes, schools, clinics and other venues
- To undertake clinical tasks e.g. immunisation of adults and children as required

MENTAL EFFORT

- Sustained period of concentration required for a range of tasks including analysing information, assisting in report writing and attending meetings
- Will be required to assess, plan, implement, deliver and evaluate episodes of care to children and young people within a defined caseload adopting a flexible approach to meet individual needs
- There is a requirement for concentration as the work pattern is unpredictable with frequent interruptions to deal with ad-hoc issues.
- The post holder is required to prioritise their work to meet deadlines

EMOTIONAL EFFORT

- On occasion may be required to deal with issues around safeguarding and promoting the welfare of children with parents and carers that may cause angry reactions or distress
- Working autonomously in client's homes may expose the jobholder to difficult situations on occasions. However, a lone worker policy is in place to support staff should this occur.
- The post-holder may be required to convey difficult and sometimes unwelcome information

WORKING CONDITIONS:

- Visits may occasionally be conducted in home environments where poor hygiene prevails

- Unpredictable client behaviour in response to sensitive issues
- Post holder will be office based but will spend a large part of working day working in school environment and other community venues.

Equal Opportunities

The Trust is committed to eliminate racism, sexism and forms of discrimination. The Trust will not discriminate on grounds of age, colour, disability, ethnic origin, gender, gender reassignment, culture, health status, marital status, social or economic status, nationality or national origins, race, religious beliefs, or non beliefs, responsibility for dependants, sexuality, trade union membership or hours of work. It is required of all employees to uphold this policy in the course of their employment with the Trust and whilst undertaking their duties.

Health & Safety at Work

You are reminded that, in accordance with the Management of Health and Safety at Work Regulations 1992 (as amended) and other relevant Health and Safety legislation, you have a duty to take responsible care to avoid injury to yourself and to others by your work activities, and to co-operate with the PCT and others in meeting statutory requirements.

Infection Control

Employee must be aware that preventing healthcare acquired infections and infection control is the responsibility of all staff. Clinical procedures should be carried out in a safe manner by following best practise and infection control policies.

Confidentiality

The post holder will maintain confidentiality when dealing with sensitive material and information, but will encourage people to be open and raise concerns.

Data Protection

All staff must be aware of the Caldicott principles, the Data Protection Act 1998 and the Human Rights Act 1998. The protection of data about individuals is a requirement of the law and if any employee is found to have permitted unauthorised disclosure, the PCT and the individual may be prosecuted. Disciplinary action will be taken for any breach.

Source: NHS 2011

Figure 8: Person specification

Hertfordshire Community Health Services

Person Specification

Job Title: Specialist Community Practitioner (Child and Family Health)

Band: 6

	Essential	Desirable	Measured By
Knowledge, Training and Experience	Registered General Nurse direct entry Midwifery qualification. Specialist Community Public Health Nurse/School Nursing Current Registration with NMC Nurse prescribing qualification (Health Visitors) Evidence of continuous professional development	Mentorship and preceptorship/ENB 998 or other relevant recognised teaching/assessment qualification or willingness to undertake Knowledge of the Education system Nurse prescribing qualification(School Health Nurses)	Application form. Relevant evidence to be submitted and noted when interviewed
Areas of experience and knowledge	Knowledge of safeguarding children procedures and relevant legislation. Awareness of implications of Department of Health initiatives/Government reports. Knowledge of integrated practice and the CAF process Organisation and time management skills Willingness to undertake further trust training Act as a resource/support to other team members able to demonstrate research used in practice		Application form, interview and references

	Ability to work with a wide range of clients in diverse settings.		
Communication Skills	Excellent oral communication skills communicating in manner which is consistent with the level of understanding, culture, background and preferred ways of communicating Excellent written communication skills, to include record keeping (both electronic and manual), report writing, data collection, and evaluations Presentation skills	Evidence of participation in audit and/or research Evidence of leadership in service change/redesign	Application form, interview and references
Analytical Skills	Ability to work independently under his/her own initiative Critical reasoning and problem solving skills Audit and evaluation skills Evidence of assessment of care needs, planning, implementation and evaluation of care plans Evidence of self-management Ability to recognise abuse of children/vulnerable adults and to follow safeguarding procedures. a		Application form, interview and references
Diversity	To demonstrate the ability to show respect and treat people with dignity Awareness of health needs of Black and Minority Ethnic groups		Application form, interview and references
Physical Skills	IT literate and knowledge of Microsoft Office applications		Application form, interview and references

	Ability to work with a wide range of clients in diverse settings.		
Communication Skills	Excellent oral communication skills communicating in manner which is consistent with the level of understanding, culture, background and preferred ways of communicating Excellent written communication skills, to include record keeping (both electronic and manual), report writing, data collection, and evaluations Presentation skills	Evidence of participation in audit and/or research Evidence of leadership in service change/redesign	Application form, interview and references
Analytical Skills	Ability to work independently under his/her own initiative Critical reasoning and problem solving skills Audit and evaluation skills Evidence of assessment of care needs, planning, implementation and evaluation of care plans Evidence of self-management Ability to recognise abuse of children/vulnerable adults and to follow safeguarding procedures. a		Application form, interview and references
Diversity	To demonstrate the ability to show respect and treat people with dignity Awareness of health needs of Black and Minority Ethnic groups		Application form, interview and references
Physical Skills	IT literate and knowledge of Microsoft Office applications		Application form, interview and references

14 List of literature

B

Ball, Jane & Pike, Geoff. (2005). School Nurses. Results from a census survey of RCN school nurses in 2005. London: Royal College of Nursing

Ball, Jane & Pike, Geoff. (2009). Past Imperfect, Future Tense. Nurses' employment and morale in 2009. London: Royal College of Nursing

Berridge, Virginia. (2007). Marketing health- smoking and the discourse of public health in Britain 1945 – 2000. 1st publication. Oxford: Oxford University Press

Bischof, Günter. (2002). Austria in the European Union. New Brunswick, NJ: Transaction Publ.

Brieskorn-Zinke, Marianne.(2007). Public Health Nursing- Der Beitrag der Pflege zur
Bevölkerungsgesundheit. 1. Auflage. Stuttgart: Kohlhammer

Bundesministerium für Gesundheit. (2010). The Austrian Health Care System- Key Facts

Busfield, Joan. (2000). Health and health care in modern Britain. Oxford: Oxford Univ. Press

D

Dür, Wolfgang, et al. (1998). Rolle und Funktion von SchulärztInnen. Ergebnisse der Befragung SchulärztInnen, SchulleiterInnen und LehrerInnen. Endbericht. Ludwig Boltzmann Institut für Medizin- und Gesundheitssoziololgie. WHO Kooperationszentrumfür Gesundheitsförderung und Krankenhaus. Wien

Dür, Wolfgang. (2008). Gesundheitsförderung in der Schule- Empowerment als systemtheoretisches Konzept und seine empirische Umsetzung. 1. Auflage. Bern: Huber

Dür, Wolfgang & Griebler, Robert (2007). Die Gesundheit der österreichischen SchülerInnen im Lebenszusammenhang. Ergebnisse der WHO- HBSC – Survey 2006. Wien: Bundesministerium für Gesundheit, Familie und Jugend

E

Engel, Roswitha.(2006). Gesundheitsberatung in der Pflege- einführende Konzepte und integriertes Ausbildungscurriculum. Band 3. Wien: Facultas Verl.- und Buchh.-AG

F

Fendt, Christian Hans. (2010). Gesundheitssysteme der Europäischen Union – Österreich und das Vereinigte Königreich im Vergleich. Unveröffentlichte Diplomarbeit. Wien: Universität Wien, Institut für Internationale Betriebswirtschaft

Frankhauser, Rainer. (2008). Schulgesundheitspflege und Schularzt- Rechtlicher Rahmen. Im Auftrag des Bundesministeriums für Unterricht, Kunst und Kultur. Wien

G

Gamper, Martina (2002). Die Entwicklung des Schularztwesens in Österreich. Eine Grundlage zur Leitbildentwicklung der Schulärztinnen und Schulärzte und

Ausgangspunkt für Überlegungen zum “Schularzt neu”. Wien: Bundesministerium für Bildung, Wissenschaft und Kultur, Abt. V/2

Gartlehner, Gerald.(2008) Nutzen und Schaden von Screening Programmen. Konfrontation Gesundheit, Präventionsmedizin: Gut oder Gut gemeint? Wien, 25. April 2008.

Gillies, Alan. (2003). What makes a good healthcare system? - Comparison, values, drivers. Abingdon: Radcliffe Medical Pr.

H

Haupt, Martin. (1963). Probleme der schulärtzlichen Tätigkeit: dargestellt an der Zeitschrift für Schulgesundheitspflege 1888-1938. Veröffentlichte Dissertation. Bonn: Universität Bonn, Hohe Medizinische Fakultät

Hendrick, Judith. (2010). Law and ethics in children’s nursing. 1st publication. Oxford: Wiley-Blackwell

K

Kaminski, Angela, Gartlehner, Gerald.(2009) Screeningmassnahmen im Schulalter, Europäisches Forum für Evidenzbasierte Prävention, 25. Juni 2009, Baden, Österreich.

Kogler, Kathrine Elisabeth. (2007). Die Einführung des Schularztes lässt sich nicht über Nacht machen. Diskurs zur Etablierung SchulärztInnen und –zahnärztInnen in der österreichisch-ungarischen Monarchie. Veröffentlichte Dissertation. Wien: Universtität Wien, Historisch-Kulturwissenschaftliche Fakultät

Königswieser, Herbert (2005) Einschulungsuntersuchung S.60-63 in Weber, Gudrun. (Hg) (2005) Kompendium für den Schularzt. 2. Auflage. Wien: Verlag der Ärzte

M

McGann, Susan, Crowther Anne & Dougall Rona. (2009). A History of the Royal College of Nursing 1916-90: A Voice for Nurses. Manchester and New York: Manchester Universtiy Press

W

Wagner-Kreimer, Renate (2005) Rechtsgrundlagen für den Schularzt S.15-51 in Weber, Gudrun. (Hg) (2005) Kompendium für den Schularzt. 2. Auflage. Wien: Verlag der Ärzte

Watkins, Dianne. (2003). Community health nursing-frameworks for practice. 2nd edition. Edingburgh: Baillière Tindall

Weber, Gudrun.(Hg) (2005) Kompendium für den Schularzt. 2. Auflage. Wien: Verlag der Ärzte

Weber, Gudnrun (2005) Sexuella Aufklärung und Geschlechtskrankheiten S. 313-320 in Weber, Gudrun. (Hg) (2005) Kompendium für den Schularzt. 2. Auflage. Wien: Verlag der Ärzte

World Health Organization. (1999). Improving Health Through Schools – National and International Strategies. School Health Component of WHO's Mega Country Network for Health Promotion. Geneva: World Health Organization

15 Internet resources

A

Ärzteakademie,
http://www.arztakademie.at/oeaeknbspdiplome-zertifikate-cpds/oeaek-spezialdiplome/schulaerzte/,
Stand 2011 [Abfrage 20.06.2011]

Ärztekammer für Wien,
http://www.aekwien.at/index.php/fortbildung/schulaerzte
Stand: nicht vorhanden [Abfrage 20.06.2011]

B

Bundesministerium Österreich,
http://www.bmg.gv.at/cms/site/standard.html?channel=CH0714&doc=CMS1164100878910
Stand: nicht vorhanden [Abfrage 11.11.2010]

C

Care UK,
http://www.careuk.com/content/treatment_centre_patients
Stand: 2011 [Abfrage 03.02.2011]

Center for economic studies,
http://www.cesifo-group.de/portal/page/portal/DICE_Content/SOCIAL_POLICY/Basic_Protection/SP060_GUARANTEEING_SUFFICIENT_RESSOURCES/bsimarck-beveridge-dicereport408-db6.pdf
Stand: 2008 [Abfrage 11.04.2011]

D

Declaration of Alma-Ata,
http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
Stand: nicht vorhanden [Abfrage 11.11.2010]

Donau Universität Krems,
http://webcache.googleusercontent.com/search?hl=en&q=cache:8zIwj6__VGcJ:http://www.donau-uni.ac.at/imperia/md/content/department/evidenzbasierte_medizin/projekte/systematische_reviews_und_health_technology_assessments/pr_vention_und_gesundheitsf_rderung/schulscreening_report_final__091211.pdf+Schulscreening+report+donau+uni&ct=clnk
Stand: nicht vorhanden [Abfrage 04.06.2011]

Department for children, schools and families,
https://www.education.gov.uk/publications/eOrderingDownload/DCSF-RTP-09-01.pdf
Stand 2009 [Abfrage 21.05.2011]

Department of Health,
http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/index.htm
Stand: 2011 [Abfrage 27.01.2011]

Department of Health, A short guide to NHS foundation trusts,
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126013
Stand: 2011 [Abfrage 03.02.2011]

I

Initiative ELGA,
http://www.initiative-elga.at/ELGA/wasistELGA.htm
Stand: 2010 [Abfrage 11.01.2011]

K

King's College London,
http://www.kcl.ac.uk/index.aspx
Stand 2011 [Abfrage 30.06.2011]

N

Netcards,
http://www.netcards-project.com/web/partners
Stand März 2007 [Abfrage 30.11.2011]

National Health System,
http://www.nhscareers.nhs.uk/nursing.shtml
Stand: nicht vorhanden [Abfrage 20.05.2011]

National Health System, Jobs
http://www.jobs.nhs.uk/cgi-bin/advsearch
Stand 2009 [Abfrage 16.08.2011]

National Health System, Choosing Health 2004:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Choosinghealth/index.htm,
Stand 2010 [Abfrage 20.05.2011]

National Health Service, UK Screening Portal,
http://www.screening.nhs.uk/
Stand 2011 [Abfrage 20.04.2011]

NHS, Direct,
http://www.nhsdirect.nhs.uk/
Stand: 2011 [Abfrage 27.01.2011]

NHS Choices,
http://www.nhs.uk/servicedirectories/pages/acutetrustlisting.aspx
Stand: nicht vorhanden [Abfrage 03.02.2011]

NHS Choices, Getting contraception
http://www.nhs.uk/Livewell/Sexandyoungpeople/Pages/Gettingcontraception.aspx
Stand: nicht vorhanden [Abfrage 04.03.2011]

O

Organisation wirtschaftliche Zusammenarbeit und Entwicklung,
http://www.oecd.org/document/10/0,3343,de_34968570_35008930_44220298_1_1_1_1,00.html,
Stand: nicht vorhanden [Abfrage 11.01.2011]

Öffentliches Gesundheitsportal Österreich,
https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/Die_Vorsorgeuntersuchung_LN.html
Stand 2011 [Abfrage 21.01.2011]

P

Physicians for a National Health Program,
http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php
Stand 2010 [Abfrage 21.03.2011]

R

Royal Nursing College,
http://www.rcn.org.uk/nursing/becomenurse
Stand 2009 [Abfrage 31.05.2011]

S

Springermedizin,
http://www.springermedizin.at/artikel/22740-allein-zwischen-lehrern-eltern-und-schule
Stand 2001 [Abfrage 11.07.2011]

T

Tony Blair,
http://keeptonyblairforpm.wordpress.com/labours-blairs-top-50-achievements-since-1997/
Stand: 2008 [Abfrage 03.03.2011]

W

Wikipedia,
http://en.wikipedia.org/wiki/List_of_controlled_drugs_in_the_United_Kingdom
Stand: 2011 [Abfrage 18.03.2011]

World Health Organization,
http://www.euro.who.int/__data/assets/pdf_file/0007/53854/E93016.pdf
Stand 2000 [Abfrage 10.05.2011]

World Health Organization, Ottawa Charta
http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
Stand 1986 [Abfrage 15.04.2011]

World Health Organization, Mental Health,
http://webcache.googleusercontent.com/search?hl=en&q=cache:jBT2qeygk5EJ:http://www.who.int/mental_health/media/en/545.pdf+www.who.int/mental_health/media/en/545.pdf&ct=clnk
Stand: nicht vorhanden [Abfrage 11.04.2011]

World Health Organization, School and youth health,
http://www.who.int/school_youth_health/resources/expert_reports/en/index.html
Stand: 2011 [Abfrage 31.01.2011]

Curriculum Vitae

Theresa Bengough

theresa_bengough@hotmail.com

Profil

Organisiert

Zuverlässig

Flexibel

Engagiert

Ausbildung

Gesundheitswissenschaften — *September 2003 - Jänner 2012*
Universität Wien (Österreich)
Institut für Sozialmedizin und Pflegewissenschaften
- Diplomarbeit: *"Two health professions within two different health care systems- or can the work of a school physician be done by a school nurse?"*

Wirtschaftsuniversität Wien (Österreich) — *September 2003 - September 2006*
Institut für Public Management

Matura — *Juni 2003*
Allgemeine Höhere Schule Perchtoldsdorf
Sprachlicher Zweig

Soziale Kompetenz

Selbstständig

Zielorientiert

Projektmanagement

Multikulturelles Team

Schnittstelle

Empathisch

Teamorientiertes Arbeiten

Schnittstelle

Motivierend

Zuverlässig

Berufserfahrung

Boehringer-Ingelheim GmbH (Osterreich) — *Seit März 2010*
Klinische Entwicklung /Projekt Management Vollzeit/ pharmazeutische Industrie
- Kenntnisse der aktuellen nationalen und internationalen Rahmenbedingungen und Anforderungen
- Kommunikation innerhalb eines internationalen Team
- Organisation und Teilnahme an internationalen Meetings
- Schnittstelle zwischen Studienteam und diversen Partnern

Studio92.com Ltd - London (England) — *Februar 2009 – November 2009*
E-marketing Praktikantin / Vollzeit / Tourismus
- Erarbeitung eines Business Plans zur Erreichung neuer Zielgruppen
- Search Engine Optimization, Übersetzungen

Novartis Pharma GmbH (Osterreich) — *Februar 2008 - Januar 2009*
Marketing/ Patient Relation Management Praktikantin/ Teilzeit / pharmazeutische Industrie
- Verantwortung über die Selbsthilfe-Hotline, Treuekundenaktion
- Organisation von Patienteninformationsveranstaltungen, Kongressen

Hypo Niederösterreich- Project: Ball in der Schule (Osterreich) — *2007*
Gesundheitsförderung / Teilzeit /
- Gestaltung des Turnunterrichts in der Volksschule unter dem Aspekt der Gesundheitsförderung
- Ansprechpartner für Schüler in Fragen betreffend Ernährung, Sport und Gesundheit

Sprachen

Deutsch: Muttersprache

Englisch: verhandlungssicher
- Korrespondenz und Firmensprache
- Gelebt und gearbeitet in England (10 Monate – 2009)

Französisch: Sehr gute Grundkenntnisse
- Regelmäßiger Besuch von Sprachkursen an der Universität
- Gearbeitet in Frankreich (4 Monate – 2003)

IT-Kenntnisse

Software
- Gute Kenntnisse von Microsoft Word, Power Point, Excel und Outlook
- Oracle Clinicle Database
- Siebel Database

Internet
- Search Engine Optimization
- Google: Analytics, Adwords, Page Rank

Andere

Ehrenamtlich	2000-2008 Katholische Jungschar Breitenfurt Sternsinger Aktion
Reisen	Großes Interesse am Erleben und Zusammenleben von und mit anderen Kulturen, Leidenschaft für Reisen