Chapter 15
Strengthening Asset Focused Policy Making in Hungary

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15.1 Introduction

Hungary is entering a new phase of public health development. The challenges of facing the social and health impact of the economic and financial crisis require a redressing of the balance between the assets and deficit models for evidence based public health. A greater focus on assets based approaches could help unlock some of the existing barriers to effective action on health inequities. Hungary has a history of asset approach in local communities but not always and appropriately supported by policy making at the national level. If an asset approach is to be realised, a number of things need to be in place to ensure that the aims and objectives of the New Hungary Development Plan (NHDP) can be reached. This chapter sets out the lessons learnt from the past and highlights the critical conditions for policy to assure they take account of the country's assets at the national, regional and local level.

15.1.1 Health Policy Environment

At the present situation in Hungary, the key elements of the macro-policy environment influencing the chances to promote health can be summarised as follows:

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- The present government undertook important new steps to carry out health care reform. The leadership of the Ministry of Health (MoH), for politically understandable reasons, paid more attention to the key elements of the reform (co-payments, restructuring of the care system, new system of insurance etc.) and had less energy and motivation to focus on long-term issues of health promotion.
- The complicated economic situation of the country is characterised by a considerable twin deficit of the state budget and the foreign debt of the country. Moreover a low rate of growth and from the second half of 2008 an explicit recession restricts the possibilities of public funding. This rather difficult financial situation requires innovative ways of thinking to use the assets of the country and a closer linkage of health and development.
- In the medium-term perspective, the European Union (EU) Structural Funds offers a historically unique opportunity of investment in building new capacities for disease prevention and health promotion.
- Inequities in health in Hungary are much greater than the EU average and they continue to increase. The present situation challenges policy development to use new techniques to efficiently tackle social and economic determinants of health inequalities in Hungary.

15.1.2 Main Characteristics of Health Promotion in Hungary

Health promotion has a long history in Hungary, the first programmes were established in the 1980s. The system is well developed, but not consistent, with fragile processes and capacities. The present Hungarian Public Health Strategy, "Johan Béla National Programme for the Decade of Health" (MoH 2003) has an uncertain sustainability due to its marginalization in health policy, limited government level political commitment and declining public funding. At the same time, there is a relative stability in institutional human resources and a number of action areas, such as non-communicable disease prevention, fight against harmful lifestyle habits, and HIV/AIDS prevention. Equity is a horizontal dimension of every programme planning and evaluation in public health in a mandatory way, an explicit concern on reducing health inequities is the prerequisite of any government based target founding. There are specific programmes matched to the needs of different marginalized groups, like the Roma population and poor children. However, inequity in health is still increasing in Hungary and the equity focus of the Public Health Strategy, despite of the explicit concern, is not a success area.

Examples of good practice appear mainly in communities and settings at regional and local level. There are a large number of outstanding programmes, successful initiatives and prime-movers in the different settings, such as workplaces and schools and at the community level. There are also a limited number of recent successful experiences in cooperation with the private sector (Healthy Settlement Association 2006; Healthy Settlement Association 2008).

The question that arises is how to put health, equity in health, and health promotion, higher on the policy agenda of a country in which economic circumstances and weak advocating power lead to a rather unfavourable context. The challenge in Hungary is similar to that of a large number of low- and medium-income countries in Europe. It is clear that the argument for a needs-based approach with a risk focus, despite all the moral considerations, may be insufficient in the given context. The experience of Hungary may offer an example of linking health and development at central, regional and local levels based on the assets of the country.

15.1.3 The Main Assets of Promoting Health in Hungary

In a Hungarian-specific situation for developing a successful health promotion strategy there are a number of organisational and infrastructural assets to take in consideration:

- In Hungary there is a rather well-developed legislation and institutional basis for equity and equal opportunities
- Strong representation of social scientists among health promotion professionals, with sensitivity to equity issues
- There is an existing and well-developed general nursing network, which has access to practically to all families with children
- There is a developing tradition of local health planning: more than 500 settlements have health plans and the Healthy Cities Network is well functioning
- The new legislation prescribes to each school to prepare a health plan
- In the last few years the, "health promoting workplaces" has been quite a successful initiative and has become a real movement (Association for Healthier Workplaces website; ENWHP 2004; Füzesi et al. 2008).

15.2 Setting the Scene

15.2.1 Background, Main Trends of Economic Development

After four decades of state socialism Hungary became a parliamentary democracy and a market economy in 1990. It was admitted to NATO in 1999 and joined the EU in May 2004.

After an economic and social crisis following the transition there was a period of growth in the economy between 1996 and 2005. The public debt was decreasing and the country seemed to be becoming competitive, attracting direct foreign investments. This trend has turned around 2004–2005. The last few years have seen significant economic problems with economic growth restrained by unfavourable international inflation trends and high taxes, which have reduced the competitiveness of enterprises and curbed employment. Although the causes of the difficulties and failures and possible reform solutions are still subject of public debates, there

seems to be a consensus, that the roots of the current problems are deep and lie within the structural problems of the economy and society.

Opportunities for development are determined and limited to a significant degree by the tensions in the government sector. The increase in welfare spending and an overstretched pace of investment led to a budget deficit which exceeds that of most of the accession countries. Therefore Hungary's current economic policy priority is to reduce both its budget deficit and foreign debt. As a consequence of failing to meet the Maastricht convergence criteria, the adoption of the Euro has been postponed.

15.2.2 Budgetary Restrictions

Health promotion activities depend primarily on financial resources from the state budget. Coupled with rather marginal advocating possibilities, this dependency led to a decrease in funding and political support which can be clearly documented in the history of the Hungarian Public Health Strategy adopted by the Parliament in 2003 (MoH 2003). State budget restrictions have been on the agenda since 2004. Measures to reduce the budget deficit in 2006 were mainly aimed at raising incomes and less at reducing expenditures. Restrictions affect the degree of financing of government-based institutions and the employment level of public employees. (For example, the number of staff at the National Institute for Health Development in Budapest was reduced from 87 persons in 2005 to 29 in 2008, and the target funding of the Public Health Programme followed a similar trend from a starting budget of 2 billion Forint in 2004 to 600 million in 2008.) In the conditions of a financial crisis, an effective use of the EU Structural Funds for health aims, linking health and development and adopting an assets approach might be an appropriate way of tackling the challenges of a economic and social crisis.

15.2.3 Facing the Uncertainties of an Economic and Financial Crisis: The Nature of Challenge

The impact of the economic and financial crisis on the health of the Hungarian population will certainly be negative, however, we have a very limited knowledge on the nature, size and the exact mechanism of the effects we have to face. The main challenges at the moment seem to be as follows:

- The impact of economic crisis on the social and economic determinants of health
- Crisis and inequities in health
- Labour market changes, unemployment, job insecurity and health
- Crisis and mental health
- The impact of deteriorating living standards on consumption (for example, changing patterns of nutrition and use of leisure time and health)
- Health of socially excluded groups facing crisis
- The impact of the economic and financial crisis on the health system

For the short and medium term future of health promotion in Hungary, the real basis is the NHDP and using the assets of local communities.

15.3 The New Hungary Development Plan as an Asset for Promoting Health at Central Government Level

The NHDP presents a historic and unique opportunity for Hungary to catch up with more developed member states of the EU. Extraordinary financial resources are provided by the Structural Funds and Cohesion Funds of the EU for the NHDP. According to the decision of the European Commission Hungary will be eligible between 2007 and 2013 for EUR 22.4 billion to accelerate the economic improvement. This remarkable amount itself represents a great asset to ensure the necessary resources to finance and implement various development programmes.

The most important objective of NHDP is to expand employment and to create the conditions for sustainable growth (Government of the Republic of Hungary 2007). New workplaces and greater employment rate will be crucial assets for the social and economic development of the country. Six priority areas are integrated in the NHDP: the economy, transport, for the renewal of the society, environment and energy, regional development and state reform. An important asset of the NHDP is that many elements of the priorities are strongly interlinked and they build a great platform for enhanced intersectoral cooperation. Moreover, the NHDP creates a dynamic process of development and keeps these objectives on the agenda. The attention of the government will be focused on the smooth implementation of the programmes.

In general, the NHDP is an extremely important asset specifically for tackling social and economic determinants of health. Public health and health promotion received a much higher priority and more significant budget than in other countries from the new member states of the EU. The NHDP explicitly underlines the importance of promoting healthy lifestyles, developing social services and reducing child poverty. The social integration of marginalised groups such as the Roma people is targeted through actions for fighting discrimination, creating more services in local communities and strengthening the activities of non government groups (NGOs).

In the present situation the implementation process of the NHDP has started. The concrete measures related to health are mainly, but not exclusively, integrated to the operative programmes for social renewal.

The key messages in the planning process of the operative programme for social renewal are that the planned development activities should contribute to:

- Realization of the aims and objectives of the National Public Health Strategy (MoH 2003)
- Increase of healthy life expectancy
- Decrease of differences between regions
- Structural changes of the health system

The action plan was adopted in July 2007, and the implementation is currently at the start of the bidding process. The plans foresee the participation of all the partners of health promotion including government-based agencies, local governments, universities and research institutions, NGOs, and private expert agencies, mainly in the form of consortiums.

In the period 2008–2010 the key activity areas of implementation should be:

- Evidence based health curriculum development for the different levels of the educational system
- Early childhood programmes
- Programmes for healthy lifestyles
- Country-wide health monitoring system on regional basis

Most of the tenders are focused on the different settings in health promotion: schools, workplaces, and local governments, with special focus on deprived areas and socially excluded populations. The communities of most disadvantaged areas without real assets and having no skills and capacities are at high risk to be excluded from the development funding. Another open question is the sustainability of increased capacities and actions after the implementation period of the NHDP. The potential for long-term sustainability is a critical element in the decision-making process of the funding allocation, but there are a number of controversial past experiences where the development processes in public health collapsed after the end of a target funding mechanism. The most characteristic lesson learnt is the lack of sustainability of the different health promotion components in the frame of the Hungarian World Bank Loan for health services in the second half of the 1990s when, with the end of the funding, most of the important achievements were lost. Building on real existing assets might be the best guarantee for the expected sustainability.

Health promotion in Hungary is now at a critical point. If the implementation process of the NHDP is successful we can hope medium-term important outputs, outcomes, processes and results in promoting health. Also the health impact of the overall development process and the different components should be assessed. This is a task for the negotiations in the near future.

15.4 Specific Features of Community Development in Eastern Europe

In evaluating the assets of Hungarian and also Central and East European communities, their specific features and different way of functioning, as compared to Western Europe, have to be taken in consideration.

The causes of difference are historical. Throughout much of the history of European civilisation, two basic concepts of individuals dominated the way of thinking about the organisation of public life. One of them is marked by a stress on the individual as a sovereign human being who is fully competent and responsible for managing his or her own affairs, having equal abilities and inalienable rights for taking part in public decision making process. Citizens in societies based on this concept may exer-

cise their abilities and pursue their ambitions within political, social and economic spheres of life relatively freely. These societies tend to create a liberal environment which is generally embodied and fixed in laws and an institutional infrastructure characterized by pluralist democracy and a free market economy.

The other concept emphasises a naturally unequal distribution of abilities among individuals and the inability of most people to solve their own problems themselves; it is therefore seen as appropriate to assign most if not all social competencies and responsibilities to an elite, a privileged group of people endowed with certain extraordinary qualities. Societies founded on this concept tend to build a paternalist environment in which citizen's political, social and economic activities are more strictly controlled and, as a compensation for this, most responsibilities are undertaken by state administrated or collectivist institutions which guarantee to citizens a basic economic and social security. These two concepts of individuals and the societies are "ideal types" as defined by Max Weber (1968).

The Western and rather protestant part of Europe can be associated with the first pathway. On the contrary, the communist regimes in East-Central Europe before 1989 represented the more typically paternalist societies. It is important to emphasize, however, that the communist regimes were not the original creators of the paternalist orientations. These regimes built upon and strengthened such tendencies which were already to be found at the time they came to power.

Serfdom in Western Europe came largely to an end in the 15th and 16th centuries, because of changes in the economy, population, and laws governing lord-tenant relations in Western European nations. With increased usage of money, paid labour, industrialization and urbanisation Western Europe followed a different pathway than Eastern Europe. Serfdom reached Eastern European countries later than Western Europe – it became dominant around the 15th century. Through increased demand for agricultural production in Western Europe during the later era when Western Europe limited and eventually abolished serfdom, serfdom remained in force throughout in Eastern Europe during the 17th century so that nobility-owned estates could produce more agricultural products for the profitable export market. This also led to the slower industrial development and urbanisation of those regions. Generally, this process, referred to as "second serfdom" or "export-led serfdom", which persisted until the mid-19th century, became very repressive and substantially limited serfs' rights.

The "second serfdom" was, according to the Marxist view, a return to the most primitive form of peasant service and a retreat from a market-based and money-based economy. Marxist historians further argued that it led to the gradual destruction of both peasant and urban economies, because it deprived urban craftsmen of markets for their products by hampering the growth of an affluent rural population and by fostering the self-sufficiency of landed estates. The second serfdom is seen to reflect the underdevelopment of Eastern Europe (Baldersheim et al. 1996).

As for Hungary, major elements contributing to this pathway in history are the following:

- The feudal and semi-feudal institutions were weaker than its Western-European versions, but they survived longer and hindered the development of new structures including a Western type development of local communities

- Middle classes appeared later and were not so strong. There was no homogeneous middle class culture as in developed industrial countries
- Achievements of the industrial revolution and capitalism were imported in a very rapid way and the adoption of them happened in a few decades, lacking the relevant social and economic antecedents and traditions
- The adaptation of socialism even strengthened the survival of the former patterns of historical development and also limited the development of local community and society

The strictly centralised structure of political power and the economic system resulted in a top-down structure of society, meaning that local power was the least influential in the system (Hankiss 1982).

Within these circumstances, civil activity appeared already in the 1970s rather as kind of resistance mentality, for example, in the economy as "second alternatives" and later in environment protection, anti-nuclear protestation, etc.

On the contrary, the community assets approach is based on positive incentives. So, for reasons deeply enrooted in Central and East European history, concepts like community resilience and citizens' participation in local community life have a very different content from the Western standards, also reflected as norms in international documents. Taking all this in to consideration, community level health promotion has been a success story in Hungary in the last two decades (Gergely 1993).

15.5 Integrating Health in Local Development Plans

15.5.1 The City Health Promotion Plan of Békéscsaba

The following case study aims to demonstrate a good example of a local health plan developed by Békéscsaba, a Hungarian city, located in a less developed, economically deprived region of the country Békéscsaba is one of the few Hungarian cities that have developed a long-term health strategy. The health plan is based on a thorough situation analysis, has set clear targets and is successfully embedded into the general, comprehensive development framework of the city.

15.5.2 The Socioeconomic Profile of Békéscsaba

Békéscsaba is the seat of the Békés county which is situated in South-East Hungary, close to the Romanian border. This region has always had a strong agricultural profile and has never been economically well-developed. Since the economic and political transition in the 1990s, the marginalised position of the region in terms of industrial production and the export in services has not improved. The gross domestic product (GDP) in Békés county is 59.5% of the national average and 38.8% of

the EU-27 average (KSH 2007). Regarding employment, the inactivity rate is 64% and the unemployment rate is four times greater than in 1990 (Békés megye területi jellemzői az európai uniós csatlakozáskor 2004). The county is characterised by a low density in population and negative demographic trends. In Békés county the birth rate is the third lowest among all Hungarian counties, yet has the highest mortality rate leading to the highest natural demographic decrease compared to other counties.

Békéscsaba has 67,000 inhabitants and, due to the number of administrative bodies, transport junctions and developing infrastructure, it is the most important and biggest city in Békés. The city is characterised by long historical traditions, a notable cultural heritage and a strong local identity.

15.5.3 Experience in Health Promotion Prior to the City Health Promotion Plan

Békéscsaba has been a member of the World Health Organization (WHO) Initiative "Network of Healthy Cities" since 1998. Thanks to a group of committed and skilled health professionals and especially a strongly engaged, charismatic expert, Békéscsaba has been an active member of the Hungarian Healthy Cities Association.

One of the key achievements of the last decade has been the establishment of the Intersectoral Committee on Health, composed of 21 members from different sectors and administrative bodies such as the public health office of the county, the local government of the city and the county, the district nurses, the family counselling centres, the police, various health care units, environmental authorities, and so on. The work of the Intersectorial Committee is coordinated by the health office of the local government. Among others this office is responsible for the implementation of the programmes linked to the Healthy Cities Network.

In 2000 a "Health Profile" was carried out by the local government to assess the health status of the population and to map the health assets of the city. This report later served as a starting point and provided baseline measures for the development of the City Health Promotion Plan.

15.5.4 The Development Plan of Békéscsaba: A General Framework

Before 2004, when Hungary joined the EU, some cities launched development plans for the application of EU grants, most importantly to the Structural Funds. The local government of Békéscsaba also prepared a so-called City Development

Plan (Városi Egészségfejlesztési and Békéscsaba 2004) for the city. The Plan consisted of several sub-programmes such as an Environment Protection Plan, a Housing Programme, a Social Policy Service Planning Concept and an Education, Culture, Sport Concept. With special respect to the objectives and activities of these sub-programmes the Settlement Development Plan was completed by a Health Promotion Plan.

15.5.5 Setting up the City Health Promotion Plan

The City Health Promotion Plan (Városi Egészségfejlesztési and Békéscsaba 2004) was prepared in 2003 and set objectives for a time frame of ten years, from 2004 to 2014. The Intersectorial Committee on Health was responsible for defining the fundamental priorities and key objectives of the Plan. Strong links were established with other sub-programmes within the comprehensive Settlement Development Plan, and the objectives were built upon the programmes of the Healthy Cities Network as well as upon the aims of the National Public Health Strategy (MoH 2003).

As a next step working groups elaborated each objective and provided a detailed description about the activities. The first draft was commented by the corresponding expert committees of the local government. This amended version was launched on the website of the self governance for a public debate. Based on the citizens' opinions and comments the second draft was launched by the Intersectoral Committee. After a final approval of the Health Committee of the local government the General Assembly accepted the plan.

15.5.6 Key Objectives of the City Health Promotion Plan

The objectives were defined along the principle that promoting and maintaining health has to be based on partnerships and multisectorality. It is clearly stated in the document that developing health is the most effective investment for the future. Therefore it is a fundamental task and interest of the local government to strengthen the assets of individuals and communities, and to foster existing programmes and structures in health development. It is strongly emphasised that promoting health goes beyond the health sector, thus all objectives have to be linked with work programmes of other sectors such as environment, education, and so on.

The plan declares medium-term and long-term objectives. On long-term, until 2014 the plan aims:

- To visibly improve the quality of life of the population
- To increase the number of healthy life years by 3–4 years
- To decrease premature mortality by 5%
- To reduce the number of people suffering from addictive behaviours by 7%
- To decrease the smoking prevalence by 5%
- To reduce fat consumption by 10%

- To decrease the prevalence of abortions by 10%
- To close the health gap for marginalised people
- To make healthy lifestyles a social norm
- To establish and to foster intersectorial cooperation in health
- To develop health prevention services and to increase the number of community-based leisure time health promotion programmes by 40%
- To improve the cost-effectiveness and the quality of health care

These objectives should be implemented through five programmes:

Programmes for creating a supportive environment for a better health.These programmes address in particular youth and the elderly in various settings. Several programmes aim to tackle health inequalities and target discriminated and marginalised groups, especially Roma people, unemployed, homeless people, disabled people and youth-at-risk.

1. Programmes for healthy lifestyles. These programmes cover smoking cessation, prevention of drug use and excessive alcohol consumption. Fostering healthy nutrition and strengthening physical activities are also integrated into the programmes.
2. Programmes for environmental health. These programmes are strongly linked to other developmental projects of the city such as creating a new system of waste management, building bypass roads to avoid the built-up area of Békéscsaba, and the eradication of ragweed or to improve drinking water quality. Moreover, the programmes also include education programmes for school children and establishing a population-based information system on environmental health.
3. Programmes for preventing premature mortality. The programmes are implemented against four major non-communicable health threats: cardiovascular diseases, cancer, mental health problems and musculoskeletal disorders. Certainly all programmes are interlinked to other programmes on smoking cessation, prevention of drug and excessive alcohol use, promoting healthy nutrition and physical activity as well as strengthening environmental health.
4. Programmes for screening tests. Information campaigns are organised to increase the participation in screening tests such as cancer screening, blood pressure screening, mammography and cervix screening.

15.5.7 Main Assets of the City Health Promotion Plan

Applying the concepts of Kretzmann and McKnight 1993, the assets tackled by the City Health Promotion Plan of Békéscsaba can be described as follows:

1. *Primary building blocks*: referring to the assets and the capacities located inside the neighbourhood and largely under neighbourhood control.
   In Békéscsaba there have been a number well-functioning services and organisations in place representing the positive capability of the city to identify key challenges and to activate solutions in health promotion.

First, the city has always shown a true commitment towards promoting health and tackling health inequalities. A series of examples illustrate these efforts, as described above, such as the active membership in the Healthy Cities Association, carrying out a situation analysis in health, etc. The leadership of the city showed a generally positive approach towards health promotion which was proved by establishing an Interesectorial Committee on Health, supporting the work of the expert team and maintaining a good relationship with civic organisations.

Second, probably due to the long historical traditions and the notable cultural heritageof Békéscsaba, its citizens have developed a strong local identity and social cohesion. It should be emphasised that this positive cooperative attitude was an important pre-requisite for launching the Settlement Development Plan. The sub-programmes of the plan from other sectors served as an essential reference point and created crucial links with the health targets: for instance reconstructing the waste management system has clearly a decisive impact on health.

Third, a number of civil organisations, local foundations and clubs play an essential role in health promotion in Békéscsaba and they are integrated in the implementation of the City Health Promotion Plan. A voluntary peer group, "Támasz–Téka", and a so-called self-knowledge programme, "Érted! Érted?" both target youth. A pregnant women club, a telephone hotline for the elderly and a cooking club are also important instruments in reaching the goals of the City Health Promotion Plan. Two foundations, the Dr Baly Mental Health Foundation and the SOS Teenager Foundation, make significant contributions to develop the health of Békéscsaba's citizens.

2. *Secondary building blocks*: referring to the assets located within the community but largely controlled by outsiders. The City Health Promotion Plan builds, to a large extent, upon those services which are located within the community but run by the government at national level. Such services are provided, for instance, by the district nurses who are in charge of counselling pregnant women and families with newborn babies. All pregnant women have to consult a district nurse in order to be entitled for maternity allowance by the state. Thus district nurses have direct and intense access to these population groups. Another key asset is given by the drug coordinators at schools. In Hungary all schools have to appoint a drug coordinator who is responsible for implementing drug prevention programmes. Moreover, a Drug Coordination Forum has to be set up by each local government to keep drug prevention high on the agenda. In addition, the Roma Minority Local Government, which exists in many local governments, ensures better access for the Roma population and makes notable contributions to the development programmes.
3. *Potential building blocks*: referring to resources originating outside the neighbourhood and largely controlled by outsiders. The New Hungary Development Plan and the EU Structural Funds are important catalysts in initiating development strategies at local levels and they ensure the appropriate funding for their implementation.

15.6 Conclusions

Current approaches to define development come under four headings:

- Economic growth
- Reduction of inequality
- Reduction of poverty
- Maximization of individual capability in these terms
- Investing in health is critical to economic productivity and human development
- Greater equity promotes economic growth and human development

The WHO document, Health: a precious asset makes the case that health is both an input and an outcome of development. The argument is as follows: *"If health is an asset and ill-health a liability for poor people, protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors - economic, environmental and social" (WHO 2000; p 20).*

The WHO document puts forward three action proposals:

- Strengthen global policy for social development
- Integrate health dimensions into economic and social policy
- Develop health systems to meet the needs of poor and vulnerable populations

The Nobel Laureate economist Amartya Sen (1999) provided a more focused analysis. Agreeing that *"good health is an integral part of good development",* he went on to argue that low-income countries should use "support-led" processes, focused strategically on more health care, education, and other social programs.

So there is a sound rationale to extend the conceptual framework of the assets approach in health to the key developmental investments and processes of development. We hope the example of Hungary offers some evidence for it.

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