SHORT THESIS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY (PhD)

THREE DECADES OF HEALTH PROMOTION IN HUNGARY IN THE LIGHT OF GLOBAL CHALLENGES AND POLITICAL CHANGES

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Three decades of health promotion in Hungary in the light of global challenges and political changes

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1. Background and objectives

Health promotion brought a new mindset, approach and methodology in health policy. The concept was born as a response to the overwhelming medicalization of health in the early eighties of the last century throughout the consultations of the World Health Organization (WHO). The term and the strategy of health promotion gained ground in global and national health policies by means of the so-called Ottawa Charter (1986) approved by the 1st International Conference of Health Promotion.

The purpose of the thesis was to demonstrate how health promotion emerged as part of health policy and in which extent it was applied in practice in Hungary. It was worthwhile to explore the antecedents of health promotion in epidemiology and in international health as well as it links with the trends of global health and the developments in Hungary. I also wished to find answers to why my country could become flagging from the position of pioneering in health promotion in Central Europe.

For the analysis, international and domestic policy documents, publications were reviewed and structured interviews with nine key public health figures of the last 30 years were carried out.

Based on the lessons drawn from the interviews and conclusions of other sources, suggestions were made to renew health promotion practice and criteria were outlined for elaborating a new complex public health program.

2. Summary of the content of the thesis

A.

Epidemiological follow-up, comparison and intervention studies led to the scientific foundation of health promotion.

In the middle of the last century in the developed Western world, mortality from communicable diseases was replaced by deaths of chronic, non-communicable diseases, particularly mortality from cardiovascular diseases. A wide range of international research tried to explore the causes of the epidemiological transition. Research also developed the concept of risk factors and clarified that the different types of risk patterns are associated with various lifestyle, morbidity

and mortality models. It became obvious that the onset of lifestyle-related diseases could be influenced by various socio-economic, cultural and environmental factors. The results of these investigations were summarized by Geoffrey Rose, who evolved the two basic courses for prevention of chronic non-communicable diseases: the population level and the high-risk approaches. His work provided evidences from the point of interventional epidemiology for the North Karelia community prevention program (Finland) cited a number of times since then. This program confirmed not only the suggestibility of risk status as well as morbidity and mortality conditions of the communities concerned in a favourable way, but also showed that in a given country health inequities determined by social and economic circumstances could be reduced by whole-in-society type interventions.

The increasing scientific knowledge on preventing diseases was translated to policies by the former health minister of Canada, Marc Lalonde in 1970s. He prepared a report on the health of the Canadians emphasizing the role of socio-economic determinants of health. As a matter of fact, Lalonde proposed an intersectoral program for health promotion while he applied the term of health promotion for the first time. He came to the conclusion that the prominent role of health

should be incorporated to the constitution of the country, as a policy objective and he offered his work as a contribution to the renewal of public health within WHO.

As early as in 1948 the Constitution of WHO formulated the still valid definition of health by saying that “health is a state of complete physical and social well-being and not merely the absence of disease or infirmity”, actually one of the basic human rights. The Alma-Ata Declaration of 1978 re-affirmed this statement. It was the first international document which ascertained that achieving health had to be one of the most important goals in a society. It was also the first time that an official WHO recognized the impact of social, economic, cultural and environmental effects on health and the importance of reducing health inequities.

The spirit of the Declaration of Alma-Ata lived on and continued at the 1st International Conference on Health Promotion resulted in the Ottawa Charter now considered to be the basic document of health promotion. The subtitle - The move towards a new public health - clearly expressed that health promotion aimed to spread a new approach in public health and health policy. The term of health promotion was defined as "the process of enabling people to increase control over, and to improve, their health.”

Selected areas of the Ottawa Charter as well as new developments in health promotion were further considered by subsequent international conferences, including the most recent one in Helsinki in 2013. The Helsinki Statement on Health in All Policies reinforced the legacy of the Ottawa Charter, namely in respect of putting across the health aspects in all public policies and of the early elimination of health inequities.

Due to the openness of the then Hungarian politics, health policymakers could attend the Ottawa Conference. The outcome document was not only translated and spread, but Hungary became the first state socialist country where the Council of Ministers Decision announced a "Long-term social program of health promotion" in 1987.

This strategy was characterized by intersectoral approach and the attached plan of action made obvious financial requirements for implementation. Thinking went far beyond the health sector towards an overall collaboration within the society for improving health of the population. It was a setting and lifecycle focused program ahead of its time, a very much project-oriented one with an unambiguous priority to control non-communicable diseases.

Political changes in 1990 blocked activities under the health promotion program of 1987 and as part of the transformation of the whole health system, a new agency was created in the form of the National Public Health and Medical Officer Service (National Public Health Service). A new law designated the public health service to be responsible for health promotion and disease prevention strictly within the frame of the health sector (1991).

Some years later, the first public health program after the regime change was elaborated with elements of health promotion (1994). This document, out of respect for the then Chief Medical Officer is still referred to "Kertai program" by the profession. Five national objectives and a number of tasks were outlined, which with different wording and different indicator values, but essentially remained unchanged in later strategies and guidelines

The "Kertai program" came into effect in the period of signing a loan agreement between Hungary and the World Bank to assist closing up the health system to international standards. The projects aimed to modernize the health care and to improve the health status of the population by piloting and introducing modern public health measures. While the World Bank sponsored provisions had approved management plans in

detail and received funding until 1998, the Kertai program fell prey to the economic stabilization and gradually wasted away. Unfortunately the World Bank projects were closed down prematurely because of political disputes between the donor and the government; only the Health Services Management Training Centre and School of Public Health in Debrecen remained sustainable.

The Law on Health (1997: CLIV) reflected the perception of the Ottawa Charter for Health Promotion, and in accordance with the spirit of the law a draft strategy was published titled "The future of health". This paper identified the main directions for improving health by 2010, but as it used to be in Hungary, it did not survive the change of government.

After the turn of the millennium Minister István Mikola returned to the principles of the "Kertai program" and had a new document elaborated under the title "Public Health Program for a Healthy Nation.". It is interesting to note that between the World Bank project and two government strategies hallmarked by Kertai and Mikola there was only one common action area, namely building the necessary network for breast cancer screening. The continuity was missing.

After the elections of 2002 again a new public health strategy was developed under the guidance of Minister Judit Csehák and Secretary of State Zsuzsanna Jakab called the "National Program of the Decade of Health." It was adopted by the Parliament with large majority. The first two-year implementation of this policy framework was well planned and managed in detail, but after a promising start the leadership of the program weakened and funding dropped significantly.

An innovative opportunity of managing health promotion and public health appeared by the establishment of the so-called Inter-Ministerial Committee on Public Health and the appointment of the Government Commissioner for Public Health (2005). However, these organizational arrangements proved to be short-lived and did not enjoy sufficient prestige in high politics.

After the change of government in 2010, though the program was not officially terminated, the implementation has not been paid attention to. The Semmelweis Plan (2011 contained promise for a detailed assessment for the "National Program of the Decade of Health" and for working out a new public health program by 2013, for the closing year of the previous program, but this did not happen until the cut-off this thesis.

After 2010, largely prohibitive regulations provided the backbone of public health measures. Based on the view of analysts, this content of legislation for health promotion was largely driven by economic interests of some groups, rather than public health considerations. The positive steps (increase in excise taxes on tobacco products, restricting food containing trans-fats) are one-sided (not associated with wider initiatives such as health promoting public catering) and do not fit into an overall concept. Neither political commitment nor intersectoral cooperation in the interests of health is palpable. The stable financial background for public health (health promotion) is also absent.

B.

For the evaluation of public health and health promotion activities of the last thirty years, professionals were asked who participated in shaping health policy in the capacity of decision-makers, university lecturers or program managers. Nine conversations took place in autumn 2012. The interview questions were as follows:

• How do you see the development of health promotion concepts and practice in Hungary since the birth of the Ottawa Charter (1986)? How did the successive governments adapt to

the challenges of global health? What were their key achievements and shortcomings?

• Which forces did influence the process beyond health governance? Which of them did strengthen, which weaken the position of health promotion?

• Where are we now? What are the most urgent tasks?

• Who could be the best alliances in promoting health?

• How health promotion will change in Hungary and in the global arena? What is the future of health promotion?

• What is your assessment on the governmental guidance, coordination and financing of health promotion in the last three decades?

In compliance with their request, the respondents do not appear by name in the dissertation.

The interviews clearly showed that wave crests alternated with and wave troughs in governments' attitude on health promotion. Apart from some exceptions the leading policymakers were replaced each or at least every second year, at the same time the institutional system of public health itself was constantly changing. Programs, initiatives in health

promotion (and public health) were largely dependent on personal interests and motivation of consecutive health ministers; many promising ideas failed before institutionalization due to personal changes at top level. Project approach at planning public health actions was missing in most of cases, monitoring and evaluation plans as well as schedule for communication were not prepared. The health promotion practice, in spite of the available modern theoretical base, got stuck at the high-risk approach. As a consequence, only screening (secondary prevention) programs survived the frequent changes of governments, health ministers and public health priorities. The occasional high quality of activities could not rely on a stable guard of professionals and despite internationally recognized, outstanding education facilities public health intelligence have not reached a critical mass.

Governments did not feel ownership for the concept of investing in health, and failed to introduce health impact assessments. Intersectoral work was hampered by the frequent changes in government positions, the constant transformation of the institutional structure, the lack of culture of horizontal cooperation and the insecurity of resource mobilization; while - as every interview emphasized- untenable health inequalities would have demanded a “whole –of government” approach for

health. Over the past thirty years, public health programs were lacking targeted resource allocation for multisectoral actions for the underprivileged. Focus was put on the middle class. As regards the future of health promotion in one respondent noted: "Health and health promotion will be available for all those who can afford. However, the disadvantaged groups of the society continue to have campaign type events – for the sake of vote maximization at the elections". A minimum ten years' programs in public health can only set if an accurate and careful planning and a budget for the entire duration of the program is provided. The annual budgetary logic undermines the credibility of long-term programs, even if they are well designed and seem to progress.

3. Conditions of the reorganization of health promotion in Hungary

Reviewing the past 30 years of health promotion internationally and at home one could ascertain that the Ottawa Charter is a still a guiding document for this field. Its findings are held true to date:

• improving the health of the population is unthinkable without healthy public policies and a full government responsibility for health;

• eliminating environmental and social risks have a decisive impact on the reduction of mortality and morbidity indicators;

• community and civil collaboration can stimulate the political commitments for health;

• by the means of developing individual skills it is achievable to make the healthier choice the easier choice;

• creating a more open and transparent health system susceptible to the lifestyle, cultural attitudes and social conditions of its clients the effectiveness of prevention and care could be improved.

Currently our country has no long-term public health and health promotion program. Evaluating the practice of the last three decades, the following criteria could be taken into account for elaborating a new program:

First, it must be recognized that promoting health is nothing more than an investment. This entails the breaking with the

prevailing view. Health promotion, but the entire public health should no longer be considered as merely a wasteful welfare service. It cannot be marked as a “non-producing” underrated sector, the perpetual victim of cuts, the "scapegoat" of public deficits, or just a battlefield of political interests. There is a need to break with the approach underestimating the macro-economic weight of investments in health, the narrow-minded views, and health should be highlighted as a priority based on its real social value. This perception could be put on place if all relevant legislation was linked with an appropriate health impact assessment.

Second, one has to adapt to global trends. The role of the health is increasing in international relations and at the agenda of global summits. Today, health has a security dimension (pandemics caused by unknown pathogens may paralyze countries, continents); an economic impact (the health sector is seen as a USD 7 trillion global growth industry); there is a foreign policy context (international conventions are negotiated to curb the risks) and health is on the social justice agenda, which advocates for health as a social value and human right (as health inequities reflect social and income differences). To some extent, health diplomacy as a new discipline may integrate the global context of health

promotion. That is why it would be important to take up the so-called "smart governance for health" recently introduced by a couple of European countries. It may be helpful to call for a national consensus conference, which can modernize the terminology of public health and health promotion, as well as related concepts.

Third, there is a need to build capacity and knowledge. Critical mass of public health professionals with advanced knowledge can help to make a difference - if the government is willing to offer an employment for them.

Fourth, the revitalization of health related NGOs, clubs in settings where health is created are essential. Inspiring their activities, expanding their rights could contribute to multi-stakeholder decision-making and a rational burden sharing in health promotion.

Fifth, it is worthwhile to apply proven recipes. The methods and actions used in the North - Karelia Project in Finland offer an appropriate model for Hungary with the chances of success. There are even modern nationwide health programs, for instance in Ireland with similar aptitudes to Hungary, which is also worth study.

4. New results of the dissertation

Among the novelties of the thesis it should be noted that the Hungarian history of health promotion in the context of health policy has not been analysed previously.

New findings:

A) In the absence of political commitments, health promotion has not become an integral part of the socio-political thinking, among others because the approach of decision-makers is still conservative: the ruling paradigm is that the health system should take on responsible for the health status of the population. Nota bene most of the citizens have the same beliefs. The situation is characterized by the legislative practice: the modern concept of the Law on Health (1997) was not assumed in its sub-laws, executive decrees.

B) The traditional biomedical approach to health and the vertical structure based public administration slowed down intersectoral health promotion thinking and mechanisms, including modern governance for health.

C) In Hungary, the policy orientation in the context of health promotion (public health) was in respect of the ideological

base of successive governments rather than international expectations. There was no insight on the nature of investments in health promotion; policymakers did not understand that most of the health promoting actions had no short term impacts to be communicated at the end of the political cycles.

D) Political instability and economic recession made the application of modern principles in health promotion difficult (however, promising public health programs with strong health promotion approach have arisen during the period of progressive political processes and economic growth: from 1986 to 1989 and from 2001 to 2003). The lessons learned include that without long-term fiscal guarantees there is no sustainable health promotion.

E) Health promotion practice even in brief upward periods did not focus on vulnerable social groups; at the most there were attempts to provide better access to health services.

F) Underdevelopment of non-governmental sector, weak middle class in being a source for fund raising and the over-taxation of businesses made it impossible to replace or supplement financing of health promotion projects when budgetary and international channels closed up.

G) The renewal of health promotion in Hungary assumes: the break-up with the view underestimating the macroeconomic weight of health; recognizing and adapting to global health trends; smart governance for health with appropriate governmental structures; increasing employment of public health professionals in other sector than health and promoting NGOs in public health (health promotion).

5. Acknowledgments

Having started my career as a medical practitioner my professional course of life has always focused on health promotion or public health. Long list of professional and political actors could be named who have raised and constantly maintained my interest in health promotion, however, due to space reasons; I can only mention some of them.

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List of publications related to the dissertation

1. Kickbusch, I., **Kökény, M.**: Global health diplomacy: five years on.
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